Thrivent comments regarding the 2013 Individual Disability Valuation Table
Thanks Eric...

We actually intended some of the questions to be input to the discussion. I edited the list to be more clear. Here are Thrivent’s comments:

1. The large number of table variations may be overwhelming for our valuation and experience study systems as well as being able to maintain the large number of tables.
2. The report needs clarification regarding which table parameters/modifiers are required to be used and which are optional both when calculating reserve factors and when determining company experience adjustments for DLR. Specifically,
   a. Paragraph H) (IX), regarding company experience analysis used to adjust claim termination rates for DLR states “when appropriate, the valuation actuary may take advantage of any flexibility built into the 2013 IDI Valuation table, such as not utilizing diagnosis specific termination rates. Such flexibility is designed in recognition that there will be some situations in which the data is unknown or the actuary is not confident in the accuracy of the underlying data. There is no flexibility in using the 2013 IDI Valuation Table structure of age, gender, duration or elimination period.” Does this mean that claim termination rate table parameters such as occ class and modifiers such as benefit period/COLA may or may not be used at the discretion of the actuary?
   b. If the answer is “yes”, then we believe there should be clarification that the table used for the company experience analysis should use the same parameters/modifiers as the table used for calculation of the DLR.
   c. The report is silent regarding this issue for ALR. Does the valuation actuary also have the discretion to take advantage of the table flexibility when calculating ALR?
3. On page 39, the formula for Z does not include group 1. It only says groups 2-5. Please clarify that the formula applies to all groups.
Thrivent comments regarding the 2013 Individual Disability Valuation Table

Thank you, Kim. I’ll add Thrivent’s comment (#5 in the list below) to our set of received comments.

At Thrivent, we’re pleased with and support the prospect of an updated industry and valuation table for Disability Income insurance that better reflects current industry experience. We’ve reviewed the report and have a few clarifying questions and comments.

1. What are the requirements for mapping occ classes when a company’s occ classes don’t match up with the IDEC occ classes? For example:
   a. A company does not have a medical occ class or has a medical occ class with fewer medical occupations than IDEC’s medical occ class.
   b. A company’s occ class covers part of two IDEC classes.
   c. A company splits IDEC class 1 (white collar) into 2 or 3 occ classes.
2. Which incidence and termination rate variables are required and which are optional for ALR? For DLR?
   a. Incidence variables: EP, Occ, Gender, Cause, Type, Smoker/non, Issue State, BP, Market
   b. Term variables: Type, BP, COLA/No, Issue State, Diagnosis (DLR only)
3. What are requirements for adding company experience for #1 and #2 above? (particularly ALR) What variables are required when constructing the “expected” for the experience adjustments? Do they have to be consistent with the variables used for DLR?
4. What other variables (if any) can be added? For example: offset or other benefits. We assume the appointed actuary has the latitude to make adjustments for these benefits but it would be helpful if the report clarified this. Is this also the case for mental nervous contract limitations?
5. The large number of table variations may be overwhelming for our valuation and experience study systems as well as being able to maintain the large number of tables.
6. Are there any requirements/guidelines about rounding in the calculation of T?
7. Page 39: does not include group 1 – only says groups 2-5? We assume group 1 is the same as groups 2-5.
Thank you for the opportunity to comment as this report starts its way toward state adoption.

Kim H Tillmann, FSA, MAAA  
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IDI Valuation Table - Some Preliminary Technical Observations
Thanks, these are helpful

Hi Doug and Bob,

I have started to receive some comments from member companies regarding the IDI Valuation Table exposure. I will develop formal comments on some of the main themes I have received and submit to HATF; however, I thought it would be helpful to go ahead and submit some ‘technical’ observations. This will allow your group to review and if modifications to correct are warranted, then those can happen. I’ve copied Eric so he is aware of these technical comments.

Here are the comments:

Diagnosis Codes – Some Ambiguity with Mapping

1. “Other Unspecified External Cause” is listed as mapped to the High CTR modifier group in the IDTWG report but in the IDTWG workbook “Other Unspec Eff Ext Causes” is mapped to the “Not included” CTR modifier group.

2. “Diseases of Skin” is assigned to the Low CTR modifier group in the IDTWG report. There is no such category in the IDTWG workbook. It appears those ICD-9 codes may have been incorrectly assigned in the workbook to “Diseases of Blood”.

3. “Ill-Defined is assigned to the Mid CTR modifier group in the IDTWG report. There is no such category in the IDTWG workbook. There is an IDTWG workbook category of “No Classifiable Diagnosis” which has been assigned to the “Not Included” CTR modifier group. It is not clear what the intent is here.

4. The IDTWG report does not mention those diagnosis groups that have been assigned to the “Not Included” CTR modifier group in the IDTWG workbook. The IDTWG workbook has four diagnosis groups assigned to the category: “No Classifiable Diagnosis”, “Normal Pregnancy”, “Other Unspec Eff Ext Causes”, and “Poisoning”.

5. ICD-9 code 312 is categorized as “Chronic fatigue”. ICD-9 code 312 is a code used for mental illness, specifically attention deficit and other disruptive behavior disorders. The correct ICD-9 code for chronic fatigue syndrome appears to be 780.71

6. It would appear that the IDTWG diagnosis category “Cancer” might be better named Neoplasms because it includes ICD-9 codes for benign neoplasms, such as uterine fibroids.

7. It has been noted that the IDTWG workbook does not map to all the ICD-9 codes. For example, the IDTWG workbook does not contain the ICD-9 E codes for External Causes of Injury and Poisoning. In addition, other codes related to pregnancy, diseases of the skin, and diseases of the circulatory system are missing. Not exactly sure how that would adversely affect carriers if that remains.
8. Neither the report nor the workbook explicitly states what the CTR modifier by diagnosis to use for the CTR modifier category "Not Included". Is it safe to assume that the modifier is 1.00 for all durations? Might be ideal to explicitly state something to that effect.

And just as an FYI for consideration, starting October 1st this year, ICD-9 codes will be replaced with ICD-10 codes. My understanding is that one-to-one mapping between these two sets of codes does not exist. It might be wise for the group to review that upcoming transition and consider the ramifications to the current mapping and what might be done to prepare for this transition.

I hope you find me sending what I find more ‘technical’ mapping issues now ok.

