

Prepared by:
Carl Friedrich
Teresa McNeela

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Chronic illness accelerated benefit riders



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DISCLAIMER OF LIABILITY

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EXECUTIVE SUMMARY

With the challenging economic climate for life insurers in the United States, more and more companies are seeking ways to enhance their life insurance offerings. One particular approach is through the offering of various forms of *living benefits* that are provided by the acceleration of life insurance death benefits under certain situations.

One of the most common approaches in use is through riders that accelerate death benefits in the event that long-term care needs occur. Those riders are often structured to comply under state laws and regulations pertaining to long-term care insurance (LTCI), and tax considerations for the riders are governed under Section 7702B of the Internal Revenue Code (IRC). Some of these riders are structured to continue paying benefits beyond the pure acceleration of the life face amount, as they can potentially pay long-term care insurance benefits that may, over time, be two or three times the life face amount or even higher. These latter products are often referred to as *linked benefit* products.

However, the topic of this report is another type of living benefit rider offered under life policies, referred to here as *chronic illness accelerated benefit riders*, or *chronic illness riders*. These are governed generally by National Association of Insurance Commissioners (NAIC) Model Regulation 620, which pertains to accelerated benefits other than tax-qualified long-term care insurance benefits. The conditions (called *qualifying events* in Model Regulation 620) on which these benefits are triggered are governed by regulation, and generally include terminal illness, conditions that require continuous confinement in an eligible facility, or other triggers such as chronic illness as defined in Section 101(g) of the Internal Revenue Code. Often, terminal illness is covered under these riders.

Many companies offering chronic illness riders in the marketplace design their riders to comply with Section 101(g) requirements for an accelerated benefit design, because it means that the accelerated benefit payments received by the policyholder (subject to limitations for per-diem plans) 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 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.

One challenge in structuring these plans is that the Section 101(g) definition of chronic illness points back to the Section 7702(B) definition, which is the same section used to define triggers for LTCI products. However, Model Regulation 620 expressly precludes companies from marketing chronic illness riders as LTCI. In fact, Section 3 of Model Regulation 620 states that the plans subject to that regulation reflect primarily life insurance risks and are treated as life insurance benefits. In reality, most chronic illness riders that are based on one of the first four *qualifying events* defined in Model Regulation 620 have more restrictive terms than the standard LTCI trigger definitions, so the prohibition of marketing those plans as LTCI is appropriate.

The Interstate Insurance Product Regulation Compact (IIPRC), which can be used as a forum for securing approval in as many as 40 states, plus Puerto Rico, through a single filing, contains a rule (item number 5 under the qualifying event definition) that is modeled after Model Regulation 620 and the Section 7702B definition of chronic illness but with the proviso that the trigger condition must be *permanent*. It is interesting to note that the IIPRC chronic illness definition is not as complete as that provided in the tax code. However, it should be noted that in order to meet the chronic illness rules of Section 101(g), it is further necessary that the benefit trigger require that the insured be chronically ill within the meaning of the tax law.

Many companies are interested in these chronic illness accelerated benefit riders, as opposed to LTCI riders, for a number of reasons. Chronic illness riders generally pose less risk to companies than LTCI-linked benefit plans, by virtue of not including benefits that are independent of base plan values. Even when compared to only LTCI accelerated benefit riders, they are not subject to administrative and legal requirements pertaining to LTCI, making them a preferred approach for many companies. Key examples

Chronic illness riders generally pose less risk to companies than LTCI-linked benefit plans, by virtue of not including benefits that are independent of base plan values.

The administrative requirements of managing claims are reduced for chronic illness riders versus LTCI riders. These cost reductions, and the tighter trigger definitions, translate to lower costs to the consumer, enhancing the marketability of Section 101(g) chronic illness riders in terms of affordability.

include the avoidance of agent health licensing and unique agent training requirements pertaining to LTCI, and the ability to avoid the requirement of a variety of forms and applicants' signatures mandated for LTCI.

As noted above, most chronic illness riders have more restrictive requirements to qualify for benefits than LTCI products. For example, section 2B(3) of Model Regulation 620 defines one of the permissible *qualifying events* as 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." This is analogous to the IIPRC requirement of permanence of the triggering condition. As a result, the probability of a claim under plans with these triggers is reduced from that under an LTCI policy. In addition, many of those policies pay benefits in a lump sum, or annual lump sums (with recertification required), in contrast to LTCI policies that typically provide benefits on a monthly basis. NAIC Model Regulation 620 also prohibits restrictions on the use of proceeds. Thus, the administrative requirements of managing claims are reduced for chronic illness riders versus LTCI riders. These cost reductions, and the tighter trigger definitions, translate to lower costs to the consumer, enhancing the marketability of Section 101(g) chronic illness riders in terms of affordability.

Despite the observations above, Model Regulation 620 does allow for other qualifying events that the commissioner shall approve, and there are chronic illness riders in the market that feature chronic illness definitions identical to those used under LTCI policies.

There are three different pricing/benefit structures used in the design of Section 101(g) chronic illness riders, with the characteristics as described below:

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 the most popular approach in the market. 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.

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.

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. LTCI 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 the chronic illness rider, 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. Under the dollar-for-dollar death benefit reduction approach, the periodic payment amount is predetermined as a percentage of the life face amount, but under the other two methods the amounts may be determined at the time of claim by the owner, within certain constraints.

The pricing of these chronic illness riders requires assumptions in a number of key areas. For example, the disabled life mortality assumption needs to be established and that assumption is not easily determined. Also, the company needs to assess whether the overall insured population mortality changes when the rider is attached. Under most designs, because the remaining death benefits available for disabled lives have been reduced for prior accelerations, the mortality rates per 1,000 of face in force should actually go down for the overall population. It might appear that, in the pricing of a discounted death benefit structure, there should be little concern about the actual incidence rates of claim, so long as the discounts are structured appropriately for the payouts to be self-supporting for those disabled lives. However, because of the phenomenon described above, incidence rates do come into play in the evaluation of profits under any particular discounting schedule. Also, there are reserving and capital requirement differences generated by the actual acceleration of benefits. For these reasons, it is highly desirable to build financial models that capture all of these moving parts in order to understand whether a particular benefit and premium structure produces acceptable profits.

According to LIMRA, life acceleration products that couple life insurance with accelerated benefit riders (ABR) for chronic illness or long-term care (i.e., including Section 7702B LTCI accelerated benefit riders) achieved a 76% growth rate in 2010. This exceeds the growth rate of linked-benefit life insurance products, which as noted above include not only accelerated benefits but also independent long-term care insurance benefits offered through extension of benefit (EOB) riders.

Milliman conducted its own chronic illness survey in late 2011. Of 43 respondents, 12 currently have or soon will have a chronic illness rider in their new business portfolio. Of the remainder, 12 intend to offer one in the future and six more are considering offering such a rider.

This research report covers the following areas relative to chronic illness accelerated benefit riders, which are intended to qualify under IRC Section 101(g):

- A review of relevant NAIC model regulations and certain aspects of applicable federal tax law
- Identification of chronic illness rider benefit structures available in the marketplace
- A review of funding methods and designs, including the lien approach, the discounted death benefit approach, and the dollar-for-dollar death benefit reduction approach
- Actuarial considerations
- Identification and analysis of differences in key rider features
- A review of sales information with various breakdowns by base plan chassis, distribution outlets, and issue age
- Results from a late 2011 Milliman survey of 43 companies regarding chronic illness riders

According to LIMRA, life acceleration products that couple life insurance with accelerated benefit riders (ABR) for chronic illness or long-term care achieved a 76% growth rate in 2010.

DEFINING A QUALIFIED LONG-TERM CARE RIDER (UNDER 7702B) VERSUS A CHRONIC ILLNESS ACCELERATED DEATH BENEFIT RIDER (UNDER 101[g])

Chronic illness riders added to life insurance policies allow the possibility of meeting two separate consumer needs: the need to provide a death benefit to heirs, and the need to pay bills during a serious long-term illness, albeit with a reduction to the benefits that would ultimately be available to life beneficiaries.

