



# The Life and Times of Individual Disability Insurance

By Rebecca Scotchie and Derek Coburn



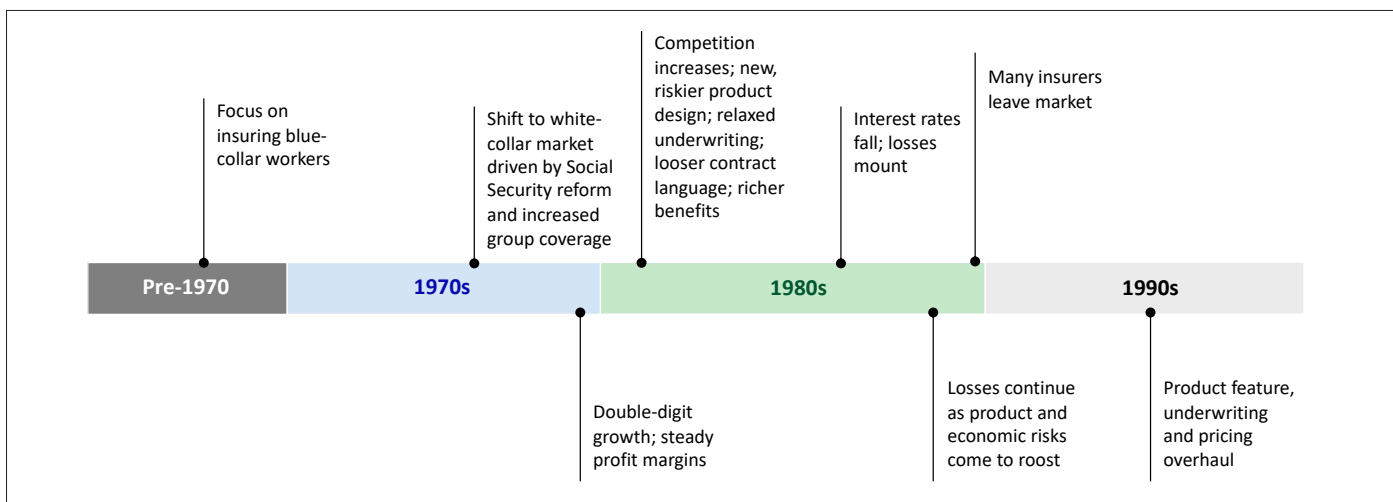
Often overlooked by consumers and even insurance professionals, individual disability insurance (IDI) is a \$4.8 billion market that achieved \$413 million of sales in 2018.<sup>1</sup> Although impressive, IDI sales are a fraction of life insurance and annuity sales and represent only single-digit market penetration. This low penetration is accentuated by the fact that more than one in four workers is expected to be out of work at least a year due to a disability.<sup>2</sup> This article explores the history of IDI, its high and low points and how actuaries have learned from the past to navigate product development and in-force management in today's marketplace.

More than one in four workers are expected to be out of work at least a year due to a disability.

## IDI'S SORDID PAST

IDI's modern form came about in the mid- to late 1970s as insureds shifted from blue- to white-collar professionals. Social security disability reform and increased group coverage left less room for IDI to cover lower-wage workers. The white-collar market proved very lucrative, and for the decade that followed, insurers saw consistent double-digit percentage increases in sales along with steady profit margins. As noted in Figure 1, the good times did not last, as rapid market growth led to increased competition and riskier product innovations.

Figure 1  
Recent History of IDI



Relaxed underwriting standards, looser contract language and continuously increased maximum monthly benefits became table stakes as insurers fought for market share. Risk management became secondary to growth. Even more troublesome was the increased creation and sale of product features that disincentivized claimant recovery, such as:

- true (or pure) own occupation, which pays full benefits if an insured is unable to perform the material duties of his or her occupation regardless of whether the insured collects income from another occupation;
- lifetime benefit periods, which pay benefits until claimant death;
- cost-of-living adjustments (COLA), which increase benefit payments by either a fixed or inflation-linked percentage; and
- increased maximum benefit amounts, \$10,000 per month or more, and increased income replacement ratios.

As liberalization of benefits and features continued, interest rates began falling, impacting what had been a major profit lever for IDI. In the late 1980s and early 1990s, the riskier features and economic factors finally caught up to insurers, and large losses were seen across the industry. To compound matters, the majority of IDI policies were sold on a noncancelable basis (i.e., premiums could not be increased), leaving insurers unable to correct past mistakes. The losses were so severe they caused many insurers to leave the market entirely.