Regards,
Steve

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June 5, 2014

Mr. Eric King  
Staff, Health Actuarial Task Force  
National Association of Insurance Commissioners  
1100 Walnut Street  
Suite 1500  
Kansas City, MO 64106-2197

RE:  2013 Individual Disability Income Valuation Table Exposure Draft Comments

Dear Mr. King,

Thank you for giving us the opportunity to comment on the 2013 Individual Disability Valuation Table Exposure Draft. We have spent some time going through the new tables and proposed regulations. Our questions/comments are as follows:

1. The addition of the Market Modifier, which recognizes the special risk-characteristics of the employer-sponsored market, is highly relevant to our business. As such, we appreciate and endorse the new approach.

2. In several sections of the new regulations, the concept of businesses within a company being grouped and/or segmented arises. We found the treatment of these groupings to be a little unclear from section to section. The specific sections in question are:

   o Company Specific Experience – Own Experience Measurement. Here, the work group put recommendations in that seem straightforward, such as “…company experience analyses [can] be segmented into any major subgroups that the appointed actuary believes may produce significantly different results (e.g. market niches, risk management practices, unique benefit designs, etc.)”.

   o Own Experience Measurement Exemption: The regulation currently reads that there is an exemption “For companies with a small claim portfolio…” Given the segmentation that is allowed in the Own Experience Measurement above, is the exemption allowed to be applied on a segment-by-segment basis, or only on a full company basis?

   o New Valuation Standard Application and Transition Rules: Again, is the decision regarding the election to move prior issue/incurred years to the new reserve standard a decision at the full company level, or can the decision be applied on a segmented basis as allowed in the Own Experience Measurement?

3. Is the intent for short-term disability plans to be included in the new reserve standard? (As a side note, the similar but unrelated changes to the Group LTD valuation tables make it very clear that the intent is not to impact short-term disability plans, defined as disability income coverage having a maximum benefit duration of two years or less. A similar level of clarity regarding applicability to short-term business is lacking in the IDI valuation tables.) In our opinion, application of valuation table to short-benefit-period business would add a significant
amount of complexity to the claim reserving process. Calculating claim-specific DLR for this kind of business would add unnecessary complexity as compared to the resulting increase in precision.

4. Regarding the new occupation class “M”, there does not appear to be an option for companies that want to apply the new tables to prior issue/incurred years, but do not have the data to identify which policies would now be classified as occupation class “M” (for example when the policies involved are very old). We think the regulations could benefit from having a “default” option for this situation, similar to the instructions provided for what to do in the event that we don’t have the data to classify a policy in terms of the new diagnosis code factors or smoking status factors in the new standard.

We appreciate all of the time and effort that have gone into the development of the new tables! If you have questions about our comments above, please do not hesitate to contact me at (847) 283-2603 or patty.kyriazes@trustmarkins.com.

Sincerely,

Patricia Kyriazes, FSA, MAAA
2nd Vice President & Actuary
Trustmark Insurance Company
PolySystems 2013 IDI Comments  Questions
Eric

I have a few comments / questions regarding the 2013 Individual Disability Valuation Table that is currently exposed for comment.

1. I did not see anywhere what the age basis was for the incidence rates and termination rates. Mortality tables typically have an age basis of ANB or ALB. Are the 2013 IDI tables ANB or ALB?
2. The incidence rates and select termination rates start at age 20. The first ultimate termination rate should be at age 30, but the table starts at age 32. My recommendation would be to extend the table down to age 30 even if it means repeating the age 32 rates.
3. The chart on page 8 of the report indicates that the attained ages for the select termination rates are from 20 to 70, but the workbook only has select termination rates from 20 to 69. Is the chart incorrect or are we missing select termination rates for age 70?

Regards,

Dana Atkins ASA MAAA
Actuarial Associate
PolySystems, Inc.
June 19, 2014

Eric King
Staff, Health Actuarial Task Force
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

Re: Proposed 2013 Individual Disability Insurance Valuation Table

Dear Mr. King,

On behalf of Unum Group (Unum), I am pleased to comment on the proposed 2013 Individual Disability Insurance Valuation Table. The Unum Group includes the following statutory insurance companies with individual disability policies inforce:

- Unum Life Insurance Company of America
- First Unum Life Insurance Company
- Colonial Life & Accident Insurance Company
- Provident Life and Accident Insurance Company
- Provident Life and Casualty Insurance Company
- The Paul Revere Life Insurance Company

A primary focus for Unum has been in products which provide financial protection to people in case of disability. Unum’s companies sell disability products through employer paid group, employee paid voluntary products, and individual policies. Our individual disability business that is impacted by the proposed 2013 table includes over 750,000 policies inforce and over $13 billion in statutory reserves across all of the statutory companies listed. In addition, we have substantial business inforce under employee paid voluntary products.

Unum believes the 2013 table is an important update to the statutory valuation requirements for individual disability insurance and we have supported the development and its implementation. Our comments are in four areas:

1. We believe clarification is needed in the regulation so that the table does not have unintended adverse tax consequences for the industry.
2. We believe that clarification is needed for claim reserve requirements for shorter benefit periods included in some voluntary and individual disability insurance policies, i.e. with benefit periods not longer than two years.

3. We have some concerns that the 2013 table (as well as the predecessor 1985 CIDA table) does not fit well for policy reserves for short term individual and voluntary disability insurance because of the very minor volume of such plans included in the experience for the industry table.

4. We point out some technical points upon examining the reserves produced from the new table.

**Tax Concerns Regarding Use of Company Experience in Claim Reserves:**

We believe that additional language should be added to the Health Insurance Reserves Model Regulation (HIRMR) describing the use of the 2013 table with company experience modifiers as described in the Actuarial Guideline as the standard table for new contract issues and new claim incursals after the adoption date. This will help the industry avoid ambiguity and make use of the 2013 table for both statutory and tax reserves. We believe that the AAA Tax Working Group can provide additional guidance on this topic.

Our suggested language is needed to clarify that the 2013 IDI Valuation Table, including the modifiers, is the prescribed standard valuation table for contract reserves. In addition, the 2013 table including the company experience modifier is the prescribed standard table for claim reserves. This standard table would be required to be updated as company experience emerges and credibility of data changes. Our language changes are in italics.