A chronic illness accelerated death benefit rider attached to a life insurance policy means, in its simplest form, that when the insured becomes chronically ill 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. The flexibility of this concept is appealing to consumers who realize that long-term illnesses can be very expensive. Chronic illness riders added to life insurance policies allow the possibility of meeting two separate consumer needs: the need to provide a death benefit to heirs, and the need to pay bills during a serious long-term illness, albeit with a reduction to the benefits that would ultimately be available to life beneficiaries.

In this research report, we are focusing on chronic illness accelerated death benefit riders under IRC Section 101(g), *Treatment of Certain Accelerated Benefits*, as opposed to long-term care riders under IRC Section 7702B, *Treatment of Qualified Long-Term Care Insurance*. It is therefore important to understand the difference between these two types of riders. The maximum amount that a Section 101(g) chronic illness rider can accelerate is the life policy's death benefit through an ABR, whereas qualified LTCI riders accelerate the full death benefit through an ABR and may also choose to provide additional LTCI benefits after the life insurance death benefit is depleted, through an EOB rider. A typical accelerated benefit coverage period found on qualified LTCI riders is two years. Supplementary EOB riders continue providing LTCI protection for another period of time that often is one to two times the length of the accelerated benefit period. These EOB riders round out the LTCI coverage by providing more comprehensive coverage for more catastrophic LTCI needs, which can extend well beyond the acceleration of benefit coverage period. Also, the inclusion of EOB riders imposes a regulatory requirement of offering the applicant inflation protection and nonforfeiture benefits for LTCI, which further increases the LTCI exposure. With qualified LTCI riders, the insurance company is often accepting more risk.

Many life insurers do not offer long-term care insurance and are not familiar with the long-term care insurance regulations that govern qualified LTCI riders. For these companies, it is an easier path to offer Section 101(g) chronic illness riders, which are not subject to the LTCI rules under 7702B or state regulations pertaining to LTCI, and in fact cannot be marketed as LTCI when regulated under state law based on Model Regulation 620. Chronic illness riders are not subject to the requirement of a variety of forms and applicants' signatures mandated for LTCI, and agents do not need a health license or LTCI training in order to sell them. However, an important advantage that Section 101(g) riders can still offer the policyholder is that accelerated benefit payments received under these 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. 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 (note: Appendix II of this report includes key regulations pertaining to qualified LTCI riders under 7702B.)

Section 101(g) chronic illness riders generally need to comply with NAIC Model Regulation 620, the Accelerated Benefits Model Regulation (or individual state variations), which will be discussed in detail later in this paper. This model regulation provides the definition of a *qualifying event* under which the company will pay the accelerated benefit. However, Internal Revenue Code Section 101(g) also imposes benefit trigger requirements, and thus it is necessary to incorporate both state regulations and federal tax benefit trigger requirements into such riders. Early chronic illness riders used one or more of the first four qualifying event definitions from the model regulation, without the tax rule definitions for chronic illness (and thus Section 101(g) did not apply to such riders). The newer riders on the market are gravitating

toward the 101(g) definition, which reflects the activities of daily living (ADL) triggers or cognitive impairment as defined in IRC Section 7702B, and as augmented by any state requirements.

IRC Section 101(g) riders 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. 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 the chronic illness benefit trigger definition provided by 7702B. Section 101(g) goes on to state that the term *qualified long-term care services* also has the meaning given by Section 7702B(c).

Section 7702B(c)(2) states:¹

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,*
- 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.

¹ Italicized items are from IRC Section 7702B(c)(2), *Treatment of Qualified Long-Term Care Insurance*.

NAIC MODEL REGULATION 620: ACCELERATED BENEFITS MODEL REGULATION

This regulation applies to all accelerated benefits provisions of individual and group life insurance policies, except those subject to the Long-Term Care Insurance Model Act.²

We will point out some highlights from this regulation; however, interested parties should review this model regulation and any state variations in detail.

MODEL REGULATION 620, SECTION 2: DEFINITIONS

Accelerated benefits are defined as *benefits payable under a life insurance contract*:

1. *To a policy owner or certificate holder, during the lifetime of the insured, in anticipation of death or upon the occurrence of specified life-threatening or catastrophic conditions as defined by the policy or rider; and*
2. *That reduce the death benefit otherwise payable under the life insurance contract; and*
3. *That are payable upon the occurrence of a single qualifying event that results in the payment of a benefit amount fixed at the time of acceleration.*

Also defined under this section, a *qualifying event* means 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.*

Instead of using one or more of the first four benefit trigger definitions above from Model Regulation 620, some insurers are looking to IRC Section 101(g), which allows insurers to use the chronic illness definition provided by 7702B.

As pointed out earlier in this paper, instead of using one or more of the first four benefit trigger definitions above from Model Regulation 620, some insurers are looking to IRC Section 101(g), which allows insurers to use the chronic illness definition provided by 7702B. It should be noted that confinement in an eligible institution is not part of the 7702B definition. Insurers choosing the 7702B definition may have a marketing advantage, in that most consumers would rather have the option to receive the necessary care in their own homes, rather than in an institution providing care.

² Italicized items in this section are quoted from NAIC Model Regulation 620: Accelerated Benefits Model Regulation.

MODEL REGULATION 620, SECTION 4: ASSIGNEE/BENEFICIARY

Prior to the payment of the accelerated benefit, the insurer is required to obtain from an assignee or irrevocable beneficiary a signed acknowledgment of concurrence for payout.

MODEL REGULATION 620, SECTION 5: CRITERIA FOR PAYMENT

- *Contract payment options shall include the option to take the benefit as a lump sum. The benefit shall not be made available as an annuity contingent upon the life of the insured.*

Note that this arguably prohibits the use of an expense reimbursement model, which is often used for Section 7702B LTCI policies.

- *No restrictions are permitted on the use of the proceeds.*
- *If any death benefit remains after payment of an accelerated benefit, the accidental death benefit provision, if any, in the policy or rider shall not be affected by the payment of the accelerated benefit.*

MODEL REGULATION 620, SECTION 6: DISCLOSURES

- *The terminology accelerated benefit shall be included in the descriptive title. Products shall not be described or marketed as long-term care insurance or as providing long-term care benefits.*
- *A disclosure statement is required at the time of application and at the time the accelerated benefit payment request is submitted that receipt of these accelerated benefits may be taxable and that assistance should be sought from a personal tax advisor. The disclosure statement shall be prominently displayed on the first page of the policy or rider and any other related documents.*

Note that Model Regulation 620 has not been updated to reflect enactment of Section 101(g), which allows for receipt of nontaxable accelerated benefits. However, there are a number of situations where benefits under Section 101(g) riders may be taxable.

- This section also contains information about solicitations. It has information specific to group insurance policies. If there is a premium or cost-of-insurance charge, the insurer must give the applicant an illustration demonstrating the effect of the payment.
- This section also has information regarding the disclosure of the premium charge and administrative expense charge.
- This section also requires that when the policy owner requests an acceleration, the insurer must send a statement showing any effect that the payment will have on the policy's cash value, accumulation account, death benefit, premium, policy loans, and policy liens. The statement must also state 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 shall 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.

MODEL REGULATION 620, SECTION 7: EFFECTIVE DATE OF THE ACCELERATED BENEFIT

This section stipulates that the *accelerated benefit provision shall be effective for accidents on the effective date of the policy or rider, and that it shall be effective for illness no more than 30 days following the effective date.* This section is important, as it sets the rule for maximum waiting periods.

MODEL REGULATION 620, SECTION 8: WAIVER OF PREMIUMS

The insurer may offer a waiver of premium for the accelerated benefit provision in the absence of a regular waiver of premium provision being in effect. At the time the benefit is claimed, the insurer shall explain any continuing premium requirement to keep the policy in force.