During the 1990s, remaining market participants overhauled products and processes. Policy features that were overly liberal were removed or revamped and underwriting guidelines were tightened. Restrictions were put in place for many riders, and benefit amounts were reduced or held steady. Given emerging experience, pricing was significantly adjusted, with pricing for physicians most affected. Retrenching in the IDI market set insurers back on the path of profitability, and the lessons learned still influence decision making today.

### BEST PRACTICES FOR IDI PRODUCT DEVELOPMENT TODAY

To avoid the pitfalls of prior generations, product development of today should be performed with careful collaboration. The first step to new product development is to build a team that has subject-matter experts from sales, underwriting, claims, compliance, legal, finance and actuarial (pricing and valuation), with all playing active roles. Exclusion of key constituents could lead to suboptimal product development with key risks being missed. Learning from the mistakes of the past, actuaries and the broader product development team need to think broadly and beyond first-order impacts to be successful.

When developing new product features or riders, it is imperative to not only consider new stand-alone assumptions but also contemplate any impact a new feature may have on base policy assumptions. Examples include the following:

- **Negligible impact.** A survivor benefit that pays out a small lump sum upon a claimant's death should have little to no impact on the base policy's incidence or termination rates.
- **Substantial impact.** The presence of a COLA rider can have a material impact on claimant termination rates, necessitating that the COLA rider charge consider not only increased benefit payments but also increased time-on-claim, of both the base policy and any other existing riders.
- **Uncertain impact.** Residual benefit coverage, which allows for reduced payments when an insured is still able to work part-time, might reduce overall claim payments and increase recovery rates by offering insureds a path to return to work. Conversely, a disabled individual currently working full-time may be encouraged to reduce workload and receive benefits.

To understand potential second- and third-order impacts, actuaries must drive—and not merely participate in—collaboration among the product development team.

Further, actuaries need to apply risk mindfulness and critical-thinking skills beyond simply relying on data. Data only informs on the past based on past conditions and does not provide insight into how a new rider will be interpreted under current underwriting guidelines or inform the potential motivation of those who will use the benefit. The actuary must ensure questions are asked and resolved. By fully engaging, they avoid potential for misinterpretation, miscommunication and mispricing.

In having product development be a collaborative effort instead of a siloed, sales-driven or data-driven mission, actuaries can help IDI carriers avoid the mistakes of the past.

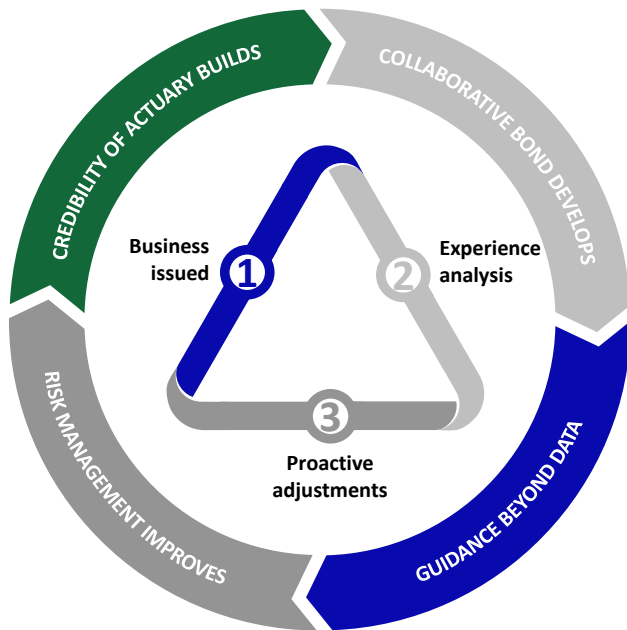
### THE FEEDBACK LOOP: EXISTING BUSINESS ANALYSIS FEEDS UNDERWRITING DECISIONS

Although an imperative component of sound product development, proper risk management does not guarantee success. Economies, regulations, technology and people are changing faster than ever; appropriate guidelines or language from a few years ago could expose an insurer to outsized risk today. Exacerbating risk further is the asymmetrical premium/claims pattern and the long-duration nature of IDI business. IDI premiums are generally level, while claim payments are low when policyholders are younger and grow at older ages. Therefore, it can take years before material risks are identified. This experience lag was a major contributor to the large losses in the 1980s and 1990s.