I. MORBIDITY

A. Minimum morbidity standards for valuation of specified individual contract health insurance benefits are as follows:

   (1) Disability Income Benefits Due to Accident or Sickness.

      (a) Contract Reserves:

      No changes from 2013 report until the following:

      **Contracts issued on or after January 1, [YEAR 2]**

      The 2013 IDI Valuation Table with modifiers as described in the 2013 Table Actuarial Report
(b) Claim Reserves:

(i) For claims incurred on or after [YEAR 2]

Use the 2013 IDI Valuation Table with modifiers
described in the 2013 Table Actuarial Report and with the
company experience modifier as described in the
Actuarial Guideline.

Claim Reserves for Short Term Individual Disability Insurance:

Consistent with group short term disability reserving, many companies use completion factor or
reserve triangle methods to set claim reserves for very short benefit period plans. These plans
typically have 3 or 6 month benefit periods and can range up to twenty four months. The
HIRMR language changes that were included in the proposed 2013 table report removed the
existing language allowing for use of company experience. We believe that language should be
included with the 2013 table HIRMR which makes clear allowance for alternative experience
and methods for these plans.

On Page 33 of the 2013 table report (Appendix 1 – Proposed Changes to the Health Insurance
Reserves Model Regulation) is quoted in part below. Our proposed change to Section 2.B. (1)
Claim reserves is the addition of item (iii).d. highlighted by bold type and underlined.

“Proposed Changes - Wording

(i) For individual disability income claims incurred prior to [Date 1], each insurer may elect
which of the following to use as the minimum morbidity standard for claim reserves:

a. The minimum morbidity standard in effect for claim reserves as of the date the
claim was incurred

(ii) For individual disability income claims incurred on or after [Date 1], but before [Date 2],
the minimum standards with respect to morbidity are those specified in Appendix A,
except that, at the option of the insurer, assumptions regarding claim termination rates for
the period less than two (2) years from the date of disablement may be based on the
insurer’s experience.

(iii) For individual disability income claims incurred on or after [Date 2], the minimum
standards with respect to morbidity are those specified in Appendix A, except that the
insurer may do the following:

a. Use the insurer’s own experience computed in accordance with Actuarial
Guidelines [XX], and

b. Make an adjustment to include an own experience measurement margin derived
in accordance with Actuarial Guidelines [XX] and,

c. Apply a credibility factor derived in accordance with Actuarial Guidelines [XX]
d. For plans with benefit periods of up to 2 years, at the option of the insurer,
reserves may be based on the insurer’s experience, if such experience is
considered credible, or upon other assumptions and methods designed to place a sound value on the liabilities.

(iv) At any point in time, the insurer may elect to apply (iii) above for all claims incurred prior to [Date 2]. This can be done if the following conditions are met:
   a. The insurer must apply (iii) to all open claims;
   b. Once an insurer elects to calculate reserves for all open claims based on (iii), all future valuations must be on that basis.”

Contract Reserves for Short Term Individual Disability Insurance:

The 2013 table did not include experience for very short elimination period and benefit period products that we and other carriers sell as primarily 100% employee paid voluntary products in the work site. These products are offered to all classes of employees, resulting in a risk pool with salary levels and average monthly indemnity benefits that are lower than traditional individual disability policyholders. These products have significantly different policy characteristics than the longer products sold through other distribution channels. These plans have available benefit periods ranging from 3 to 24 months, and the average length of disability is less than 90 days. In addition, these short benefit period products typically cover maternity claims, while the longer benefit period products only cover complications from pregnancy.

We propose clarity of wording that short benefit periods (up to 24 months) can apply alternative valuation methods and use company experience where credible. This is consistent with other provisions in the HIRMR and adds clarity that these products can be treated with those provisions. We suggest the following language (in italics) be added to the 2013 table HIRMR language.

Contracts issued on or after January 1, [YEAR 2]

The 2013 IDI Valuation Table, except for short benefit period policies (up to 24 months) where alternative assumptions may be used including company experience where credible.

At any point in time, the insurer may elect to apply the current morbidity standards for all policies issued prior to [YEAR 2]. This can be done if the following conditions are met:

   a. The insurer must apply the morbidity standard to all inforce policies;
   b. Once an insurer elects to calculate reserves for all inforce policies based on the current morbidity standard, all future valuations must be on that basis.
These short term disability products are typically sold using industry premium ratings rather than occupation classes as is presumed under the 2013 table. To handle the situation where a qualified actuary can place a sound value on the liability for these short term disability products, but does not have occupation class information on the policyholders, we suggest that language be added to allow blended occupation factors for products sold through distribution channels that do not collect occupation information. For example, voluntary short term disability benefits sold in hospitals where some employees would fall under the Medical (M) occupation class and others like clerical and maintenance would fall under a non-medical class should use blended incidence and claim termination rate factors based on the expected distribution of medical and non-medical employees. We suggest the following language in italics be added to the 2013 table report.

*For products sold through distribution channels where occupation classes are not collected and where pricing is based on industry or factors other than occupation classes, the occupation class distinct incidence and claim termination rates may be blended based on the expected distribution of occupation classes.*

**Technical Comments:**

We note that the 2013 table can result in negative active life reserves and that companies should be aware of the requirement that policy reserves should be floored at zero. We believe that negative reserves were also present under the 1985 CIDA table which was addressed with a floor on the reserves. Without such a floor, reserves can turn negative in certain circumstances. This is covered in paragraph 35 of the HIRM which we assume will be maintained:

*"Negative reserves on any benefit may be offset against positive reserves for other benefits in the same contract, but the total contract reserve with respect to all benefits combined may not be less than zero."

We believe that diagnosis modifiers for claim reserves with regard to mapping of the ICD9 codes will lead to some ICD9 codes not having a direct mapping. To alleviate this concern, we believe that ranges of ICD9 codes should be mapped rather than the individual codes. The ranges should be set so that any individual code will fall into one and only one range. In addition, the AAA committee should have plans for mapping ICD10 codes which become the standard code at some point after 2015.

We believe that guidance is needed as to how “age” is defined for incidence and claim termination rates for the 2013 table. We believe that the table development documentation contained in the AAA valuation committee report should specify this information. Our understanding is that age last birthday was utilized for the experience studies that were used to develop the 2013 table but would like clarification. For the termination rates, we believe that age should be defined the same way when calculating ALR’s and DLR’s.
Unum appreciates the opportunity to comment on the 2013 table. We look forward to working with you to complete this important valuation initiative.

