



AMERICAN ACADEMY *of* ACTUARIES

January 9, 2003

Lucy Huffman
Project Manager
Office of Microeconomic Analysis, U.S. Treasury
1500 Pennsylvania Avenue, NW
Washington, D.C. 20220

Re: Comments on Study of the Impact of Threat of Terrorism on Availability of
Group Life Insurance

Dear Ms. Huffman:

On behalf of the American Academy of Actuaries' (Academy¹) Life Practice Council, we would like to thank you for contacting us for information on the Study of the Impact of Threat of Terrorism on Availability of Group Life Insurance mandated by the Terrorism Risk Insurance Act of 2002 (Act).

The U.S. Department of the Treasury is seeking information concerning the characteristics of the group insurance marketplace. Some of this information is related to market capacity and availability of coverage. We believe that information of that sort can be better provided by an organization such as the American Council of Life Insurers (ACLI). We do, however, have several items that may assist you in understanding some of the product and market characteristics for group life, as well as understanding some of the issues related to the threat of terrorism on group and health insurance markets.

¹ The American Academy of Actuaries is the public policy organization for actuaries practicing in all specialties within the United States. A major purpose of the Academy is to act as the public information organization for the profession. The Academy is non-partisan and assists the public policy process through the presentation of clear and objective actuarial analysis. The Academy regularly prepares testimony for Congress, provides information to federal elected officials, comments on proposed federal regulations, and works closely with state officials on issues related to insurance. The Academy also develops and upholds actuarial standards of conduct, qualification and practice and the Code of Professional Conduct for all actuaries practicing in the United States.

Attached is a copy of the monograph "Group and Health Coverage in the Wake of September 11" developed by the Academy's Terrorism/Extreme Events Work Group. The section on "Group Life, Disability, and Other Non-Medical Coverage" (beginning on page 12) addresses the risk exposures of customers and how they are concentrated. We have previously provided you with a copy of the draft monograph, which has now been released as final.

Also attached is a copy of the group life insurance portion of the Society of Actuaries' Study Notes on Group Health, Group Life, and Managed Care. Study notes are materials that are provided for the basic education of actuaries. In addition, we have also attached the Group Life Insurance Benefits chapter of the ACTEX Publications *Group Insurance* textbook, which is generally considered the textbook of choice for actuaries in the field. Both of these documents address characteristics of group life insurance offerings and were prepared prior to the events of September 11, 2001.

We think that there are two important arguments for including group life insurers under the Act:

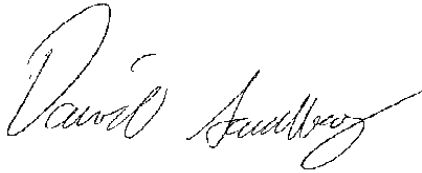
- First, terrorism events cannot be priced. Group insurance is primarily sold in the employer marketplace. This characteristic, which provides for efficient delivery of coverage to employees, has an inherent risk of "contagion." That is, workers are likely to be concentrated geographically, and may often be working in the same facility. A catastrophic event of any type can produce losses for a particular group plan that represent a significant number of insured lives. The insurers of these groups can have a significant exposure. That is why catastrophic reinsurance and its availability are important for group coverage. By contrast, a company writing individual insurance coverage does not have the same concentration of risk.
- Second, group life insurance is uniquely important in providing life insurance protection to many Americans. In fact, more Americans are covered by group life insurance than by individual insurance. Many only get coverage because employers pay the cost as part of an employee benefit package. Even though these people may have access to individual life insurance, it is often less convenient, and may be subject to medical underwriting. Furthermore, individual coverage commonly has a higher initial cost and may be less attractive in the short term to many workers.

It is important that group and individual life insurers be able to protect their financial viability so that benefits can be paid when due. We believe that further information should be gathered to determine appropriate deductible levels and industry aggregate retention levels. In addition, consideration needs to be given to the fundamental differences in the risk and claim levels between group life and property/casualty coverages. In fact, consideration of these factors will also reveal the value of creating two separate and distinct pools for group life and property/casualty coverages. The Academy would be willing to provide some additional analysis, but would require more time than is available within the current comment deadline.