### What Can be Done to Eliminate the Lag?

Establishing a feedback loop promotes active analysis of both existing and newly written business and regular communication between actuaries, claim specialists and underwriters, steering future direction and informing decision making. Building the feedback loop, as noted in Figure 2, requires trust and time, with recognition by the actuary that connections and credibility must be formed with those on the front lines.

Figure 2  
Feedback Loop



A common pitfall of actuaries is falling back on a great wealth of aggregated data, rather than seeing the benefit of anecdotal or singular information points. For most insurance, and especially IDI, problems start on a small scale. Underwriters and claims specialists are the first to see problems emerge. Being able to identify and rectify issues before they become catastrophic problems will avoid repeating the mistakes of IDI’s past.

Central to the feedback loop is the relationship between key stakeholders. The actuary’s skills can be leveraged to improve underwriting and claims operations. Using the wealth of data available and deep modeling skills, actuaries can provide items such as the following to better manage risk:

- risk dashboards that show key underwriting or claims metrics against historical benchmarks or limits;
- risk scores that apply historical experience to recently sold business to estimate future performance; and
- tools that allow underwriters to quickly look up similar policy or case situations and see key experience metrics.

By listening, understanding needs and providing valuable assistance, actuaries will form a collaborative and beneficial bond with their underwriting and claim counterparts.

As trust and credibility build, underwriters and claim specialists will proactively bring ideas and issues to the actuary, ranging from organization-changing concepts to simple and interesting trends on recent policyholder applications. These one-off conversations are vital in understanding emerging risks within insurance products like IDI. They provide insight with an immediacy not found in data. But they do not happen unless a bond is formed, which often requires time and effort beyond what might be construed as the “normal” role of an actuary.

### Example of the Feedback Loop

The actively-at-work (AAW) requirement commonly found on guaranteed-standard issue (GSI) IDI policies generally states that if an individual has been actively working at his or her employer for a specified length of time without taking time off for a disability, then that person is entitled to an IDI policy with no additional underwriting required. This simplified underwriting approach has worked well for insurers, and the market for GSI IDI continues to grow as a result. However, as medical technology advances and workplace economies shift, so too must the thinking around what it means to be “actively at work.” Ten years ago, if an applicant had cancer, the individual would almost always have to take time off from work to address the condition and thus not be considered actively at work. Today, between targeted chemotherapy treatments and the ability to work from home, individuals who have cancer may be able to correctly claim that they have been actively at work despite their condition.

If an actuary failed to be collaborative and solely focused on data, this developing trend could go on for years before any impact was discernible. Instead, when the feedback loop is well established, it may take only a few weeks or months before claims, underwriting and the actuary are informed of the emerging trend. This speed means solutions can be developed before profitability is significantly impacted.

### THE FUTURE OF IDI

Despite the past trials and tribulations of IDI, the future looks bright. Increasing numbers of brokers and individuals recognize the need for supplemental income protection.

The most important means to increase market penetration is to increase education and raise awareness regarding the need for disability insurance coverage. Technology makes it easier to address the needs associated with the sales and enrollment process as well as with data analysis and risk management. The latter, further facilitated through communication and feedback, is now at the forefront of both product development and in-force management. Although there will always be risks associated with long-tailed products like IDI, actu-



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aries are well equipped to address product challenges and to continue serving insureds and shareholders successfully and profitably. ■

#### ENDNOTES

- 1 U.S. Individual Disability Market Survey: Summary of 2018 Results. Gen Re Research, 2019, <http://media.genre.com/documents/surveyhidsum1905-en.pdf> (accessed March 10, 2020).
- 2 Maleh, Johanna, and Tiffany Bosley. Disability and Death Probability Tables for Insured Workers Born in 1997. Social Security Administration, October 2017, <https://www.ssa.gov/oact/notes/ran6/an2017-6.pdf> (accessed March 10, 2020).



# SECURE Act 2019: A World of Opportunities for Annuity Carriers

By Ian Laverty

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The Setting Every Community Up for Retirement Enhancement Act of 2019, now referenced as the “SECURE Act of 2019,” was enacted into law in the United States in late 2019 and became effective January 1, 2020. While this appears to be a case of the bill’s authors coming up with the acronym before determining what the letters stood for, that shouldn’t detract from the excitement it should create for annuity carriers.