MODEL REGULATION 620, SECTION 10: ACTUARIAL STANDARDS

Financing options:

- The insurer may require a premium charge or cost-of-insurance charge for the accelerated benefit.
- The insurer may pay a present value of the face amount. The calculation shall be 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
 - The current maximum statutory adjustable policy loan interest rate
- The insurer may accrue an interest charge on the amount of the accelerated benefits. The maximum interest rate used is the same as is detailed above.

The interest rate accrued on the portion of the lien that is equal in amount to the cash value of the contract at the time of the benefit acceleration shall be no more than the policy loan interest rate stated in the contract.

Effect on cash value:

1. *Except as provided in paragraph 2, when an accelerated benefit is payable, there shall be no more than a pro rata reduction in the cash value based on the percentage of death benefits accelerated to produce the accelerated benefit payment.*
2. *Alternatively, the payment of accelerated benefits, any administrative expense charges, any future premiums and any accrued interest can be considered a lien against the death benefit of the policy or rider and the access to the cash value may be restricted to any excess of the cash value over the sum of any other outstanding loans and the lien. Future access to additional policy loans could also be limited to any excess of the cash value over the sum of the lien and any other outstanding policy loans.*

When payment of an accelerated benefit results in a pro rata reduction in the cash value, the payment may not be applied toward repaying an amount greater than a pro rata portion of any outstanding policy loans.

MODEL REGULATION 620, SECTION 11

This section details the requirements for the actuarial memo and the reserves.

Not all states have adopted the NAIC model regulation verbatim, and therefore variations by state exist, for example in New York.

It should be noted that not all states have adopted the NAIC model regulation verbatim, and therefore variations by state exist, for example in New York. The authors of this paper would be happy to discuss state variations of the model with interested parties.

INTERSTATE COMPACT AND STANDARDS FOR ACCELERATED DEATH BENEFITS

The Interstate Insurance Product Regulation Compact (IIPRC) adopted standards for accelerated death benefits on February 28, 2007. Insurers that would like the faster approval the IIPRC may provide across a large number of states will need to take these standards into consideration when designing their chronic illness riders.

QUALIFYING EVENT

Specifically, the IIPRC standard states the following for *qualifying event*:³

Qualifying event means the following:

1. *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;*

And, at the option of the company, may include one or more of the following:

2. *A medical condition that requires extraordinary medical intervention, such as major organ transplant or continuous artificial life support, without which the insured would die;*
3. *A condition that usually requires 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;*
4. *A specified medical condition that, in the absence of extensive or extraordinary medical treatment, would result in a drastically limited life span; or*
5. *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), and/or permanent severe cognitive impairment and similar forms of dementia.*

Items 1, 2, 3, and 4 above are derived from the NAIC Accelerated Benefits Model Regulation 620, whereas it appears that item 5 above seems to point generally to IRC Section 101(g) and 7702B, although it does not nearly cover the full 7702B definition. As such, the terms in item 5 are not sufficient to assure compliance with Section 101(g) requirements. However, it also references *permanence* of the chronic illness for this trigger to be met.

Although the 90-day language found in Section 7702B's benefit trigger definition is not found in the IIPRC language above, the IIPRC is willing to accept this language if it is being included to ensure that the rider retains its tax-qualified status under Section 101(g), because this benefits the consumer. It would seem that other provisions in Section 101(g) would need to be added as well.

It appears that one problem the IIPRC qualifying event definition creates for insurers wanting approval through the IIPRC is that terminal illness (item 1 above) must be included in the chronic illness rider. It would therefore not be surprising to see more insurers in the future filing a combined chronic illness/terminal illness ABR, in order to receive approval from the IIPRC. The terminal illness and chronic illness riders may be separate rider forms, as long as the insurer certifies to the IIPRC that the chronic illness rider will not be provided without the terminal illness rider. Note that for items 2-5 above, one or more may be listed in a given company's accelerated benefit rider, each of which could serve independently as a qualifying event, therefore allowing the company discretion as to which to include.

One problem the IIPRC qualifying event definition creates for insurers wanting approval through the IIPRC is that terminal illness must be included in the chronic illness rider.

³ Italicized items in this section are from the Interstate Insurance Product Regulation Compact (IIPRC), *Standards for Accelerated Benefits*, adopted February 28, 2007, and made effective May 31, 2007.

WAITING PERIODS

The IIPRC standard also states the following within the *Qualifying Events* section:

1. *The form shall specify the terms and conditions applicable to each qualifying event.*
2. *The form shall not require that the cause of a qualifying event first manifest itself or be diagnosed after issuance of the individual policy or form.*
3. *The form shall not include a waiting period requirement. A requirement that the individual policy or form be in force past the incontestable period is prohibited.*

As indicated above, the IIPRC will not approve chronic illness forms containing a waiting-period requirement.

Insurers filing with the Interstate Compact should also remember to include in their chronic illness rider filing a sample of the disclosure form to be provided at the time of claim.

Insurers filing with the Interstate Compact should also remember to include in their chronic illness rider filing a sample of the disclosure form to be provided at the time of claim. It is a statement that will be used to demonstrate the effect the accelerated death benefit payment will have on policy values. This statement has to be provided prior to or concurrent with the owner's election to accelerate the death benefit.

Please note that the IIPRC standards for accelerated death benefits discuss several other topics including, but not limited to, benefit design options, effect of benefit payment on other benefit provisions, incontestability, payment options, reinstatement, and termination. Therefore, insurers filing chronic illness riders with the IIPRC should review these standards in their entirety.

BACKGROUND AND SALES INFORMATION ON LIFE COMBINATION PLANS (INCLUDES CHRONIC ILLNESS RIDERS)

Industry sales information is generally not gathered separately for chronic illness riders. In this section, sales information will be provided on life combination plans, which includes both life insurance plans with chronic illness riders and life insurance plans with LTCI riders. Therefore, it is helpful to understand the overall background for life combination plans. In particular, LTCI accelerated benefit riders address many of the same consumer needs as chronic illness riders. The Pension Protection Act of 2006 (PPA) opened the door for combination products featuring long-term care riders. The PPA appears to preserve the view that charges against cash values for tax-qualified or non-qualified LTCI riders on life policies are deemed distributions (retroactive to the enactment of HIPAA in 1996); however, it indicates that 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 combination plans. We have seen about 30-35 life/LTCI combinations introduced into the market, and product development activity continues at a steady pace.

Consumers may be driven from standalone LTCI products to combination products for a number of reasons. Premiums on the standalone products have increased because of updated interest and lapse assumptions. As a result, the standalone product is unaffordable for many who would benefit from LTCI. Also, buyers dislike the idea of paying premiums for many years and possibly getting nothing in return. Combination life/LTCI designs, and to some degree chronic illness riders, can address these concerns.

SALES OF LIFE COMBINATION PLANS (INCLUDES BOTH LIFE WITH LTCI AND LIFE WITH CHRONIC ILLNESS RIDERS)

The statistics shown in this section are based on annual LIMRA surveys regarding individual life combination sales.⁴ LIMRA's definition of life combination plans includes both life with LTCI and life with chronic illness riders.

FIGURE 1: LIFE COMBINATION BENEFIT SALES (INCLUDES BOTH LIFE WITH LTCI AND LIFE WITH CHRONIC ILLNESS RIDERS)

	2006	2007	2008	2009	2010
TOTAL SINGLE PREMIUM (\$ MILLIONS)	\$350	\$455	\$515	\$752	\$1,156
TOTAL ANNUAL RECURRING PREMIUM (\$ MILLIONS)	\$30	\$126	\$118	\$61	\$62
TOTAL POLICIES SOLD	10,500	15,200	16,100	22,000	26,000
TOTAL FACE AMOUNT SOLD (\$ BILLIONS)	\$2	\$4.2	\$5	\$4	\$5.9
FACE AMOUNT IN FORCE (\$ BILLIONS)	N/A	\$17.5	\$21.9	\$19.0*	\$12.4*

n/a = Not available

*Note: Only 11 companies participated in the 2010 survey, whereas 14 companies participated in 2009 and 16 companies participated in 2008. Also, not all companies provided both sales and in-force data. These factors may account for the apparent decline in face amount in force.