We appreciate the opportunity to be of service to you, and invite a continuing dialogue to help meet your needs.

Please contact Steve English (english@actuary.org), the Academy's Senior Life Policy Analyst, if you have any questions or comments.

Sincerely,

A handwritten signature in cursive script that reads "David Sandberg". The signature is written in black ink and is positioned above the typed name and title.

David K. Sandberg,
Vice-Chair, Life Practice Council
Chair, Life Financial Soundness/Risk Management Committee

Other members of the Academy who contributed to this letter are: Faye S. Albert, Cecil D. Bykerk, Andrew M. Erman, Alan D. Ford, Andrew S. Galenda, Mindy B. Giraldo, Eric L. Smithback, and Daniel L. Wolak.

Public Policy Monograph

December 2002

Group and Health
Coverage in the Wake
of September 11



AMERICAN ACADEMY *of* ACTUARIES

American Academy of Actuaries

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Group and Health Coverage in the Wake of September 11

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Executive Summary

The events of September 11, 2001 had a substantial effect on the insurance industry, particularly in the property/casualty, workers' compensation, and reinsurance areas. The events alerted us to the possibility that future attacks could significantly affect the group and health insurance industry and self-insured employer market. This is particularly significant for plans provided through employment, which usually have the unique characteristic of concentrated risk in limited locations.

How would group and health coverage be affected if a suicidal terrorist detonated a bomb in a crowded area or if a "dirty bomb" was used to spread radiation? How would the marketplace react if a biological agent were introduced into the water and food supply?

This monograph examines the impact of catastrophic terrorist events on group and health coverage including medical benefits and non-medical benefits such as group life, disability, and long-term care.

Medical Coverage

Any type of catastrophic terrorist event would have a broad effect on various entities including individuals, employees, private employers, insurers, reinsurers, health care providers, and all levels of government. Effects could be immediate, as in the need for medical care, or they could be longer-term, as in the need for delayed or ongoing mental health services.

A catastrophic terrorist event would likely cause increased medical claims as people affected by the attack seek treatment and as individuals experience symptoms that may or may not be related to the event. It would likely result in higher premiums for survivors of a catastrophic terrorist event due not only to higher claims costs, but also to increased reinsurance costs.

In addition, a catastrophic terrorist event could have a significant impact on solvency and reinsurance availability for medical insurers. Reinsurance is critical to maintaining solvency of insurance carriers, but it may not be available to provide for coverage of a terrorism event. Damages resulting from a catastrophic terrorist event could be large enough to threaten the solvency of health insurance carriers and self-insured plans, especially if reinsurance or a federal backstop is not available.

Group Life, Disability, and Other Non-Medical Coverage

As mentioned above, a catastrophic terrorist event could have a broad and varied effect on many different entities. Some of the impact could be in the area of predicting claim costs and the resultant effect on financing and capital for non-medical insurers.

The impact of a terrorist event on the capacity to write insurance could be significant for group life, disability, and other non-medical insurance carriers, especially if catastrophic reinsurance or a government terrorism program is not available. A catastrophic terrorist event would also have an impact on the need for capital since the industry needs to have sufficient capital to meet its claim obligations. Reinsurance allows insurers to write more coverage with the same amount of capital. Since September 11, there has been a significant decrease in catastrophic reinsurance capacity, particularly for group life insurers. Providing reasonably priced reinsurance coverage is an increasing concern for disability and specified illness coverage as well, since the impact of a catastrophic terrorist event would emerge over an extended period of time.

Additionally, the cost of coverage would be affected by a terrorist event. There are several considerations that could influence pricing and underwriting in the wake of such an event, such as increased cost of coverage where risk is concentrated in areas of higher perceived risk, or where insurers pass along increased reinsurance costs.