The SECURE Act achieves its goals on several fronts, including expanding the availability of retirement plans, loosening or eliminating limits on contributions and participation, and generally increasing flexibility regarding tax-qualified retirement savings. As part of this, and the key focus of this article, there was an intentional removal of what were widely considered impediments to offering annuities within 401(k) and other similar defined contribution (DC) retirement plans.

## THE OPPORTUNITY

According to research statistics published by the Investment Company Institute (ICI), Americans held \$8.5 trillion in DC retirement plans at the end of the third quarter of 2019. Of that, \$5.9 trillion was held in 401(k) plans, \$1.1 trillion in 403(b) plans, and \$342 billion in 457 plans. These are the three largest types of qualified DC plans in the United States, representing over 24% of U.S. retirement assets. All three were explicitly modified by the SECURE Act to make offering annuities in retirement plans more attractive for consumers, plan sponsors, and annuity writers.

According to other ICI research performed using data through 2016, \$335 billion was contributed into DC retirement plans



in 2016, and that number has been growing at a pace of about 7% each year since 2010. If that growth continues, contributions could well exceed \$400 billion in 2020.

Now consider this: According to LIMRA Secure Retirement Institute, individual deferred annuities contained just north of \$3 trillion of assets at the end of the third quarter of 2019. Of that, nearly 70% is held in variable annuities, which may have relatively less appeal than in the retail market as they would often be competing against similar investments offered within retirement plans. However, variable annuities offer insurance benefits that are generally not available within a typical DC plan and may provide access to some investments not otherwise available under the plan. Accordingly, there will still be a role for variable annuities within a DC plan. Non-variable (fixed, indexed, structured, and payout) annuities, however, likely stand to gain the most. They can be sold as alternatives to fixed income investments and/or lifetime income solutions. As of the third quarter of 2019, contributions to individual deferred annuities were on pace to total \$240 billion in 2019, with just over \$155 billion in non-variable annuities.

A limiting factor in today’s annuity market is that the average American’s knowledge and understanding of annuities is fairly limited. For those of us who have been working in the annuity industry in some capacity, when mentioning to people that “I work with annuities,” the most common response is undoubtedly, “What’s an annuity?” Because of that general lack of familiarity, annuities are much more often sold, not bought, by advisors with the expertise to educate those looking for ways to enhance retirement savings or income. Added to that, many advisors steer clear of annuities for a variety of reasons.

Consequently, there are a few challenges that limit the growth of annuity assets.

- Exposing retirement savers to annuities
- Providing easy access to annuities
- Educating retirement savers about the value of annuities

Including annuity offerings within DC plans will substantially reduce the first two, which easily present the largest hurdles. The third will remain an ongoing, but necessary aspect of offering annuities.

If even 5% of current assets in the defined contribution plans mentioned above finds its way into annuities, that's nearly \$370 billion of assets up for grabs. If only 5% of future contributions flow into annuities, that's conservatively \$20 billion of additional contributions per year and growing. Especially when considering only non-variable annuities, those contributions would drive significant growth in the annuity market.

## THE KEY CHANGES

The changes made by the SECURE Act that open up this opportunity relate to two previous impediments:

- Fiduciary responsibility
- Portability

### Fiduciary Changes

Previously, under ERISA, an annuity offered within a retirement plan subjected the plan fiduciary to the same duties and responsibilities as applied to any other investment option within the plan. Furthermore, in the case of a breach of fiduciary duties with respect to the annuity, the plan fiduciary was liable for any losses incurred resulting from the investment in the annuity and the insurer's inability to pay the guaranteed benefit.

The burden of the fiduciary duties associated with offering an annuity within the plan, and the potential liability of doing so, significantly reduced the willingness of plan sponsors to offer annuities.

The key change in the SECURE Act is the addition of an explicit safe harbor for annuities. The key parts of this safe harbor explicitly include:

1. The responsibilities of the fiduciary when selecting the insurance carrier are clearly stated and appears to be less burdensome.
2. Fiduciary responsibilities of the plan sponsor are not ongoing after the annuity is elected by the participant.
3. The annuity selected need not have the lowest cost (it is reasonable to believe this could be interpreted to conceptually apply to no longer requiring the highest credited rates and/

or income payouts). The overall value and attributes of the carrier may be considered.