Sincerely,

[Signature]

Albert A. Riggieri, FSA, MAAA
Senior Vice President and Chief Actuary
Unum Group
June 26, 2014

Steve Ostlund, Chair  
Health Actuarial Task Force  
National Association of Insurance Commissioners

Dear Steve,

The American Academy of Actuaries’ Tax Work Group appreciates the opportunity to comment on the 2013 Individual Disability Income Valuation Tables.

Section 807 (d)(5)(A) of the Internal Revenue Code requires that tax reserves be calculated using the most recent commissioners’ standard tables prescribed by the NAIC which are permitted to be used in computing reserves for that type of contract under the laws of at least 26 states when the contract was issued. Section 807 (d)(5)(B) provides a transition period during which either the previous prevailing table or the current prevailing table may be used in calculating tax reserves.

We are proposing a revision to the Health Insurance Reserves Model Regulation to clarify what the NAIC considers to be the standard table. This clarification of the definition of the standard table would promote uniformity in the determination that the NAIC-prescribed standard table to be used for tax reserves includes modifiers and adjustments, which are integral and necessary to determining the appropriate statutory reserve level.

In addition, since tax reserves are to be determined using the table and interest rate as of the "issue date," we have proposed language to clarify for tax purposes that for claim reserves, the claim incurral date is to be considered the "issue date" for determining the table and interest rate to be used for disabled-lives reserves. This is a clarification and not a substantive change as, for example, Appendix A, II., B. states "For claim reserves on policies that require contract reserves, the maximum interest rate is the maximum rate permitted by law in the valuation of whole life insurance issued on the same date as the claim incurral date."

Proposed changes to the regulation:
1. I. A.(1) (a)  
Replace "The 2013 IDI Valuation Table" with "The 2013 IDI Valuation Table with the modifiers described in the Actuarial Report for the 2013 Table"

2. I. A.(1) (b) (ii)  
Replace "use the 2013 IDI Valuation Table" with "The 2013 IDI Valuation Table with the modifiers described in the Actuarial Report and adjustments for company experience as

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prescribed in the Actuarial Guideline"

3. Section 2. A.
Add: “(4) For claim reserves on policies that require contract reserves, the claim incurral date is to be considered the "issue date" for determining the table and interest rate to be used for disabled-lives reserves."

Please contact Bill Rapp, Assistant Director of Public Policy at the American Academy of Actuaries, (rapp@actuary.org; 202-223-8196) if you have any questions or comments.

Sincerely,

Barbara Gold, Chairperson
Tax Work Group
American Academy of Actuaries
The Standard 2013 IDI Table Comments
June 27, 2014

Mr. Steve Ostlund, Chair Health Actuarial Task Force
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

Dear Steve:

First, The Standard thanks the members of the Individual Disability Table Work Group (IDTWG) for a great advancement in the topic of how to improve the valuation of individual disability insurance contracts and claims. This is a critical topic impacting long term industry solvency to buyers and regulators of individual disability coverage and the investors in this business.

Second, thank you to the Health Actuarial Task Force of the NAIC for the opportunity to opine on the recommendation.

This commentary will first articulate some guiding principles applied to the issue of responding to this recommendation. As noted above this recommendation will have significant ramifications for the IDI industry for years, maybe decades. Thereafter the actual commentary begins and is segregated into two sections. The first section addresses higher order issues and the second, the more mechanical aspects of the proposal.

GUIDING PRINCIPLES

1. **Solvency** – if anything, the final new valuation table should increase the odds that all market participants (IDI carriers) remain solvent long term, by helping more accurately quantify their financial obligations. The net effect is not necessarily to just add more to statutory minimum liabilities but to more effectively identify higher or lower liabilities amounts appropriately. So the recommendation should claim to improve the measurement and monitoring of carrier long term solvency.

2. **Promote equity** – in two ways. The new valuation process shouldn’t unduly affect the outcomes of the IDI market. In particular, the size of an IDI operation shouldn’t become any more positively correlated with success than the concerns for solvency dictate. So smaller operations shouldn’t be any more disadvantaged than absolutely needed, nor larger ones, advantaged. The second aspect is the balance between policyholders (and by proxy, regulators) and investors. The capital requirements implied by a valuation basis can make the market more or less attractive to investors. This could limit the size and development of the market if excessive amounts are required. What constitutes “excessive” is of course, one of the key issues in this recommendation, but the point is that a healthy private IDI market must balance both appropriate solvency standards and efficient use of capital.
3. **Minimal market impact** – the features of the new valuation process, after the two items above are addressed, shouldn’t determine nor limit how the IDI market evolves in the next decade or two due to particular features or attributes.

4. **Minimal complexity** – the complexity of the new valuation process should be just enough to produce increased solvency in a cost effective way but no more. The marginal impact of additional refinements versus their cost in computation, compliance and likely errors should be applied to discern the halting state where theoretical rectitude is counterbalanced by the direct and indirect costs of those additional refinements.

**THEORTICAL CONCERNS**

1. **Own Experience Adjustment:**

   The Individual Life industry is moving towards first principle valuation (own experience and option pricing) away from setting minimum tabular reserves. CIDC is purely tabular with limited margins. Both the GLTD 2012 and the 2013 IDI Recommendation are taking a compromise position: Start with tabular plus larger margins then allow some limited credit for own experience. But there is a key distinction between Life and DI coverages. Mortality rates have declined consistently, making the only point in controversy is, “How fast will they drop?”

   Morbidity seems to have much greater volatility associated with it. If the trend of relying on own experience is based on the experience of the life insurance valuation, this suggests caution for the IDI market.

   Furthermore, in comparison, the impact of own experience adjustments is much greater in the LTD market (several competitors would max out the own experience adjustments where the full credibility standards are more readily attainable) than in the IDTWG recommendation. Only a few IDI carriers will be able to avail themselves either positively or negatively of own experience, especially in the out years of a claim when reserves are highest. So for most IDI carriers it will be essentially a tabular valuation basis.