Group and Health Coverage in the Wake of September 11

A catastrophic terrorist event could have a substantial impact on group and health coverage—both medical and non-medical benefits. In response to a terrorist event, insurers could experience increased claims and reinsurance premiums, decreased availability of reinsurance, and possible insurer insolvency. Although catastrophic terrorist events cannot always be prevented or avoided, their impact on the financial security provided by insurance and employee benefit programs could be minimized through risk-sharing mechanisms that involve the partnership of all affected entities.

Introduction

The tragic events of September 11, 2001 have changed us in many ways. We have renewed appreciation for our relationships and their meaning to us. We have also re-examined our security on many levels — recognizing that there are many aspects that extend beyond protection of life, limb, and property. Security also means protection from the financial burden of unexpected, and once unimaginable, events. Insurance and employee benefit programs can help enhance our financial security.

The September 11 attacks were indeed singular and catastrophic, but they alerted us to the possibility of future terrorist actions, and to the fact that terrorism can take many forms. Attacks by suicidal terrorists through conventional bombs remain possible, especially in areas where people gather or in places such as nuclear power plants where greater devastation is possible. But our concerns are not limited to direct physical attacks. There are other actions less direct and slower to emerge that are nonetheless equally devastating. There is the possibility of the general dissemination of biological agents in our water and food supplies, and the possibility of radiation, spread through so-called “dirty bombs.”

Much of our financial security comes from insurance and employee welfare benefit programs. In this monograph, we will first discuss the implications of potential catastrophic terrorist events (CTEs) on the future of insurance and financial security provided through medical coverage. Next, the monograph addresses the implications of a potential CTE on the future of non-medical coverage, including long-term disability income (LTD); short-term disability income (STD); long-term care (LTC); limited benefit plans (such as hospital income); specified illness plans; and death benefits provided through group life, accidental death, and travel accident plans. Although each section focuses on specific types of coverage, some of the implications will apply to both medical and non-medical coverage as well as to pension benefit programs and individual life and annuity policies.

For some acts of terrorism, the effect on medical benefits is immediate, such as an increased need for antibiotics due to a biological event. For other acts of terrorism, there may be longer-term effects on medical benefits, such as delayed or ongoing utilization of mental health services.

Similarly, there could be an immediate effect on non-medical insurance and employee benefits, or there could be longer-term effects on benefits that provide for disability and long-term care. For example, a “dirty bomb” would likely cause relatively few immediate deaths and injuries, but illness, disabilities, and the need for long-term care would emerge over time. A biological, chemical, or radiological attack could spread illness over extended periods of time. The economic effects of terrorism may change the characteristics of disability experience, since the ability to find jobs affects the frequency and length of claims. When looking at employee benefit programs, we might find that terrorist acts would reduce some costs while increasing others (e.g., death benefits replacing annuity costs.) However, any terrorist act would likely change the level and pattern of expected costs for insurance and employee benefit programs.

CTEs could change the dynamics for handling contingent events by potentially overwhelming parts of the insurance and employee benefit systems and by causing some parts of these systems to be re-defined. CTEs have the potential to produce events that will impose a sustained demand for services in addition to large initial demands.

Group plans, especially those provided through employment, usually have the unique characteristic of concentrated risk in limited locations. Terrorist attacks at the workplace make it likely that a number of employees covered under a single plan (perhaps even all of them) would be at the same site. Regardless of the number of participants, the risk for that plan at that location is concentrated. For that reason, appropriate insurance and reinsurance are needed to make sure the promises of the plan can be met. This is true for all types of risk-bearing entities, including insurers, health care plans, or self-insured employer plans.

The discussion that follows describes in more detail the entities that are affected by potential CTEs, and how they are affected by the new climate of concern in the wake of September 11. We will be looking at topics such as: the availability of insurance and reinsurance, cost and underwriting issues, and solvency concerns.

Medical Coverage

Who is Affected?