4. Compliance with the above should absolve the plan fiduciary from liability resulting from the insurance company's inability to pay the guaranteed benefit.

### Portability Changes

Subject to some limitations and fiduciary responsibilities, plan sponsors are permitted to change available investment options offered within a plan. In some cases, fiduciary responsibilities may require the removal of investment options (even under the new, clearly defined fiduciary responsibilities outlined in the SECURE Act).

However, prior to the SECURE Act, if an annuity was removed as an investment option available under the plan, the participant may have been forced to:

1. Liquidate the annuity, paying any fees or charges associated with such liquidation.
2. Take the annuity as a distribution from the plan, which would be a taxable event and result in an early distribution penalty, if otherwise applicable.

There was no mechanism to move the annuity out of the plan without tax consequences. This reduced the willingness of sponsors to offer annuities and was also a deterrent to participants to elect an annuity, even if the plan made one available.

Various sections of the tax code were amended to address this lack of flexibility. The combined effect of these changes will allow an annuity to be rolled out of a qualified DC plan into an eligible retirement plan, including an IRA or individual annuity, without causing a taxable event or being assessed an early distribution tax penalty.

## THE FUTURE

As with any material change in law, there are a lot of unknowns. There is still significant work remaining to understand how to operate within the new law. From there, the administration, distribution, and operations necessary to take advantage of this market present another mountain to climb. However, the passing of the SECURE Act presents incredible growth potential for the annuity industry that is worthy of much attention from carriers.

The purpose of this article was to provide an overview of the changes brought about by the SECURE Act, which creates this opportunity in the annuity market. However, a great deal more remains to be discussed, such as:

- A deeper dive into the changes produced by the SECURE Act that create this opportunity
- The design and pricing of products for this market

- The potential operational challenges and solutions
- The potential distribution models

We anticipate covering various aspects surrounding this topic in more detail in future articles. ■



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# Term Life Insurance Survey Results

By Susan J. Saip

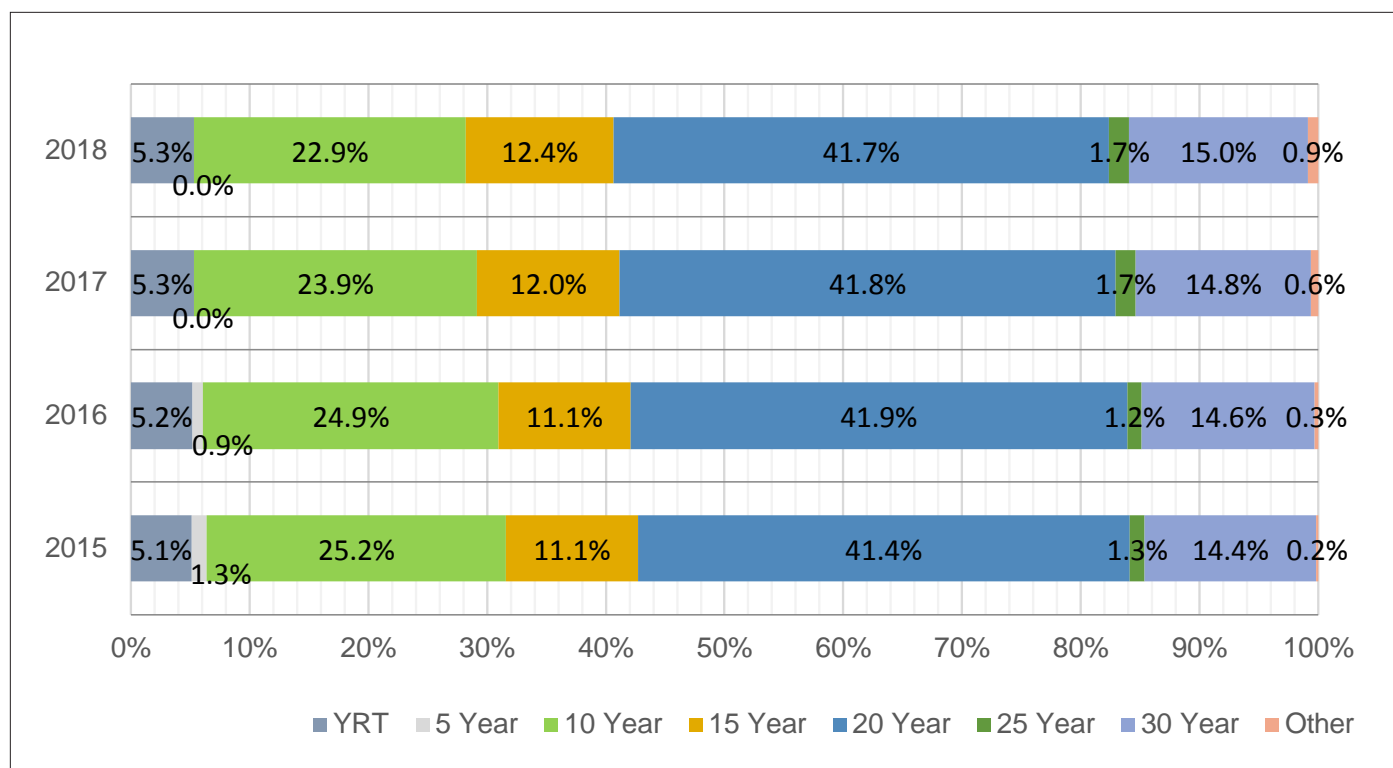
In 2019, Milliman conducted its second biennial survey on term life insurance, capturing historical data for key industry competitors, as well as company perspectives on a range of issues pertaining to these products into the future. The survey covered product and actuarial issues such as sales, profit measures, target surplus, reserves, risk management, underwriting, product design, compensation and pricing. Twenty-eight life insurance companies submitted responses.