   Given the inapt metaphor of first principles from life insurance valuation and uneven impact of own experience adjustment perhaps it would be better to eliminate the own experience adjustment from the recommendation. Alternatively the IDI credibility thresholds could be lowered from the level set by the GTLD 2012 valuation standard under the theory that a block of IDI claims might attain a given credibility level faster than a block of LTD claims due to the fact that much more information is known at issue on IDI risks compared to LTD risks. This would produce an impact for the own experience adjustment more similar to that in the 2012 GLTD.

2. **Margin may be too conservative:**

   As stated above, there should be an appropriate balance between solvency and capital efficiency established for every insurance line of business. This recommendation seems to add greater redundancy to the reserve valuation. So the question arises is this needed or appropriate? For example, having margin in both termination and incidence – does this support the 85% probability of adequacy rule implied indirectly on page 16 (adequacy of loaded base incidence rates for 10 of 12 carriers) and directly in the 2012 GLTD valuation table recommendation page 9. Surely this implies the risk of inadequacy is less than 15% as both components of loss, frequency and severity, are loaded to that standard and compounded in the valuation basis. Setting the margin standard at 85% of termination process, as it is in the 85 CIDC or the 2012 GLTD seems appropriate or perhaps applying the 85% standard to imputed
claim costs across all carriers would adequately support both ends. Furthermore given that some contributors have much larger blocks than others, as a regulator, I’d wonder which 2 were out of bounds. If it was the two largest that would be about 50% of the market. So does the margin cover 85% of the carrier’s variability or does it cover 85% of the claims variability? This could make the margin more or less conservative but it would be nice to know one way or another. Also, incidence rates are loaded on the basis of the 12 companies contributing to the entire study period (1990 to 2007), some of which are now closed blocks which never enjoyed the benefits of stricter underwriting. Hence some portion of the embedded experience encompasses not the entire UW cycle but one weighted towards the worse durations. So the margin is doubly conservative (if not the experience table itself). Given that the proposed own experience relief from excess conservatism is not available to most market participants this seems imprudent. The current margin requirements seem clearly oriented towards the solvency needs to the detriment of the market growth. Constraining market growth may be a legitimate objective if the IDI market is irremediably damaged, but it shouldn’t be the implicit function of a tabular valuation basis. To the extent such concerns exist, they should be embedded in RBC calculations or explicit requirements on the appointed actuary.

3. **Complexity of calculation:**

The addition of new valuation parameters (new medical occ class, expanded attained ages and elimination periods, contract type, smoker status, issue state, benefit period, issue market, presence of COLA, disability diagnosis) adds a great deal of refinement to the existing gender, claim cause, occupation class, attained age and elimination period structure. This higher level of informational and computational overhead can probably be supported with today’s technology but shouldn’t be underestimated. Furthermore it demands a higher level of table renewal and maintenance, with shorter refresh cycles (can’t wait 30 years again). As more parameters are fed into the statutory valuation process then continually revalidating and re-estimating their impact becomes mandatory. This adds to the burden on the industry as well as individual carriers. So at some point there has to be a halting state where additional structure impedes the health of the market rather than supports it.

4. **State as a Valuation Parameter:**

As long as the states have yet to cede the adoption of acceptance or maintenance of statutory valuation standards to the NAIC, the inclusion of state of issue could become problematic. If a domiciliary state (not CA, NY or FL) approves the recommendation but CA, NY or FL don’t, there appears to be a lack of clarity how the tables will be used. For example, do CA policies issued by CA carriers become cheaper than CA policies issued by non-CA carriers? Does the CA DOI only approve CA rates that don’t reflect CA increased reserve bases? Until federal regulation of insurance liabilities can impose equity in a uniform manner to address such issues, it is unclear whether an NAIC based solvency tool like minimum reserve standards be an adequate platform for such an issue. Unless the various complexities surrounding state specific parameters are clarified, geography should be dropped as a valuation parameter.

5. **Level of Granularity:**

The work group selected a number of additional modifiers for this proposed valuation process. Perhaps the intent of additional incidence and termination modifiers is to drive recognition of undervalued contractual obligations under the existing valuation process. This is appropriate but perhaps there is another way. If undervalued risk attributes (e.g., smoker status) or contract
provisions (e.g., COLA) threaten the market, a bright light should be shown upon them. However, no statutory valuation system can adequately illuminate all risk features equally and fairly. So if a valuation parameter does not address an existential risk or support market equity, careful consideration is needed to justify its inclusion, even if by some statistical measures it is significant. The countervailing issue with refining the valuation process is that unless it is based on first principles and statistically adequate and credible it can lead equally false conclusions or support true ones only ephemerally. Consider the absurd outcome of including a much broader set of modifiers – one that establishes a unique valuation basis for every policy. Would such a scheme give regulators and investors more or less confidence in the industry? Probably not, but also certain policyholders would be barred from the market because their premiums would become exorbitant. Risk pooling would be broken if we acted as though we could assign an exact reserve to every claim and policy. So we should examine whether this proposal strikes a good balance between allowing for robust risk pooling and the benefits that accrue from that (and form the raison d’être of the industry) and the risk of endemically undervalued liabilities like lifetime benefits. But the balance must be preserved so the clarification of risk doesn’t have the unintended consequence of swamping opportunity. Besides issue state variations, the least meaningful modifiers seem to be smoker status and contract type. But all the newly proposed modifiers should be scrutinized from this perspective.

MORE MECHANICAL CONCERNS

1. Negative ALRs vs. floored at zero: can the IDTWG clarify whether this can be applied in aggregate, by sub-block or seriatim? On the face of it there are a number of scenarios where individual policies will produce negative ALRs in some durations. What is the intended way to handle these situations?

2. The meaning of the “Employer Sponsored Multi Life” (ESML) phrase needs clarification. What exactly is multilife? Two lives? How much employer sponsorship is required? Sponsorship can mean as much as the employer defining the benefit plan and paying for it to the employer merely allows a producer to approach employees on the premises of the worksite. Some minimal description of ESML to justify the large difference in reserving seems justified.

3. The definition of Class M is quite broad – nurses, chiropractors, podiatrists and therapists have significantly different morbidity patterns than doctors and dentists. Would it be possible to re-estimate without the minor medical occupations or give guidance on splitting the Class M?