Individuals/Employees

Individuals affected by CTEs require medical care. Depending on the type of attack, certain individuals such as rescue workers and other disaster-related personnel are also at elevated risk. For example, nearly one-third of the survivors of the September 11 attack who were treated for injuries were rescue workers (firefighters, police officers, emergency medical technicians, and other disaster-related personnel).¹ During a biological or chemical attack, maintenance workers, custodial workers, mailroom employees, emergency medical technicians, health care workers, public health officials, police, and fire personnel are all at elevated risk for medical services.

Private Employers

A CTE may cause interruption of business and the loss of key employees — a critical risk for employers. Since September 11, corporate risk managers have been scrambling to find ways to address the peril of terrorism risk. Insurance coverage, loss control, and alternative risk transfer are three risk management approaches employers use to deal with the risk of a CTE.

Insurance

Corporate risk managers will need to analyze medical plans offered and the ability of carriers to accept medical risk. The risk manager needs to consider the surplus of the primary writer in relation to the carrier's concentration of insureds. Reinsurers may exclude terrorism coverage, leaving primary carriers without reinsurance for terrorism losses.

Loss Control

Since September 11, loss control assumes an even greater importance in the marketplace. Employers (and insurance companies) should address issues such as concentration of risk, security measures, and the relative safety from terrorism at work-site locations.

Alternative Risk Transfer

There is renewed interest in other alternative risk financing tools for employers, such as captive insurance companies, formed by firms banding together to create their own risk-bearing entity and risk retention groups.

There are also significant medical risks for employers. Much of the medical coverage of the September 11 event was provided through workers' compensation policies.² Workers' compensation carriers do not have the discretion to drop terrorism coverage. Unfortunately, while some workers' compensation carriers are providing terrorism coverage, rate increases are as much as 100 percent for businesses with significant terrorism exposure. Other insurance plans are leaving the market (at least for larger white-collar employers in urban areas). For example, at least one insurer reportedly was not providing workers' compensation coverage to any business with more than 50 employees in any one location in New York City.

Health Insurance Industry

In addition to the terrorism risks shared in common by all employers, health insurance companies, including health maintenance organizations, have additional insurance risks. There is the potential for high claims due to direct terrorism incidents such as smallpox, anthrax, plague, and botulism. Plus, there are the potential indirect costs including mental health and post-traumatic stress. Because of these additional risks, changes to premium structures and marketing are likely.

Group and Health Coverage in the Wake of September 11

Government regulations are likely to affect how the insurance industry must respond to potential attacks. The presence or lack of government stop-loss protection would have a significant effect on the risk borne by insurance carriers.

The health insurance industry depends heavily on effective information technology. The National Academy of Science warns that private computer systems are one of the areas vulnerable to terrorist attacks. In addition, effective response to any type of biological attack requires that information be disseminated quickly and accurately to all key players in the medical process. Effective information dissemination is likely to be hindered due to the lack of standards for identifying patients with electronic medical records.

Health Care Providers

Health care providers play a critical role in the defense against CTEs and are greatly affected by such events. Providers face the financial risk of delayed or reduced reimbursement as a result of a CTE. This could happen if a provider's billing system broke down under the pressure and urgency of responding to a CTE, if health plans lacked the financial capacity to immediately meet all of their benefit obligations, or if the banking system were to be disrupted for an extended period.

In the event of a CTE, clinical enhancements, adequate staffing, and improved information systems would be essential.

Providers need to develop increased capacity for clinicians and hospitals to engage in disease surveillance and disease reporting related to the intentional release of biological or chemical agents. Providers should also be educated on the diagnosis of smallpox, anthrax, and other contagious diseases. In addition, guidelines are needed to manage contaminated patients and adequate supplies of vital resources are necessary for effective treatments.

Additional health care workers must be available to provide essential emergency services in the event of a CTE. Staffing issues could be critical if health care workers stay away from a facility out of concern for personal or family safety. The Centers for Disease Control have proposed procedures that enable a public health authority to compel a health care facility, including physicians' offices, to provide services or the use of its facility if necessary for emergency response. Uses may include transferring the management and supervision of the health care facility to the public health authority for an unlimited period of time.