The life combination market continues to grow, accounting for 6% of the total individual life market based on total new premium. Because of the large portion of single premium products sold, this market represents just under 2% based on new annualized premium per LIMRA measures, which weight single premium at 10%. According to LIMRA International, Inc., single premium sales had a 61% market share of life combination business in 2010, while recurring premium sales achieved a 39% market share (based on policies sold). Single premium life combination sales in 2010 increased 62% over 2009, while recurring premium life combination sales in 2010 increased by 81%. Average sizes in 2010 are shown in Figure 2 by premium type.

Single premium life combination sales in 2010 increased 62% over 2009, while recurring premium life combination sales in 2010 increased by 81%.

⁴ LIMRA's *Individual Life Combination Products: 2010 Annual Review* (June 2011), *U.S. Individual Life-LTC Combination Products: 2009 Annual Review* (2010), *U.S. Individual Life-LTC Combination Products: Annual Review 2008* (2009), and *U.S. Individual Life/LTC Combination Products: 2007 Annual Review* (2008).

FIGURE 2: AVERAGE SIZES BY PREMIUM TYPE, 2010

SIZE BASED ON:	SINGLE PREMIUM	RECURRING PREMIUM
AVERAGE PREMIUM	\$72,500	\$6,000
AVERAGE FACE AMOUNT	\$123,000	\$387,000

The most popular chassis for life combination products is universal life (UL), accounting for 80% of total premium, 70% of new policies, and 54% of face amount sold in 2010. Policies sold in 2010 with a variable chassis accounted for 18% of sales, while the whole-life chassis garnered 12% (based on policy count).

Regarding sales by gender, 2010 in-force data indicates that 65% of life combination policy owners are female, up from 59% reported in the 2009 results. The table in Figure 3 represents 2010 in-force market share by gender and issue age group.

FIGURE 3: LIFE COMBINATION 2010 IN-FORCE MARKET SHARE BY GENDER AND ISSUE AGE GROUP, BY POLICY COUNT

	UNDER AGE 50	AGES 50-59	AGES 60-64	AGES 65-69	AGES 70-74	AGES 75-79	AGES 80+
FEMALE	8%	21%	19%	19%	14%	13%	6%
MALE	9%	22%	20%	19%	12%	10%	8%
TOTAL	8%	21%	19%	19%	14%	12%	7%

Sales by distribution channel show the following breakdown of new policy sales in 2010: 29% in the broker/dealer channel, 28% in the independent agent channel, 21% in the career agent channel, 11% in the bank channel, and 10% in the financial planners/advisors channel. Data from a separate 2009-2010 bank life insurance study, in which data was collected from 74 financial institutions, indicated that 66% of the participants currently offer a life/LTCI product.

In breaking down the life combination market further, one may look at product sales with only accelerated benefit riders (ABRs) versus sales that also include an independent benefit, also referred to as an extension of benefit rider (EOB). In 2010, life combination policy sales with only ABRs had a 55% market share, while policies with EOB riders had a 45% market share (by policy count). However, viewing the data by total new premium, sales with only ABRs account for only 34% of new life combination premium, while sales with EOB riders accounted for 66% of new life combination premium.

Over the past few years, most of the growth in the life combination market had come from linked-benefit products. However, sales growth of acceleration products exceeded linked-benefit products in 2010 with a 76% growth rate for acceleration products compared to a 60% growth rate for linked-benefit products.

The number of insurance companies selling standalone LTCI products has declined in the last several years as a result of consolidation and strategic concerns. Some of the companies that offer standalone LTCI plans also offer combination products. In addition, a growing number of other carriers are selling life combination plans.

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CHRONIC ILLNESS RIDER STRUCTURES DEFINED

There are three basic structures that are used in the marketplace by insurers who offer chronic illness riders: the lien approach, the discounted death benefit approach, and the dollar-for-dollar death benefit reduction approach.

LIEN APPROACH

Using the lien approach, when an accelerated benefit is paid under a chronic illness rider, a lien is created against the policy, similar to a policy loan. Some chronic illness riders use a lien without interest, but that calls for charges. Current limits on the lien rate to be charged are approximately 4.8% if set based on the Moody's rate (although a rate equal to the cash value rate plus 1% could be used), which could dilute the returns normally targeted by the company. In addition, lien amounts in excess of reserves are viewed as non-admitted assets, which could further impact the company's financial results.

With the lien approach, the company will usually assess an administrative fee at the time of the accelerated benefit payment.

DISCOUNTED DEATH BENEFIT APPROACH

Some plans discount the death benefits being advanced, so for each dollar of chronic illness benefit paid out, the death benefit will be reduced by more than a dollar. Under some designs, the level of discount is predetermined based on attained age. Under other designs, the discount is determined based on underwriting conducted at the time of claim, but these are unusual in the market.

As with the lien approach, companies using the discounted death benefit approach will normally not charge a premium but will usually assess an administrative fee at the time of the accelerated benefit payment. Sample administrative fees assessed by companies in the marketplace: \$200, \$500, and \$1,000.

DOLLAR-FOR-DOLLAR DEATH BENEFIT REDUCTION APPROACH

Similar to the lien approach and the discounted death benefit approach, under the dollar-for-dollar death benefit reduction approach there are no restrictions on the use of the accelerated benefits and no proof of expenses is required. However, unlike the previous two approaches, the dollar-for-dollar death benefit reduction approach normally has a charge associated with the policy owner's election of the rider. The rider charge is normally part of the monthly deduction of cost of insurance (COI) charges from the account value for universal life and variable universal life type policies or a separate charge or premium for whole-life policies. The administrative fee that the other two approaches apply at the time of the accelerated benefit payment is not normally seen with the dollar-for-dollar death benefit reduction approach.

ACTUARIAL CONSIDERATIONS FOR CHRONIC ILLNESS RIDER STRUCTURES

KEY FACTORS DRIVING PROFITS

The pricing of the dollar-for-dollar death benefit reduction approach clearly requires standard life pricing models to derive the appropriate premiums or charges to cover the cost of the accelerated benefits. These models need to recognize incidence rates, claim termination rates, disabled life mortality rates, and the impact of the removal of disabled lives from the active (nondisabled) life population and the resulting impact on their mortality rates. The various populations of active lives, disabled lives, and those individuals that previously were disabled but have since recovered should be recognized and blended in some fashion within the financial models in order to assess the profitability of the overall block.

The discounted death benefit approach and the lien approach to accelerated death benefits are usually forms of riders that feature no charges assessed to the policyholder prior to the point of claim.

The discounted death benefit approach and the lien approach to accelerated death benefits are usually forms of riders that feature no charges assessed to the policyholder prior to the point of claim. To restore the profitability of the policy with these chronic illness riders, a back-end charge needs to be assessed to the policyholder.

With the discounted death benefit approach, the insurer usually calculates an actuarially reduced value of face amounts accelerated for the policyholder when the claim is submitted. Once the acceleration benefits are paid, the face amount will be reduced based on a predetermined discounting mechanism, which reduces the face amount by a larger amount than the acceleration benefits paid.

The actuarial reduced value for the discounted death benefit approach typically reflects the present value of the future expected benefits the insured is eligible to collect, and the foregone premiums on whole-life policies (or charges on UL policies) that the insurer will not be collecting, less dividends that the insurer will not be paying out, because of the reduction to the policy face amount tied to acceleration of a portion of the death benefit. An administrative expense charge may apply as well. For example, for a whole life non-par policy, the simplest form of the calculation based on the above principle is the present value of future death benefits minus the present value of future expected premiums that would have been needed to keep that portion of the policy in force, discounted using the appropriate interest rate and mortality.

If the intent is to have the insurer in a profit-neutral position before and after inclusion of accelerated benefits, then the pricing objective under the discounted death benefit approach is to actuarially equate the present value of the cash flows generated from the policy with accelerations to the policy without the accelerated death benefit rider. In reality, there are regulatory restrictions on the discount rate to be used in the discounting formula. The disabled life mortality assumption needs to be established and that assumption is not easily determined, and the company needs to assess whether the overall population mortality changes when the rider is attached. Also, there are reserving and capital requirement differences generated by the actual acceleration of benefits. For these reasons, it is highly desirable to build financial models that capture all of these moving parts in order to understand whether a particular discounting formula, with its parameters, is actually profit-neutral.