4. Segmentation – must closed blocks be reported separately? What if they are acquired through merger or acquisition? What are the standards for breaking out a block as distinct or not? Beside the actuarial opinion of the appointed actuary, there should be some minimal numerical standard for guidance on when to separate for margin adjustments. The critical decision of segmenting the block or not is the key decision of the appointed actuary. Piling on more flexibility without guidance on usage could undermine regulator faith in the recommendation.

5. Look back period in (H) (IV) (5 years unless longer – page 24) could be defined better than just at the whim of the appointed actuary. Perhaps a credibility based sliding timeframe of at least 5 years but at most 10 years with smaller blocks expected to use longer baselines.
6. It seems as though block segmentation lowers the credibility of a large block, meaning a large aggregate block with some credibility can be split into smaller segments, each with less credibility. If a large block with bad experience can escape an adverse own experience margin adjustment through segmentation and a small block with good experience can get none, there seems to be a danger of unintended consequences. Perhaps a comparison between pre- and post-segmentation reserves can be done asymmetrically so the benefit to a poorly performing large block is less than the benefit of a well performing block.

7. Since the overhead expense product is reimbursement based and that seems to explain much of the variation in claim behavior, perhaps it would be better to reposition the contract type (BOE) modifier as a reimbursement versus indemnity benefit modifier.

Thanks again to the HATF for spearheading this very important project and the IDTWG for all their efforts and dedication to the IDI industry and the IDE Committee of the AAA. It is deeply appreciated.

Sincerely,

Robert Wade, FSA, MAAA
Director Asst. Actuary
Principal comments on IDI Valuation Final
June 30, 2014

Mr. Steve Ostlund
Chair, NAIC Health Actuarial Task Force
Alabama Department of Insurance
Via Email

RE: Exposed Draft – Individual Disability Income Table

Dear Mr. Ostlund:

**Executive Summary**

This letter offers comments regarding the new Individual Disability Valuation methodology and tables, which have been exposed for comment. The comments in this letter are on behalf of Principal Life Insurance Company. As of the end of 2013, Principal Life was ranked in the top 5 in total IDI sales and the top 5 in non-cancellable IDI inforce premium (per LIMRA). This new standard is obviously important to Principal Life. As an active and large player in this market, we were surprised to see some areas where our internal experience and market perspective were inconsistent with the proposal. While we support the general direction of the proposal, we believe there are several key aspects that require more time and research. We recommend that these issues be studied in greater detail by technical experts so that appropriate revisions to the proposal can be made before it’s ready for NAIC adoption.

Our strongest areas of concern, which are discussed in greater detail later, are below:

- **Modifiers for Employer Sponsored Business:** The proposed market modifiers do not distinguish between the various types of employer sponsored business. Fully underwritten multi-life business has better experience than Guaranteed Standard Issue (GSI) business. The GSI business, which is a growing market, could be under-reserved going forward using the proposed factors. There should be distinct modifiers for GSI-Employer and GSI-Voluntary business.

- **Medical Occupation Concerns:** Grouping all medical occupations into a single medical class does not appropriately reflect the wide range of experience that exists within this risk class. Also, the high claim cost assigned to this class does not represent recent medical experience that is based on today’s underwriting, plan designs, and demographics. As proposed, the new medical class table would unnecessarily increase consumer costs and tie up capital for carriers. We recommend having a few separate medical classes with tables more reflective of claims costs from policies issued in the last 15 years.

- **Time for Testing:** The proposed changes in methodology are significant. It has been difficult for the industry to evaluate the financial impact of the proposal because of its complexity as well as the resource impacts of the new group LTD reserve requirements. Insurers should be given additional time to model the potential impact of the changes.

As discussed elsewhere in this memo, there are other parts of the proposal that deserve further evaluation. Our company would be happy to participate in any further analysis or discussions.
Detailed Comments

We thank the individual disability experience and valuation committees for their hard work. It’s been a long time since such a comprehensive study of the industry has been completed. The 1985 CIDA has been outdated for quite some time. We greatly appreciate the efforts involved with putting together this new standard. We applaud the general direction of the work group’s recommendation.

There are some areas in the proposal which deserve further research and discussion. Here is a brief discussion of those items.

1. The modifier table by market is a welcome addition, since we know that experience varies by market type. However, the presence of underwriting does impact anticipated experience. As such, the current proposed factors may significantly understate the necessary reserves for GSI business – particularly GSI business sold on a voluntary basis. We would recommend three separate factors for the Employer Sponsored market: Underwritten, GSI-Employer, and GSI-Voluntary.

2. We appreciate the addition of the medical occupation class, since that general occupation category makes up a significant portion of IDI business and often has separate rate tables. However, we struggle with putting all medical occupations into a single class. There is a wide range of disability risks within the medical profession, much as there is within the non-medical professions (which get 4 classes in the recommended standard). Chiropractors and nurses are a much different risk than pediatricians and allergists. Specialists doing invasive procedures are a different risk than those primarily doing office visits. This is evident when looking at how companies assign the various medical occupations to classes for pricing purposes. If there is going to be a separate standard for medical, it seems that there should be more than one class.

Also, we are concerned with the high level of new active life reserves and claim costs for the medical class. In some cases, the proposal’s net level premium values for the medical class are higher than those for blue collar occupation classes. The medical business written in the 1990s did have poor experience. Based on our own experience, medical experience has been much more in line with non-medical experience on policies issued since 2001. While we could understand some conservatism because of the history and potential volatility in the medical market, the values in the proposal seem too high and inconsistent with current pricing and risk management practices. We could support values that are higher than the top non-medical class given the historical concerns, but would not go as high as the current proposal suggests.

3. The new reserving methodology is much more complex than the current methodology and will require considerable effort and resources to implement. Unfortunately, it is difficult to determine the impact of the changes without some financial modeling. Given that this standard was exposed at the same time that finance and systems resources were dedicated to the implementation of the Group LTD reserve changes, we feel that more time is needed to model the impact of the changes for IDI. In general, we would also support revisions that would simplify the new methodology and calculations.

4. The number and granularity of some of the proposed modifiers was higher than expected. For example, the modifiers By Smoking Status and By Benefit Period suggest a level of exactness that may be unrealistic. In addition, we noted that some of the patterns appear inconsistent, which may indicate the level of precision has been taken too far. Some of those cells likely have very little business in them, and we believe the credibility of the underlying cells should be
considered to determine whether the resulting factors are supportable. We would suggest revisiting these tables and making the modifiers simpler and more consistent.