Information systems need to be enhanced to effectively address potential CTEs. For example, only 13 percent of hospitals have fully operational computerized patient record systems.³ Most U.S. hospitals are still using paper records, with no potential for quickly moving medical information electronically. The Wall Street Journal reports that the retail pharmacy industry has a powerful database that could provide important information during bio-terrorism attacks.⁴

Reinsurers

The losses incurred by reinsurers from the events of September 11 arose primarily from property and casualty claims. To a lesser extent, claims developed from life insurance coverages. The events of September 11 had little impact on the financial results of health reinsurers.

The market for catastrophic health reinsurance was relatively small prior to September 11 since the coverage was difficult to price and the market was mostly individual coverage for accidents and multiple births. In 2002, an increasing number of health insurers have approached reinsurers about providing catastrophic coverage. The reinsurers have had a limited response to the demand for such coverage since: 1) the pricing of such coverage is difficult; 2) the reinsurer has little control over where the insurers write business; and 3) the reinsurers need to manage capital. Another difficulty in providing reinsurance for terrorism health claims is in developing a clear definition of what constitutes a "claim" arising out of terrorism.

Governments

All levels of government would be touched in the event of a CTE. Key areas of government responsibility during a terrorist attack would be:

- Assisting in the data analysis and detection of an event;
- Diagnosing and characterizing biological and chemical agents;
- Developing the proper response and communication to key response-workers and the public; and
- Declaring an “event.”

In addition to the strategic role federal, state, and local governments would play in these events, government workers — firefighters, emergency medical service personnel, police officers, public health officials, health care workers and public health workers — would play a key role as first responders to a CTE.

What is the Impact on Medical Claims?

Whether a CTE is biological, chemical, or conventional, health care costs would increase. Claims would be likely to increase as people directly affected by the attack seek treatment for both physical injuries and illnesses and for psychological reasons. There may also be a shift in consumers’ behavior toward illness. People afflicted with minor illnesses would likely visit the doctor — or emergency room — when they would ordinarily have recuperated at home without medical attention.

Direct Effect

The immediate requirements following a CTE are likely to include ambulance services (air and land), emergency room visits, inpatient hospital stays, prescription drugs, specialty care physician visits (e.g., surgeons, neurologists, anesthesiologists, radiologists, psychiatrists and psychologists, etc.) as well as follow-up appointments with primary care physicians.

An attack similar to September 11 could expose surviving victims to injuries such as inhalation of dust or aerosols, ocular injuries, lacerations, sprains and strains, contusions, fractures, burns, closed head injuries, or crushing.

Diagnosis and treatment of illnesses and injuries due to a biological attack such as anthrax, plague, botulism, or tularemia would require specific antibiotics or antidotes. Depending on the prior preparations, there could be shortages of the required drugs in affected regions. If the cure is not administered, other medical conditions could develop such as paralysis or pneumonia.

Chemical attacks such as nerve gases could cause a delayed reaction affecting long-term medical well-being. Areas most often affected are eyes, skin, and the respiratory and central nervous systems.

There would also be an impact on the cost of professional services and equipment:

- Contracted providers would have strengthened positions in contract negotiations, resulting in higher negotiated reimbursement rates.
- Depending on the location of the attack (e.g., tourist areas), health plans could experience higher non-contracted and unmanaged out-of-area expenses.
- Demand surge would cause prices of prescription drugs and supplies to increase.
- New drugs would be developed (or re-developed) with brand-name patents that will allow for higher prices.
- Shortage of resources, such as hospital beds, might cause an increase in costs.

Insufficient numbers of hospital beds or a lack of home health care resources could delay the recoveries for those injured, resulting in claims for a longer period.

Group and Health Coverage in the Wake of September 11

Indirect Effects

CTEs could have impacts that are less obvious than the injuries suffered. In an attack similar to September 11, surviving victims could suffer from and seek treatment for non-injury related cardiac, respiratory, neurologic, or psychiatric illnesses.