Under the NAIC model regulation, the discount rate on the net amount at risk being accelerated is capped by the greater of the 90-day Treasury bill yield and the maximum statutory adjustable policy loan interest rate. As for the disabled life mortality table, no regulatory prescribed table exists. Also, the actual discounting mechanism is flexible. The NAIC model regulation generally calls for the use of *sound actuarial principles*.

The lien approach does not require an explicit discounting mechanism. The acceleration benefits are treated as a lien against the death benefits (and a portion or all serve as a lien against cash surrender values as well). The lien amount grows at an interest rate determined by the insurer, subject to the same limitation as noted above for the discount rate used in discounting formulas. The policy in large part works as if there were no acceleration rider until the accumulated lien amount plus the unpaid loan amount exceeds the death benefits of the policy. Then, typically, the insurer will end the policy unless the policyholder repays the lien or loan. The additional cash cost (compared to a policy without an

acceleration rider) under the lien approach for the company is the lien amount in excess of the cash values paid in advance to the insured. The lien interest can help to mitigate part of the cost but usually cannot cover all of it because the lien interest rates are also capped by the statutory maximum-allowed adjustable policy loan interest rate. The statutory maximum rate may be lower than the average return of the actual invested assets and is generally much lower than the target returns on capital expected by the insurer. Further, any lien amounts in excess of the statutory reserves are treated as non-admitted assets under statutory accounting, in which case the company may need to provide additional capital to support the acceleration payments. To help compensate for the uncovered cost, the company can limit the amount of acceleration benefits in excess of cash value amount that a policyholder can access. Often those schedules in the market reflect very low limits as a percentage of face amount at the younger ages, grading up gradually into the older ages.

RESERVES AND BALANCE SHEET IMPACTS

For the discounted death benefit approach, the NAIC model regulation indicates that the life policy reserve shall follow the Standard Valuation Law. There are general requirements that the company needs to demonstrate that the reserves with the acceleration rider are no less than those as if there were no acceleration rider. When acceleration benefits are determined based on actuarially equivalent benefits, no additional policy reserve is needed as long as the aggregate policy reserve is deemed to be sufficient.

A claim reserve may be established depending on the benefit structure, either a lump sum or a present value of remaining installment acceleration payments needs to be set up until the acceleration benefits are paid. The company may take a position to just establish additional claim reserves based on a net amount risk basis because, under both the discounted death benefit and the dollar-for-dollar death benefit reduction approaches, part of the life policy reserve will be released upon the acceleration to help fund the acceleration benefits if necessary.

Generally, the impact on the balance sheet that is due to the discounted death benefit approach compared to the same life policy without such an acceleration rider is a relatively lower in-force amount of the policy reserves, which is due to the reduction of the face amount and cash value upon prior accelerations. Reserves under the dollar-for-dollar death benefit reduction approach are similarly reduced by virtue of the reduction in policy values.

Under the lien approach, because the face amount is not reduced upon the acceleration payments, the life reserve is not impacted by the acceleration. A lien amount that is equivalent to the acceleration payment is recorded on the balance sheet as an asset to offset the cash payouts for the acceleration. The lien recorded on the statutory balance sheet can grow at the lien interest rate, and the lien interest is shown as investment income on the income statement line. Note that, if the lien amount grows beyond the total reserve, the excess part will be treated as non-admitted assets under statutory accounting.

Generally, chronic illness riders are filed with the base life insurance contracts and are subject to life insurance regulations. Thus, the capital requirements follow the NAIC guidelines for life insurance.

Generally, the impact on the balance sheet that is due to the discounted death benefit approach compared to the same life policy without such an acceleration rider is a relatively lower in-force amount of the policy reserves, which is due to the reduction of the face amount and cash value upon prior accelerations.

UNDERWRITING APPROACHES

Some companies with chronic illness riders do not issue the rider on policies rated—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.

Companies offering a chronic illness rider using the dollar-for-dollar death benefit reduction approach are likely to have stricter underwriting approaches, as compared to either the lien or discounted death benefit approaches.

Companies offering a chronic illness rider using the dollar-for-dollar death benefit reduction approach are likely to have stricter underwriting approaches, as compared to either the lien or discounted death benefit approaches. Additional underwriting and an application supplement are 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.

As an example of one specific underwriting approach, one of the chronic illness riders on the market that uses the dollar-for-dollar death benefit reduction approach requires that the insured must be rated a Table 6 risk or better in order for the rider to be issued, with some exclusions including:

- Alzheimer's or another form of dementia
- Mild cognitive impairment
- History of stroke at any time or transient ischemic attack within the last three years
- Severe rheumatoid arthritis or severe osteoarthritis
- Any impairment requiring the use of an ambulatory aid
- Neurodegenerative or neuromuscular disease including multiple sclerosis, Parkinson's, and other similar impairments
- Current inability to perform one ADL including ambulation, bathing, continence, dressing, eating, toileting, and transferring

The base life insurance coverage and the rider are underwritten separately. However, if approved, the rider will not have a separate risk class associated with it. It is possible for an insured to be offered a life insurance policy while being declined for the rider.

For one company, if the rider is elected on the application, a two-page application supplement must be completed. This supplement asks questions regarding whether the insured currently needs help regarding the ADLs and whether the insured receives any type of disability benefit or workers' compensation. It also asks several questions regarding whether the insured has been diagnosed with memory loss, confusion, or amnesia, has any condition that causes limited motion, or has suffered an amputation or several other diseases such as amyotrophic lateral sclerosis, multiple sclerosis, Parkinson's, and more. The supplement also asks for a list of all medications prescribed in the past 24 months and the reason for taking them. The client would complete the application supplement during the tele-interview.

In contrast to this underwriting approach, some other companies 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.

BASE PRODUCT PLATFORM

Chronic illness 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. One company offers its chronic illness rider only with its guaranteed UL policies. Because there can be the need for special rules or factors in different base plans, many companies confine their chronic illness riders to a limited set of products.

WAITING PERIOD

The waiting period is the length of time that the chronic illness rider must be in force before the coverage begins. Charges for the rider would typically apply during the waiting period. The state of New York does not allow a waiting period and instead requires that the coverage is effective on the issue date of the policy or rider. NAIC Model Regulation 620 (the Accelerated Benefits Model Regulation), Section 7, stipulates that the accelerated benefit provision shall be effective for accidents on the effective date of the policy or rider, and that it shall be effective for illness no more than 30 days following the effective date.

The decision on the length of waiting period is intertwined with the decision on the underwriting approach. Looser underwriting requirements would suggest a longer waiting period, where allowed, to mitigate anti-selection under structures where the ABR payouts are determined to be actuarially equivalent.

As mentioned earlier, the IIPRC standards do not allow a waiting period requirement. In general, most chronic illness riders offered in the marketplace do not impose a waiting period.

RESIDUAL DEATH BENEFITS

The purpose of a residual death benefit feature is to guarantee that some life insurance coverage is available 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 policy death benefit. One thing to keep in mind is that the meaning of *residual death benefit* in chronic illness riders is different than the meaning when used in many LTCI riders offering independent benefits. Chronic illness riders do not accelerate 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 is still accelerated even though a residual death benefit is offered.

There doesn't appear to be a specific trend in residual death benefits on chronic illness riders. Some companies do not offer a residual death benefit on the chronic illness rider, and therefore allow 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. Other companies do offer residual death benefit provisions on the chronic illness rider. For example, one company maintains a \$50,000 residual death benefit, while another company's residual death benefit is the greater of 5% of the death benefit on the initial rider election date or \$10,000. Yet another company allows only 50% of the death benefit to be accelerated, up to a maximum of \$250,000.