A summary of the results of the survey is covered in this article, revealing trends in the U.S. individual term life insurance marketplace.

## TERM SALES

The graph in Figure 1 illustrates the level premium term period mix as reported by survey participants from calendar years 2015 through 2018. Term sales were reported for yearly renewable term (YRT), 5-, 10-, 15-, 20-, 25- and 30-year level premium term periods, as well as some sales in other level premium term periods. The market share by level premium term period was fairly stable for term products over the survey period, with the 20-year term at 41 percent to 42 percent, followed by the 10-year at 23 percent to 25 percent, the 30-year at 14 percent to 15 percent, the 15-year around 11 percent to 12 percent and YRT at about 5 percent. The market share over the survey period primarily shifted from the 5-year term (-1.3 percent) and 10-year term (-2.2 percent) to the 15-year term (+1.3 percent) and other term periods. Note that the shift away from the 5-year term was primarily driven by one participant.

Figure 1  
Level Premium Term Period Mix by Year





Of the 28 survey participants, six reported return of premium (ROP) term sales (included in the total term sales reported above). ROP term sales reported as a percentage of total term sales by all survey participants were 3.9 percent in 2017 and 4.0 percent in 2018. For these six participants, ROP term sales as a percentage of their total term sales ranged from 3.6 percent to 22.8 percent in 2017 and from 2.6 percent to 27.1 percent in 2018. ROP term sales were reported for 15-, 20- and 30-year term periods, with the majority in the 20-year and 30-year terms.

Total term sales were reported separately by underwriting approach. Underwriting approaches were defined as follows:

- **Simplified issue (SI) underwriting.** Less than a complete set of medical history questions and no medical or paramedical exam.
- **Accelerated underwriting (AU).** Any fully underwritten life insurance program that allows some applicants to forgo having a medical or paramedical exam and providing fluids, if they meet certain requirements and/or meet certain predetermined thresholds.
- **Fully underwritten.** Complete set of medical history questions and medical or paramedical exam, except where age and amount limits allow for nonmedical underwriting.

The distribution of 2018 term sales by underwriting approach was 7.1 percent SI, 19.0 percent AU, and 73.9 percent fully underwritten. We expect further shifting away from fully underwritten term sales as additional companies adopt alternative underwriting methods. Note that the distribution shown for AU sales includes only those policies that were eligible and ultimately qualified for the AU program. It does not include those policies that were eligible but ultimately did not qualify for the AU program. Also, the AU figures may be influenced by the makeup of the survey participants, which are traditional insurers (versus insurtech companies).

## PROFIT MEASURES

The predominant profit measure reported by survey participants relative to the pricing of new term sales issued today is an after-tax, after-capital statutory return on investment/internal rate of return (ROI/IRR). The average ROI/IRR target reported by survey participants was 9.8 percent. Profit margin is also a popular profit metric used by survey participants for term insurance. The average profit margin is 3.8 percent on an after-tax, after-capital basis.