Mental Health

Regardless of the method, CTEs would most likely result in psychological problems for many people. According to Asst. Surgeon General Brian W. Flynn, “psychological problems, specifically post-traumatic stress disorders that result from terrorist attacks, tend to be more serious, more complicated, and longer lasting than the types of problems that arise after natural disasters.”

While some suffering from mental health issues following a terrorist attack would seek care immediately, some will not. Those who do not might ultimately receive care on a long-term basis. The hoaxes that follow an attack could also add to the instability of the situation.

Laid-Off Employees

Businesses and industries affected by the terrorist attack would, more than likely, be forced to lay off employees. Laid-off workers could continue their benefits through COBRA for 18 months. Studies show that laid-off workers on COBRA use more medical services, generating costs that are often significantly higher than the costs for active employees.⁵

In addition, recent lay-offs have targeted lower seniority (younger) employees, increasing the impact of changing demographics on health care costs.

While COBRA provides important protection for laid-off workers, it is only available as long as the employer's health plan still exists. COBRA continuation coverage will not be available if employers go out of business, or are forced to discontinue their benefit programs. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) guarantees continued access to coverage to workers who have had health coverage for at least 18 months. Widespread business failures or employers' abandonment of their health plans could place a strain on the high-risk pools and other mechanisms states use to guarantee access to HIPAA-eligible individuals.

In the extremely rare event that an employer loses nearly all of its employees, the employer may cease to exist. This would create a dilemma for some employees and dependents of the company since they would have no way to access group health insurance on their own through the federal COBRA law.

Similar Symptoms

Several modes of attack result in flu-like symptoms as the first indicator of infection. Public awareness of this fact has been heightened and the result is more visits to the doctor or emergency room. Patients want assurance that their affliction is the flu rather than the result of biological terrorism. Physicians and hospitals may also increase the normal number of diagnostic tests to defend against the possibilities of illnesses brought on by attacks.

There has also been an increase in the number of requests for preventative flu shots, which resulted in shortages of the vaccine over the fall and winter of 2001-2002.

Uncertainty

Given the inexperience of the United States in dealing with terrorist attacks, there is a great deal of uncertainty that goes with estimating the impact of an event. Managing and reporting financial results with certainty would be difficult.

Cost Offsets through Potential Government Involvement

On June 12, 2002, President Bush signed the Public Health Security and Bioterrorism Preparedness and Response Act of 2002 (Public Law No. 107-188). This law allocates \$4.6 billion to strengthen the nation's defenses against a bio-terrorist attack.

The bill establishes a national disaster medical system to provide appropriate health services, health-related social services, and, if necessary, auxiliary services (including mortuary and veterinary services) to respond to the needs of victims of a public health emergency. It would also:

- Provide \$640 million to maintain a strategic stockpile of vaccines, therapies, and medical supplies to meet the health needs of the United States population, including children and other vulnerable populations in the event of a biological threat or attack or other public health emergency;
- Expand the availability of potassium iodide for communities near nuclear plants to treat radiation poisoning in case of terrorist attack;
- Provide a total of \$1.6 billion in grants to states for hospital preparedness and assessments of the vulnerability of local water systems; and
- Provide \$300 million to the Centers for Disease Control and Prevention to upgrade its facilities.

What is the Impact on Medical Premiums?

In an already inflationary environment for medical costs, the primary effect of CTEs would be higher premium increases assessed on CTE survivors as a result of the direct and indirect claim costs described previously. Depending on the type of CTE, total premium expected by the insurer may be significantly reduced due to the extreme mortality and subsequent loss of membership/exposure. Loss of premium might present the insurer with a short-run cash flow predicament and will likely create long-term solvency concerns.

Increased premiums might be anticipated in areas that are likely targets of terrorism. Large metropolitan areas and areas of sensitive political importance are such targets. Regional health plans, with a high concentration of risk in small geographical areas, will also be more vulnerable to catastrophic risks. Similarly, employer groups with significant exposure concentrated in these areas might receive premium increases based on the perceived risk.