5. We were confused by the decision to single out the state of Florida with a 79.4% factor for claim termination rates. We would recommend using the same claim termination rates in all states, unless there is convincing evidence that Florida is an obvious outlier for most carriers.

6. We support a lower claim incidence modifier for overhead expense (OE) policies as suggested by the work group. In fact, we would recommend that a similar factor be applied to disability buy-out (DBO) business, which should have experience that is similar to OE.

7. While reflecting a company’s own experience in the claim reserves makes sense, it is rather complicated and will require additional programming and experience studies. It will be difficult for most if not all insurers to achieve a reasonable level of credibility on claims beyond the first claim year. In order to maintain a level playing field, we would recommend either applying company experience to only the earliest durations or removing the experience component altogether.

8. The proposal suggests that claims subject to the new standard will use the latest set of assumptions, regardless of the incurral year. Given the potential volatility in IDI claim results, this could result in large periodic adjustments to financial results for some companies. We would recommend including an option to allow companies to change the basis prospectively for new claims only.

In general, there are instances where our internal experience differs from the Individual Disability Experience Committee (IDEC) experience study, upon which most of the proposed tables and factors are based. While we participated in and appreciate the value of that IDEC experience study, we also recognize that claims incidence and terminations are greatly influenced by claim practices, contract nuances and other factors that are company specific. The fact that the experience table underlying the valuation table is reportedly represented by 40% of one carrier’s experience might explain why some of the factors are inconsistent with our own experience. The 1990s represented a unique period in the IDI industry. Many changes have been made to contracts and market practices since then. While we would support using the IDEC study as a guide, we would call for more analysis in those areas we’ve identified above, where factors are potentially not in line with current experience for carriers with a significant amount of IDI business.

We appreciate the opportunity to submit comments on the new IDI reserve standard. We hope these comments will be helpful in shaping the final recommendation.

Sincerely,

Tracy K. Koch
Actuary-Pricing (IDI)
Principal Life Insurance Company
Phone: (515) 248-9806
Email: koch.tracy@principal.com

cc Eric King, NAIC Health Staff
June 30, 2014

Mr. Steve Ostlund, Chair Health Actuarial Task Force
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

Via email: eking@naic.org

RE: Observations on New 2013 Individual Disability Income Valuation Table

Dear Steve:

The American Council of Life Insurers (ACLI)\(^1\) appreciates the opportunity to provide industry comments to the exposed 2013 Individual Disability Income (IDI) Valuation Table and accompanying workbook. We appreciate all the work that the Society of Actuaries and American Academy of Actuaries working groups have done to produce the new IDI valuation table.

While the new IDI valuation table is more robust and provides more specificity than the current valuation table(s), we do have some concerns with the number and granularity of proposed modifiers, both the with claim termination rate (CTR) and claim incidence rate (CIR) modifiers. Since claims incidence and terminations are greatly influenced by claim practices, contract nuances and other factors that are company specific, any concentration of one company’s data can mean a valuation table is more biased toward that company’s practices and experience. The fact that the experience table underlying the valuation table is reportedly represented by 40% (after “scaling down”) of one carrier’s experience, too many modifiers may lead to a false sense of precision.

Member feedback has produced the following observations and thoughts for further review and consideration before finalizing the IDI valuation table:

### Numerous Modifiers – Possible Double Counting

The presence of numerous modifiers may have the unintended effect of double counting certain factors, which may lead to inappropriate and overly conservative reserves. An example of this may be as follows: Assume a certain subset of a risk characteristic (Occupation class M) exhibits a lower CTR than another subset of that same risk characteristic (Occupation class 1). If such subset of the risk characteristic (Occupation Class M) is also concentrated in another risk characteristic that exhibits a lower claim termination rate (for example, lifetime benefit period), the lower claims termination factor will be multiplied. However, the modifier for lifetime benefit period is the same factor for all occupation classes since it was derived by comparing the claim termination statistics of all lifetime claims to those of all “To

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\(^1\) ACLI is a Washington, D.C.-based trade association with approximately 300 member companies operating in the United State and abroad. ACLI advocates in federal, state, and international forums for public policy that supports the industry marketplace and the 75 million American families that rely on life insurers' products for financial and retirement security. ACLI members offer life insurance, annuities, retirement plans, long-term care and disability income insurance, and reinsurance, representing more than 90 percent of industry assets and premiums.
Age XX” claims. The lower Occupation Class M termination rates seem to be accounted for in the Occupation Class M rate and in the Lifetime Benefit Period modifier, thus duplicating the lower claim termination factor and resulting in reserves that are too conservative. Has this scenario (or double counting in general) been discussed by the Academy Working Group?

ICD-10 Codes
ICD-9 codes will be replaced by ICD-10 codes starting October 1st of this year. There is no one-to-one correspondence from the ICD-9 codes to ICD-10 codes. A potential solution of this issue is to consider simplifying the number of codes (some of them are ambiguous) with additional review to determine if the factors are still a good fit for the new diagnosis categories. We bring this to your attention as there may be possible implementation issues when the final IDI valuation table is finalized and adopted.

State Specific Modifiers
Some members question having state modifiers for California, Florida, and New York as their experience does not suggest the necessity of all three modifiers. However, several ACLI members consider these modifiers appropriate for the new IDI valuation table. We note that neighboring states usually exhibit similar trends in experience as its neighbors. ACLI seeks to clarify if this particular “neighboring state/similar claim pattern” issue has been reviewed by the Academy Working Group.

Incidence Modifiers by Benefit Period
Feedback has suggested that the Incidence Modifiers by Benefit Period should also vary by issue age. For example, a policy issued to an insured at age 60 with a “To Age 65” benefit period policy or with a “5 year” benefit period policy are the exact same risk and the industry charges the exact same premium for these two policies. Under the current proposal these two policies would generate different reserves because the IDI valuation table does not vary the Benefit Period Incidence Modifiers by issue age. Can the Academy Working Group opine as to whether this suggestion was reviewed or can be reviewed as a possibility?