Survey participants reported their actual results for 2018 relative to profit goals. For all term products, 11 percent of participants were exceeding, 50 percent were meeting or close to, and 39 percent were short of their profit goals. The primary reasons reported for not meeting profit goals in 2018 were low interest earnings and higher than targeted expenses.



## PRINCIPLE-BASED RESERVES AND THE 2017 CSO

Implementation of principle-based reserves (PBR), in accordance with the National Association of Insurance Commissioners (NAIC) Valuation Manual Chapter 20 (VM-20), was allowed as early as Jan. 1, 2017, subject to a three-year transition period. Half of the survey participants (14 of 28) intend to implement PBR in calendar year 2020. Twelve of the 28 implemented (or planned to implement) PBR in calendar years 2019 or earlier. The final two survey participants are not implementing PBR. Factors that impacted the rationale for participants' implementation plans include resource issues, levels of reserves under PBR, reserve solutions, system and modeling issues and New York state regulations.

Similar to PBR, the earliest effective date for the use of the 2017 Commissioner's Standard Ordinary (CSO) mortality table was Jan. 1, 2017, also subject to a three-year phase-in period. Twenty-three of the 28 survey participants implemented (or planned to implement) the 2017 CSO in 2019 or earlier. Four of the remaining five participants intend to implement the 2017 CSO in 2020. The final participant noted that implementation would be in both periods.

A description of the aggregation of mortality segments for purposes of credibility under VM-20 was provided by 24 of the 28 participants. The majority of participants expect to aggregate mortality segments across broad categories, such as all life products, all permanent products or all fully underwritten products.

Only five survey participants reported using or considering using third-party mortality consistent with the underwriting of their term business in order to increase the credibility of the company experience.

Participants were asked about their views regarding the impact of principle-based reserves on term product prices. Of the 27 responses, 15 participants reported that term prices will stay the same, seven reported term prices will decrease and five reported they will increase.

Term insurance is currently offered in the state of New York by 18 of the 28 survey participants. The New York version of PBR will be required for policies issued on or after Jan. 1, 2021. New York includes a floor that is equal to 70 percent of the current New York term insurance reserve requirements. Therefore, the minimum New York term reserves will be equal to the maximum of 70 percent of the current New York requirement and VM-20 reserves. Fourteen participants reported they plan to offer term insurance in New York on or after the required use of PBR (Jan. 1, 2021). Three participants do not plan to offer term insurance in New York after that date, five are not sure and the remaining six did not respond to the question.

### RISK MANAGEMENT

In planning for new term products under VM-20, 10 participants anticipate changes to their reinsurance structures in light of PBR. A variety of changes were reported, including ending captive structures and moving from coinsurance to YRT reinsurance.

Figure 2  
Place Rates

Basis	Number of Companies	Average	Median	Minimum	Maximum
<b>Fully Underwritten Term Insurance</b>					
Policy count	23	70%	69%	59%	99%
Face amount	18	71%	69%	61%	99%
<b>Simplified Issue Term Insurance</b>					
Policy count	9	67%	70%	33%	100%
Face amount	9	74%	70%	53%	100%

Figure 3  
Accelerated Underwriting (AU) Experience (Based on Policy Count)

Question	Average	Median	Minimum	Maximum
Percentage of business issued that was eligible for AU, assuming only the age and face amount requirements are considered	57%	53%	4%	94%
Percentage of business issued that was eligible for AU, assuming all requirements are considered	38%	39%	4%	77%
Percentage of cases eligible for AU that ultimately qualified to have requirements waived	40%	36%	10%	100%
Percentage of qualified cases that became sold cases	75%	84%	12%	98%
Percentage of cases that did not qualify for AU that became sold cases	63%	66%	42%	72%

In both 2017 and 2018, the percentage of new term business that was ceded by survey participants ranged from 1 percent to 100 percent, with an average of 44 percent. The median was 45 percent in 2017 and 38 percent in 2018.

### UNDERWRITING

Of the 28 responses, SI underwriting is being used by 12 participants, AU by 19 participants (with one additional participant to implement its program in 2019) and full underwriting by 27 participants. The ages and face amounts where these underwriting approaches are used vary widely among survey participants.

Place rates (defined as issued policies, excluding not taken policies, and then divided by those policies applied for) for fully underwritten and SI term insurance were reported by 24 survey participants. Responses are summarized in Figure 2.