Premium increases would also be generated due to increased reinsurance costs, in anticipation of potential CTEs, especially for regional carriers and for groups with high concentrations of risk.

Health plans could also consider steps that affect availability of coverage in order to protect solvency and coverage for those they insure. Exclusion of terrorism events is one method that has been considered for certain types of insurance. Alternatively, caps might be placed on the reimbursement level for services provided after concentrated events.

What is the Impact on Solvency & Reinsurance?

The catastrophic damages resulting from a CTE could be large enough to threaten the solvency of insurance carriers and self-insured health plans. The total cost of the September 11 World Trade Center loss is estimated to be in the tens of billions of dollars. The property and casualty industry carriers covered most of this loss. Reinsurance helped to spread the risk among many different insurance companies. In the case of large catastrophic losses, reinsurance is critical to maintaining the solvency of insurance carriers. No single carrier could handle a major catastrophic event, such as the World Trade Center loss, without facing the possibility of financial ruin. An effective reinsurance market is essential to carriers who participate in a market subject to catastrophic risk. Similarly, an effective reinsurance market is essential to carriers who offer coverage that does not exclude terrorism events.

Group and Health Coverage in the Wake of September 11

Almost all insurance contracts had war exclusions before the September 11 attack. Whether terrorist attacks would be considered war, however, was ambiguous. Furthermore, reinsurers and carriers would find themselves under regulatory and political pressure to cover the insurance expenses arising from CTEs, such as the September 11 attack. As a result, indemnification of losses and payment of benefits are likely to be provided without dispute or as ex gratia payments.

Property and casualty reinsurers, along with life catastrophic reinsurers, have begun implementing clear contract provisions to exclude terrorism of any kind since September 11. The exclusions could create a gap in coverage if any party in the insurance/reinsurance chain of coverage is required to provide terrorism coverage while the risk-takers on the upstream side are not. This could be particularly alarming because many reinsurers are foreign owned, and smaller foreign reinsurers might not follow directives or mandates from federal or state governments to cover losses outside contractual and legal obligations. A federal back-stop is one alternative to fill the potential insurance gap.⁶

The demands for capital are significant when considering the potential costs of terrorist events, whether a single CTE or a series of smaller but repeating terrorist events. The National Association of Insurance Commissioners (NAIC) capitalization formulas call for roughly one dollar of surplus for each four dollars of risk premium for medical stop-loss underwriting risk. However, the terrorism risk within the United States has not been quantified historically. (Indeed, the level of risk may have increased significantly in recent years, making the use of historical data problematic at best.) Adjusting the NAIC Risk Based Capital (RBC) formula or any other capital formula to accurately assess the capital required for extreme terrorism events will likely be very difficult. If capital is insufficient and an insurer becomes insolvent, state guarantee funds may be available.

CTEs within a small geographic concentration, such as a “dirty bomb” targeting a single town, would have a major impact on local health plans. Many health plans are regional entities. In certain geographic areas, one or two health plans dominate the market share. These health plans are often provider-owned organizations. When hit by a CTE, these local health plans would sustain major financial losses from their insured population as well as from the uninsured or under-insured populations requiring emergency medical care. Smaller health plans would likely have reinsurance coverage; however, the frequency and level of claims experienced with a CTE might still place a health plan at the risk of insolvency. In the event of insolvency, reinsurance will generally provide coverage for a short period, e.g. 30 days. Once a health plan is in financial ruin, covered members might not have any other local carrier options.

National carriers or health plans could sustain a local terrorism event more readily than local health plans. First, these carriers do not have the concentration of risk local health plans have to deal with. Second, these carriers generally have stronger capital positions than the local carriers. Despite diversification and surplus strength, only a few carriers have a capital position in the billions that would enable them to withstand the excess medical expenses resulting from an extreme terrorist attack. Perhaps most frightening of all is the possibility of a biological attack that could not be contained regionally but that affected most or all of the nation. Such an attack could threaten the financial strength of even the largest insurers.