WAIVER OF CHARGES

If a company decides not to assess a premium or charge for its chronic illness rider, there are no rider charges to be waived. Because there are no rider charges, the cost of waiving underlying charges on the base policy (at the time the owner begins to take accelerated benefit payments) cannot be covered by the rider.

Those riders that have a chronic illness rider charge that is deducted monthly from the account value, or a separate rider premium, also normally have a waiver-of-costs provision for both the base policy and rider cost. When an insured is on claim, once the policy value is insufficient to cover monthly deductions, benefit payments will continue until the lifetime benefit amount is exhausted, assuming the insured continues to qualify for payments under the rider. If the client comes off claim and monthly deductions were being waived, the policy will enter the grace period and normal rules will apply.

FREQUENCY OF PAYMENTS

Most chronic illness riders appear to offer an annual lump-sum payment, but annual recertification is required. Some companies allow a choice of two semiannual payments or monthly payments during the benefit year.

Most chronic illness riders appear to offer an annual lump-sum payment, but annual recertification is required. Some companies allow a choice of two semiannual payments or monthly payments during the benefit year.

A couple of companies allow only one lump-sum accelerated death benefit payment under the chronic illness rider, in which case the question of annual recertification is a moot point. These structures may cause ABR payouts to exceed HIPAA limits (and actual costs of care) and thus be taxable, especially for larger policies.

POLICYHOLDER TAXATION

Clarifications and changes to the tax treatment of combination plans featuring LTCI were addressed in the Pension Protection Act of 2006 (PPA). The provisions enhance the tax treatment of combination coverages that include LTCI, and are effective generally for contracts issued after December 31, 1996, but only with respect to taxable years beginning after December 31, 2009.

With respect to LTCI or chronic illness, ABR designs that do not qualify under Section 101(g) or 7702(B), either stand-alone or accelerated benefits, it is not clear whether benefits are tax-free. Further, the charges for these riders against the base plan cash value may be taxable distributions to the extent there is gain in the contract. Compliance with Section 101(g) requirements for an accelerated-benefit design assures that the benefits (subject to limitations for per-diem plans) will be tax-free (as they are deemed to be death benefits), but Section 101(g) imposes a number of other requirements. The construction of some of these is even less clear than the requirements imposed by Section 7702(B).

EXECUTIVE SUMMARY OF MILLIMAN'S CHRONIC ILLNESS RIDER SURVEY

In December 2011, Milliman conducted a survey relative to key areas of interest in the chronic illness rider market. The survey covered chronic illness plans structured under NAIC Model Regulation 620: Accelerated Benefits Model Regulation (i.e., Section 101[g] plans). Long-term care riders and terminal illness riders were not included in the scope of the survey. The survey was sent to 64 life insurance carriers, and 43 companies submitted responses, which indicates the high level of interest in this topic.

Thirty-two of the survey participants do not currently market a chronic illness rider. Of those 32, 12 are planning to market a chronic illness rider in the future, while an additional six are considering it.

Twelve companies currently marketing a chronic illness rider responded to various questions regarding features of that rider:⁵

Base life insurance plan: Offering chronic illness riders with multiple base life insurance plans is common. All 12 companies offer their chronic illness rider with a UL base life insurance plan, making it the most popular base plan to use. Six companies offer it with a whole life plan, five with a variable life plan, and three with a term life plan.

Rider structure used: The most popular approach is the discounted death benefit approach, with eight companies reporting use of this approach. Five companies use the lien approach and two use the dollar-for-dollar death benefit reduction approach. (Note: three companies reported using two approaches.)

Chronic illness benefit triggers: The most common benefit trigger used is two of six ADLs and cognitive impairment, which is used by 10 of the companies. One company uses two of six ADLs plus confinement to a nursing home. The last company's chronic illness benefits are triggered upon terminal illness with 12 months or less life expectancy or immediate need to provide the insured with extraordinary medical intervention, continuous life support, or continuous confinement in an eligible institution.

Cap on chronic illness benefits at HIPAA limits: Six of the 12 companies allow the chronic illness benefits to exceed HIPAA limits, while four companies reported that chronic illness benefits are capped at the HIPAA limits. (Two companies did not respond to the question.)

Benefit payment frequency: A majority of the 12 companies do offer the option of periodic lump-sum payments. The payment frequency offered by the companies varies: a few companies offer the client the full spectrum of frequencies, including monthly, quarterly, semiannual, or annual, while others offer only one or two frequencies. The frequency most commonly offered is annual (offered by seven companies) with monthly coming in second (offered by six companies). Note: Some companies specified that annual recertification is required. Some companies call the benefit payment a *single lump sum*, and, should the client want to continue payments, the client must go through the process of electing the benefit payment on an annual basis.

The chronic illness riders offered at a few companies allow the customer only one request for a chronic illness payment. At one company this is paid out in a lump sum, while at another, the client may choose whether to have it paid out in a lump sum or in periodic payments. At yet another company, the customer may choose a single lump sum, or to have the maximum acceleration taken within one year.

Residual death benefit: Six companies require a residual death benefit after payment of chronic illness benefits, while six do not require a residual death benefit.

Note: Please see the appendix section of this report for a copy of the survey and its full results.

⁵ Includes responses from 11 companies with chronic illness riders in the market and one company that, at the time of the survey, had not yet launched, but was close to launching.

Milliman conducted a survey relative to key areas of interest in the chronic illness rider market. The survey covered chronic illness plans structured under NAIC Model Regulation 620: Accelerated Benefits Model Regulation.

APPENDIX I: GLOSSARY

ABR: Accelerated benefit rider. When a policy has an accelerated benefit rider, it means that the insurance company is willing to make a payment (or payments) to the owner while still living, after a qualifying event, in exchange for some or all of the death benefit proceeds that would otherwise be payable at death.

ADLs: Activities of daily living (eating, toileting, transferring, bathing, dressing, and continence).

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

Combo or combination product: A plan that combines a life or annuity base plan with one or more LTCI riders.

CVAT: Cash Value Accumulation Test. A test to determine if a policy qualifies as a life insurance contract for tax purposes.

EOB: Extension of benefit. Also known as EBR (extension of benefit rider). An extension of benefit rider normally kicks in to provide independent LTCI benefits after the life insurance death benefit has been depleted through the accelerated benefit rider.

HIPAA: Health Information Portability and Accountability Act.

Linked-benefit life insurance: A life insurance base plan that offers not only an accelerated benefit rider, but also provides independent LTCI benefits through an extension-of-benefit rider.

NAIC: National Association of Insurance Commissioners.

APPENDIX II: SELECTED REGULATIONS PERTAINING TO QUALIFIED LTCI RIDERS (UNDER 7702B)

This white paper is intended to cover chronic illness accelerated benefit riders covered under IRC Section 101(g). The following regulations listed in this appendix apply to qualified LTCI riders under 7702B; they do not apply to riders covered under Section 101(g). They have been provided in this appendix as educational material, in order to provide a bigger picture and promote a better understanding of the differences in the rules between the two types of riders. (Note: This section is not intended to cover all the LTCI regulations.)