Various statistics on the use of AU were compiled based on survey data relative to new term business issued in 2018. Figure 3 includes a summary of the questions and associated statistics (based on policy count). Results are quite variable, as is the experience that survey participants have with their AU programs. Some carriers just started their AU programs in 2019 and others have been using their programs since 2013–2014. If eligible, AU programs typically waive requirements such as blood, urine and other medical testing that is typically associated with full underwriting.

The use of predictive modeling in the life insurance industry continues to increase. Fifteen survey participants use predictive analytics in their AU algorithms. Six participants reported using predictive analytics in underwriting of term products under other underwriting approaches (i.e., other than AU).

No survey participants have yet received an objection from the state of New York regarding the use of external data sources, algorithms or predictive models. In January 2019, the New York State Department of Financial Services set forth new requirements in Circular Letter No. 1 (2019) for all insurers authorized to write life insurance in the state of New York. The letter includes requirements for insurers using “external data sources, algorithms or predictive models” in the underwriting process. Included in these new requirements is the prohibition of the use of these tools unless the insurer can demonstrate that their use is not unfairly discriminatory. The insurer must also determine that the external data or predictive model is based on sound actuarial principles or experience. It will be interesting to see the impact these new requirements will have on the future use of predictive modeling in the life insurance industry.

**PRICING**

The overall level of mortality experienced on term insurance relative to that assumed in pricing was reported by survey participants. Figure 4 shows the aggregate mortality levels that were reported for calendar years 2016, 2017 and 2018. The percentage of participants reporting that mortality rates were close to or lower than those assumed in pricing was 80 percent in 2016, 86 percent in 2017 and 86 percent in 2018. Note that, of the 20 participants reporting aggregate mortality levels, 12 included experience after the level term period.

Figure 4  
Overall Level of Mortality, Aggregate

Aggregate Mortality Rates	Number of Participants		
	2016	2017	2018
Close to expected	9	6	10
Lower than expected	7	12	8
Greater than expected	4	3	3
Total	20	21	21

Similarly, the overall level of lapses experienced on term insurance relative to that assumed in pricing was reported by survey participants. Aggregate lapse rates were reported for calendar years 2016, 2017 and 2018. Actual lapse experience on an aggregate basis was close to or lower than that assumed in pricing for 90 percent of participants in 2016, 77 percent in 2017 and 81 percent in 2018.

For the majority of survey participants, the overall level of conversion rates for the period from 2016 to 2018 was close to that assumed in pricing for all level premium term periods. With the exception of YRT and the 5- and 25-year term periods, the percentage of participants that reported conversion rates close to those assumed in pricing ranged from 78 percent (15-year term) up to 82 percent (30-year term).

The percentage of calendar year 2018 sales to permanent products (based on the number of policies sold) that originated from term conversions was reported by 21 participants. The percentage ranged from 1 percent to 50 percent, with an average and median of 17 percent.

**CONCLUSION**

As term carriers continue dealing with the implementation of PBR, the 2017 CSO mortality table, accelerated underwriting programs and predictive models, one wonders what the next significant challenge will be for the term market. The implications of these changes are yet to be seen fully, and monitoring of the results will be important in the years to come. How will actual term mortality experience relate to the new mortality table? What will emerging mortality experience look like for term products issued under AU programs? How will carriers react to potential new regulations relative to predictive modeling? Perhaps the next biennial term survey will have answers to these questions.

A complimentary copy of the executive summary of the December 2019 *Term Life Insurance Issues* report may be found at <https://www.milliman.com/insight/2019-Term-life-insurance-issues>. ■



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## Get Plugged in—New InsurTech Partnership

The SOA and Plug and Play relationship will allow InsurTech start-ups to validate their technology and modeling processes with actuaries. In turn, SOA members will have an exclusive look inside the world of emerging technologies.

These efforts will help with the development of fair and financially sound insurance products to better serve consumers.

The strategic partnership with Plug and Play demonstrates the SOA's commitment to providing its members with dynamic learning experiences, rewarding volunteer opportunities, and collaborative events where they can learn from the experiences and ideas of peers around the world. Through this partnership SOA members and start-ups can share best practices and advance ideas for the benefit of the insurance industry, regulators and the public. The SOA and Plug and Play [officially announce this partnership](#) to support an exchange of knowledge between actuaries and start-ups. ■