Smoker Status
If it is determined that there could be some reduction of the number of modifiers, we suggest as one avenue that consideration be made to ‘reduce’ Smoker status down to two factors, “nicotine” and “non-nicotine” incidence modifiers. This would reduce the 34 factors that are currently in the IDI valuation table and not have to split by occupation class, gender and elimination period. Or asked as a question, has the experience been reviewed to ensure that the smoker to elimination period (smoker/EP) pattern is not driven by the mix of the contributing companies?

Pregnancy Claims
We request that consideration be made to assign all pregnancy claims, including normal pregnancy, their own CTR modifier group, which would be consistent with the 2012 Group Long Term Disability Valuation Table approach. Or has the Academy Working Group already analyzed this possibility?

Benefit Period Modifiers
Does the experience for policies with benefit periods less than “To Age 65” but greater than five years support grouping them with short-term benefit periods rather than “To Age 65” benefit periods? Although experience with benefit periods above five years and less than “To Age 65” is limited, the experience on these policies seems to be more consistent with “To Age 65” policies. Thus, it appears that it may be more accurate to group experience and develop factors by lifetime benefit periods, short-term benefit periods (five years or less), and other benefit periods (greater than five years and less than lifetime).

Occupation M – Claim Termination Rates
We question why ultimate claim termination rates in Occupation Class M are lower than Occupation classes 1-4. Since it appears that mortality is basically the sole driver of claim termination rates in those
ultimate durations (11+), we ask why there is a difference by in termination rates by occupation class. Clarification on this issue would be appreciated.

**Claim Termination Modifiers**

It has been observed that the longer an insured is on claim, the higher the proportion of claim terminations is from death rather than recovery. It appears that by claim duration 11, the vast majority of the claim terminations are from death. With the current proposed IDI valuation table and modifiers, there appears to be a discontinuity observed in the reserve patterns from year 10 to year 11. To avoid this potential discontinuity, we suggest that there be some type of review and analysis to determine if there should be some type of grading (“smoothing”) towards 1.0 by duration 10. This would help eliminate the discontinuity that is being observed. Appendix One provides graphs showing this discontinuity of the reserve pattern. One will see that the claim termination rates after application of the COLA and Benefit Period modifiers do not grade to a factor of 1.0 by duration 10.

**Overhead Expense Modifier**

The modifier by contract type (Overhead Expense = 67%) appears to add a layer of complexity for what appears to be a small product in the industry. Since Disability Buy-Out product (another small product in the industry) has no modifier, we seek clarification as to why.

**Reinsurance - Consideration**

As currently proposed, the IDI valuation table will require all companies, except those with a small claim portfolio, to utilize their own experience to determine minimum reserves. There is no distinction made for assumed or ceded reinsurance. This provision may create differences in reserve standards on the same business between an assuming and a ceding company. If not already done, we would ask that the Academy Working Group review this issue.

In summary, ACLI appreciates the work that has been done to date by the American Academy of Actuaries producing an updated individual disability income insurance valuation table. Thanks again for the opportunity to provide member feedback. We hope that these observations (and some suggestions) will help improve the final product.

Sincerely,

Steve Clayburn

cc: Eric King, NAIC
Appendix One

Male, Claim age = 40, All BP years 6+ on claim

**OBSERVATIONS:**
- Cola doesn’t differentiate CTR when the BP is Lifetime
- Big discontinuity when hitting the ultimate duration, except for To Age 65, No COLA
- Medical occs die slower than class 1 until age 75

Female, Claim age = 40, All BP years 6+ on claim

**OBSERVATIONS:**
- Cola doesn’t differentiate CTR when the BP is Lifetime
- Big discontinuity when hitting the ultimate duration, except for To Age 65, No COLA
- Medical occs die slower than class 1 until age 75
Thank you for the opportunity to comment on the proposed 2013 IDI Valuation Standards.

- For a policy with COLA benefits that may increase with some measure (CPI, for example), is 3% being suggested to be used? The sample spreadsheet that was provided used a COLA rate of 3%.
- Please ensure sufficient time is provided to implement the final standards.

Glen Simpson, FSA, MAAA
Actuarial Analyst III
Life/Health Actuarial
State Farm Insurance
(309) 766-7796
MARC Comments on Proposed 2013 Individual Disability Income Valuation Tables
Eric,

We appreciate the opportunity to provide industry comments on the exposed 2013 Individual Disability Income (IDI) Valuation table. Please find our comments below; please note that these are comments from several individuals within Munich Re.

2012 IDEC vs. 2013 IDI
- Base incidence rates have changed in IDI 2013 comparing to IDEC 2012. Basis for the change?

2013 IDI incidence rates
- Female EP30 base sickness rates show a noticeable dip between ages 40 and 55. Any thoughts?
- A very steep increase is noted in female EP0 base accident rates; much steeper than for males and/or other EPs.
- Is it reasonable to except that male EP7 base accident rates for class 1 and M to decrease with age while rates for other EP’s remain constant or increase?
- Incidence smoker adjustments are very high for occupation class 1 and M but are much lower for other classes; any thoughts?

Inconsistency between spreadsheet and report
Some inconsistencies are noted in the claim termination modifiers between the spreadsheet and the report. Please clarify which source is correct.

<table>
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<th>Claim Termination Modifiers</th>
<th>Spreadsheet</th>
<th>Report</th>
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</tr>
<tr>
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<td>263.0%</td>
</tr>
</tbody>
</table>

Possible implementation issues
- Considering that we are in the reinsurance industry, we don’t always get occupations (or occ classes) split by Medical vs. Non-Medical from our client. Please clarify on how we should implement the new "M" table.
- As a reinsurance company, please provide guidance on how to appropriately reflect company specific experience (i.e. need to calculate the experience for each ceding company separately or as whole). If
we are allowed to use company experience as a whole, do we have concerns around risk transfer? On the contrary, it appears cumbersome if we need to calculate experience for each ceding company.

- The report is silent on the treatment of riders. Please provide any guidance on reserving for riders.
- The report specify single adjustment for all accident claims, but not for sickness. Aggregate termination table may not be appropriate on cases where waiting period for accident/sickness differs and/or for accident only coverage. Please advise on a combined adjustment for sickness (all causes) termination rates for ALR.

Best Regards,

Evi Tedjasukmana, FSA, MAAA
Associate Actuary
Living Benefits Reinsurance - Pricing

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