NAIC LONG-TERM CARE INSURANCE MODEL REGULATION

1. Key forms requirements under the NAIC LTCI model regulation

A majority of states have adopted the NAIC long-term care insurance model regulation. This regulation dictates a number of key forms requirements that apply to both accelerated benefit riders and independent LTCI riders:

- **Outline of coverage:** Section 31 of the model regulation stipulates the format and wording for the outline of coverage.
- **Required disclosure provisions:** Section 8 of the model regulation reviews certain disclosures to be made in the policy, such as including a statement that premium rates may change, a definition of the terms *reasonable and customary*, standards in relation to payment of benefits, any limitations or conditions on eligibility for benefits, a description of benefit triggers such as activities of daily living and cognitive impairment that will be used to measure an insured's need for long-term care, and a disclosure 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.
- **Replacements:** Section 14 of the model regulation deals with requirements for application forms and replacement coverage. It lists certain replacement questions to be asked on the application, and discusses the replacement notice requirements. It states that Section 14 should be complied with on life insurance policies with ABRs if the policy is being replaced by a long-term care insurance policy. If the policy being replaced is a life insurance policy, the insurer should comply with the replacement requirements of the NAIC life insurance and annuities replacement model regulation (or a similar state regulation). If a life insurance policy with an ABR is being replaced by another life insurance policy with an ABR, then the insurer needs to comply with both the long-term care and the life insurance replacement requirements.
- **LTC replacement and lapse reporting form:** Section 15 of the model regulation covers requirements for insurers to report certain replacement information annually to the commissioner.
- **LTC claims denial reporting form:** Section 15 of the model regulation also requires that insurers report annually for qualified LTC contracts the number of claims denied for each class of business, expressed as a percentage of claims denied.
- **Filing of advertising:** Section 22 of the model regulation requires LTCI advertising materials to be filed with the states, although it does allow for the commissioner to exempt certain advertising from the filing requirement when it may not be reasonably applied. It also requires that insurers retain advertising materials for a three-year period from the date the advertisement was first used. Most states require advertising to be filed. Some states are *file and use*, while others require approval.
- **Personal worksheet:** Section 23, titled *Standards for Marketing*, requires that a *Long-term care Personal Worksheet* is completed at the time of application. A copy of this worksheet can be

found in Appendix B of the regulation. This section also dictates that a copy of the *Long-term care Insurance Potential Rate Increase Disclosure Form* be provided to the applicant.

- **Rescission reporting form:** Section 11, titled *Prohibition Against Post-Claims Underwriting*, requires that insurers selling LTCI benefits maintain a record of policy rescissions, both state and countrywide, and report the information annually to the insurance commissioner. Rescissions voluntarily effectuated by the insured are not required to be included. A copy of the rescission reporting form can be found in Appendix A of the model regulation.

2. Requirements within the NAIC LTCI model regulation that apply only to independent LTCI benefits (not to ABRs)

There are a number of sections in the NAIC long-term care insurance model regulation where life insurance policies that accelerate benefits for long-term care are exempted from certain requirements, and therefore will apply to only independent LTCI benefits. These include:

- **Suitability** (Reg 641, Section 24)
- **Loss ratio** (Reg 641, Section 19. Note: Only Subsection B of Section 19, which dictates considerations in evaluating the expected loss ratio, does not apply to ABRs)
- **Inflation protection benefit** (Reg 641, Section 13)
- **Nonforfeiture benefit** (Reg 641, Section 28)
- **Shopper's guide** (Reg 641, Section 32)
- **Availability of new services or providers** (Reg 641, Section 26)
- **Right to reduce coverage and lower premiums** (Reg 641, Section 27)

3. Market conduct issues within the NAIC LTCI model regulation

Sections 23 and 24 in the NAIC long-term care insurance model regulation cover market conduct issues.

Section 23: Standards for marketing

This section states that insurers must establish marketing procedures and agent training requirements to assure that marketing activities are fair and accurate and that excessive insurance is not sold. It also discusses several other requirements such as:

- Displaying a notice to buyer on the outline of coverage
- Providing copies of certain disclosure forms
- Identifying whether prospective applicants already have sufficient LTC insurance
- Establishing auditing procedures for verifying compliance
- Providing notice to prospective policyholder of the state's senior insurance counseling program, if one exists
- Proper use of the terms *noncancellable* or *level premium*

The section also covers prohibited practices, such as twisting, high-pressure tactics, cold lead advertising, and misrepresentation. Also included in the section are materials that must be filed with

the insurance department. Finally, there are also requirements listed for associations that are selling or endorsing long-term care insurance policies.

Section 24: Suitability

This section does not apply to life insurance policies that accelerate benefits for long-term care.

NAIC LONG-TERM CARE INSURANCE MODEL REGULATION ACT 640

The NAIC Long-Term Care Insurance Model Regulation Act 640 also contains some helpful information. Section 6K, titled *Disclosure and Performance Standards for Long-Term Care Insurance*, contains requirements for a *monthly report* that should be provided to the policyholder during the time period that LTCI benefit payments are being made from a life insurance policy with an accelerated death benefit. The report should include:

- Any LTCI benefits paid out during the month
- An explanation of any policy changes (e.g., death benefits or cash values that are due to LTCI benefits being paid out)
- The amount of LTCI benefits remaining

The NAIC LTCI Model Regulation Act 640 also addresses *policy summaries and illustrations*. Section 6J of the model act requires a *policy summary* with specific provisions to be furnished at the time of policy delivery. The statement should include:

- An explanation of how the LTCI benefit interacts with other components of the policy, including deductions from death benefits
- An illustration of the amount of benefits, the length of benefit, and the guaranteed lifetime benefits, if any, for each covered person
- Any exclusions, reductions, and limitations on LTCI benefits
- A statement that any LTCI inflation protection option required by Section 13 of the LTCI Model Regulation Act 640 is not available under this policy
- If applicable to the policy type, the summary should also include:
 - A disclosure of the effects of exercising other rights under the policy
 - A disclosure of guarantees related to LTCI costs of insurance charges
 - Current and projected maximum lifetime benefits
- The above policy summary provisions may be incorporated into either:
 - A basic illustration required to be delivered in accordance with the state's basic *illustration* requirement (comparable to Sections 6 and 7 of the Life Insurance Illustrations Model Regulation)
 - The life insurance policy summary, which is required to be delivered in accordance with the state's life insurance policy summary requirement (comparable to Section 5 of the Life Insurance Disclosure Model Regulation)

APPENDIX III: MILLIMAN SURVEY RESULTS REGARDING CHRONIC ILLNESS RIDERS

BACKGROUND

Interest in individual life insurance products with chronic illness riders has been increasing over the last few years. Milliman recently conducted a survey relative to key areas of interest in the chronic illness market. The survey covered chronic illness plans structured under NAIC Model Regulation 620: Accelerated Benefits Model Regulation (i.e., Section 101[g] plans). Long-term care riders and terminal illness riders were not included in the scope of the survey.

The survey was sent via email to 64 carriers active in the life insurance market on December 19, 2011. Forty-three companies submitted responses to the survey, which indicates the high level of interest in this topic. The 43 companies that participated in the survey are:

1. Alfa Life Insurance Corp.
2. Allianz Life Insurance Co.
3. American Family Life Insurance Co.
4. American National Insurance Co.
5. Ameritas Life Insurance Corp.
6. Aviva USA
7. AXA Equitable Life Insurance Co.
8. Cincinnati Life Insurance Co.
9. CNO Financial Group
10. Farm Bureau Life of Michigan
11. Genworth Financial
12. Guardian Life Insurance Co.
13. Harleysville Life Insurance Co.
14. Illinois Mutual Life Insurance Co.
15. ING Life Group – US
16. Jackson National Life Insurance Co.
17. John Hancock Financial Services
18. Kansas City Life Insurance Co.
19. Legal & General America, Inc.
20. Liberty Life Assurance Co.
21. Lincoln Benefit Life Co.
22. Lincoln Financial Group
23. Metropolitan Life Insurance Co.
24. Midland National/NACOLAH
25. Modern Woodmen of America
26. National Life
27. New York Life Insurance Co.
28. Northwestern Mutual
29. Ohio National Financial Services
30. OneAmerica Financial Partners
31. Pacific Life Insurance Co.
32. Penn Mutual Life Insurance Co.
33. Phoenix Life Insurance Co.
34. Principal Financial Group
35. Prudential Insurance Company
36. Securian Financial Group
37. State Farm Life Insurance Co.
38. Symetra Financial
39. The Hartford Life Insurance Cos.
40. Thrivent Financial
41. United of Omaha
42. USAA Life Insurance Co.
43. Western & Southern Financial Group

DISCLAIMER OF LIABILITY

Milliman has relied upon the information and data supplied by the survey participants. We performed no reviews or independent verification of the information furnished to us, although we have reviewed the data for general reasonableness and consistency. To the extent that there are material errors in the information provided, the results of our analysis will be affected as well. This report may not be shared with any third party without Milliman's prior consent. Any distribution of this report must be in its entirety. Nothing contained in this report is to be used in any filings with any public body, including, but not limited to, state regulators, the Internal Revenue Service (IRS), and the U.S. Securities and Exchange Commission (SEC).

SURVEY SUMMARY

The following is a summary of the responses received to the Milliman Chronic Illness Survey. A total of 43 participants responded to the survey out of 64 companies invited to participate. The response rate of 67% indicates the high level of interest in this topic in the marketplace today.

MARKETING CHRONIC ILLNESS RIDER

Of the 43 responses, 11 participants indicated that they are currently marketing a chronic illness rider and the remaining 32 indicated they are not marketing a chronic illness rider. Thirty of these 32

participants reported that they have not marketed a chronic illness rider in the past and the two remaining did not respond to the question. Of the 32 participants that do not currently market a chronic illness rider, it was nearly evenly split between those that intend to market one in the future and those that do not intend to market one in the future. The table in Figure 4 includes a summary of the responses that were received regarding future intentions to market a chronic illness rider:

FIGURE 4: FUTURE INTENTIONS TO MARKET A CHRONIC ILLNESS RIDER

INTEND TO MARKET CHRONIC ILLNESS RIDER IN THE FUTURE?	NUMBER OF RESPONSES
YES	12
NO	11
MAYBE	6
NO RESPONSE	3
TOTAL	32

One participant reported that it currently does not market a chronic illness rider, but will be launching a chronic illness rider soon, so it responded to questions 2-8. Therefore, a total of 12 participants considered the following questions.

APPROACH/STRUCTURE USED

The survey asked participants that are marketing a chronic illness rider to report the type of approach/structure being used. The choices given were as follows:

Lien approach: The payment of accelerated death benefits is considered a lien against the death benefit of the policy or rider 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.

Discounted death benefit approach: The insurer pays a discounted death benefit of the face amount being accelerated.

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.

The most popular approach used is the discounted death benefit approach with eight participants reporting the use of this approach. Five participants reported using a lien approach and two using a dollar-for-dollar death benefit reduction approach. Note that three participants reported using two approaches. The first reported both a discounted death benefit and pro rata death benefit reduction approach. The second reported the use of a lien approach and discounted death benefit approach. The third participant reported that it is using a lien approach for new sales and a discounted death benefit approach for its in-force business.

BASE LIFE INSURANCE PLAN

Using chronic illness riders with multiple base life insurance plans is common. Five of the 11 participants use their chronic illness rider with two different base plans, three use it with three different base plans, three additional participants use it with one base life insurance plan, and the final participant uses it with four base plans. By far, a universal life (UL) base life insurance plan is the most popular base plan currently being used with chronic illness riders. All 12 participants use their chronic illness rider with a UL base life insurance plan. Six companies use a chronic illness rider with a whole life plan, five with a variable life plan, and three with a term life plan.

BENEFIT PAYMENT FREQUENCY

Results were evenly split between survey participants that allow benefits to be paid as a single lump sum, and those that allow periodic lump-sum payments. Seven of the 12 participants offer only one option and

the remaining five offer two options. Eight participants reported that a single lump sum is allowed, and eight participants allow periodic lump-sum payments. One of the respondents that allowed periodic lump-sum payments noted that multiple accelerations are allowed (one per year), but they must be requested individually. Two other options were reported by two participants. The first noted that the maximum acceleration must be taken within one year. The second reported that it pays out benefits as requested as long as the trigger is satisfied up to four times per year.

Of the eight companies that offer periodic lump-sum payments, three offer only one payment frequency option, an additional three offer four payment frequency options, and two offer two payment frequency options. The table in Figure 5 summarizes the frequencies offered by survey participants for periodic lump-sum payments. Annual payments, closely followed by monthly payments are the most popular option.

FIGURE 5: FREQUENCY OF PERIODIC LUMP-SUM PAYMENTS

BENEFIT PAYMENT FREQUENCY	NUMBER OF RESPONSES
ANNUAL	7
MONTHLY	6
SEMIANNUAL	3
QUARTERLY	3

ANNUAL RECERTIFICATION

Only four survey participants reported that annual recertification is required (of the eight reporting that periodic lump-sum payments are offered). Six participants indicated that in their opinion such certification is not required, and two additional participants noted that only a single lump-sum option is offered so this question does not apply.

CAP ON CHRONIC ILLNESS BENEFITS AT HIPAA LIMITS

It is more common to allow chronic illness benefits to exceed HIPAA limits than to cap them at the HIPAA limits. Six of the 12 participants that market a chronic illness benefit allow the benefits to exceed the HIPAA limits. Four participants reported that chronic illness benefits are capped at the HIPAA limits, and the remaining two participants did not respond to this question.

MINIMUM AMOUNT OF LIFE INSURANCE

Survey participants were asked if they require a minimum amount of life insurance to remain in force after payment of chronic illness benefits. The responses were evenly split between those participants that have this minimum requirement those that do not, with six responses apiece.

CHRONIC ILLNESS BENEFIT TRIGGERS

By far, the most common chronic illness benefit trigger is two of six activities of daily living (ADL) and cognitive impairment. This trigger is used by 10 of the 12 participants. One additional participant noted that it uses two of six ADLs, but not cognitive impairment, and also requires confinement to a nursing home. Another participant requires confinement to a nursing home, as well as another trigger. Chronic illness benefits are payable by this participant conditioned upon terminal illness with 12 months or less life expectancy or immediate need to provide the insured with extraordinary medical intervention, continuous life support, or continuous confinement in an eligible institution.

APPENDIX IV: MILLIMAN SURVEY QUESTIONS REGARDING CHRONIC ILLNESS RIDERS

The following survey was emailed to survey participants on December 19, 2011.

Interest in individual life insurance products with chronic illness riders has been increasing over the last few years. Milliman invites you to participate in the following brief survey that covers some key areas of interest in the chronic illness market. The survey covers chronic illness plans structured under the NAIC Model Regulation 620: Accelerated Benefits Model Regulation [i.e., 101(g) plans]. Long-term care riders and terminal illness riders should not be included. Generally, the survey is structured for ease in completion by checking the correct response to each question. Participants in the survey will receive a complimentary copy of the survey responses (on an anonymous basis).

Please complete your response by January 10, 2012, and email it to sue.saip@milliman.com.

1. Are you currently marketing a chronic illness rider?

- Yes (If so, please respond to questions 2 through 8)
 No

If not,

a) Have you marketed a chronic illness product in the past?

- Yes (If so, please respond to question 2 only)
 No

b) Do you intend to market a chronic illness product in the future?

- Yes
 No

2. If you currently market a chronic illness rider, or have marketed one in the past, what type of approach/structure do/did you use?

Lien approach: The payment of accelerated death benefits is considered a lien against the death benefit of the policy or rider 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.

Discounted death benefit approach: The insurer pays a discounted percentage of the face amount being accelerated.

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.

3. What type of base life insurance plan is the chronic illness rider attached to? (indicate all that apply)

- Universal life
 Variable life
 Term life
 Whole life

4. What benefit payment frequencies are allowed under your chronic illness rider? (indicate all that apply)

- Single lump sum
- Periodic lump-sum payments (indicate frequency below):
- Annual
- Semi-annual
- Quarterly
- Monthly
- Other: Please describe _____

5. Is annual recertification of the chronic illness required?

- Yes
- No
- Not applicable; single lump-sum payment only is provided.

6. Chronic illness benefits:

- May exceed the HIPAA limits.
- Are capped at the HIPAA limits.

7. Do you require a minimum amount of life insurance to remain in force (i.e., residual death benefit) after payment of chronic illness benefits?

- Yes
- No

8. What are the triggers for payment of chronic illness benefits?

- Two of six activities of daily living (ADLs) or cognitive impairment
- Confinement to a nursing home
- Other: Please describe _____



Two Conway Park
150 Field Drive
Suite 180
Lake Forest, IL 60045
USA
+1 312 726 0677 tel

milliman.com