Solvency and Self-funded Health Insurance

Many large employers self-fund their health insurance benefit plans. Roughly one-third of the population receiving health benefits from employer-sponsored plans are covered under self-funded arrangements. These employers often have far less financial capability to absorb catastrophic expenses in the event of a CTE than would insurance and health plan companies. While many self-funded employers purchase stop-loss coverage in excess of a specific amount per covered person (e.g., \$100,000) and per the entire covered population (e.g., 125 percent of the expected claims), they are subject to the medical expense risks below these specified claim levels (attachment points). The largest employers have in the past retained all the risks without any stop-loss coverage.

Just as health plans and health insurers suffer from terrorism losses, self-insured employers are also at risk. Self-insured employers may have difficulty finding affordable stop-loss coverage due to the risk of CTEs. Some employers might return to the fully insured market for coverage rather than self-insure. Whether reinsuring or buying fully insured coverage, employers seeking protection against the risk of terrorism would face increased costs. In addition, there may not be sufficient market capacity to handle an influx of terrorism-exposed employers returning to the fully insured market.

Work site-related medical expenses are likely covered by workers' compensation coverage. Nonetheless, the impact on employed workers could result in psycho-physiological effects on workers' spouses and other dependents. These effects could result in increased mental health and prescription drug costs, and could delay the recovery from non-CTE-related catastrophic illnesses.

Group Life, Disability, and Other Non-Medical Coverage

Who is Affected?

Individuals

Individuals affected by CTEs may experience financial devastation caused by the death or disability of a breadwinner, the costs of treating injuries and illness, or the costs of caring for dependents who are unable to care for themselves.

Individuals provide for these contingencies by purchasing private individual and group insurance, by paying taxes for government-sponsored programs, by establishing personal investment and savings programs, and by contributing to charities that provide support.

Employers

Employers may incur higher costs for their benefit programs, even if they escape the direct impact of a CTE. They may experience slower benefit payments from insurers, or they may receive only partial payments in the event of insurance company bankruptcies. They may lose facilities and employees because of CTEs. In addition, they may lose employees because of necessary social responses to the CTE, such as military reserve call-ups or emergency worker requirements. Material supply and product distribution may be affected, as well as basic communication and utility infrastructures such as mail, telephone, and electrical services.

Insurance Companies

Insurance companies' solvency may be impaired if experience is unfavorably impacted by a CTE. Insurers may choose to withdraw from markets or limit coverage where they believe their solvency could be jeopardized in the future. Reinsurance availability for CTEs may change, with lower limits, exclusions, and higher prices likely. Insurance companies may lose facilities and employees because of a CTE itself, or because employees are involved in the community's response. Insurers may be affected by infrastructure breakdowns, such as loss of utility or communications services, just like any other employer.

Insurance Industry

The insurance industry as a whole may experience a reduction in capacity because of earnings and solvency concerns. Insurance promises cannot be made without adequate financial resources to back them up. Reinsurance may be more restrictive and cost more. Risk-based capital standards may be re-evaluated. Surplus requirements would tend to increase, and investment capital would tend to decrease because of solvency concerns. State guarantee funds could be of some limited assistance should insurance company insolvencies occur.

Self-insured Plans

Self-insured plans could be overwhelmed financially and administratively. In the most severe cases, they could be unable to pay benefits. They could lose the ability to obtain catastrophic reinsurance vehicles at a reasonable cost.

Governments

Governments would be affected at all levels. Programs such as Medicaid, Medicare, and Social Security, as well as state disability and unemployment programs, could face significant pressure for additional benefits. Local governments that provide the initial response to a CTE could experience major facility and personnel losses, significantly impacting their ability to react. Federal hazard management processes would likely expand and require a deployment of resources initially intended for other uses.

Group and Health Coverage in the Wake of September 11

Potential CTEs would affect different entities in different ways. Some of the impact would be in the area of predicting claim costs and the resultant effect on financing and capital. These issues are discussed in the following sections. Other impacts are more general in nature, and affect business, governments, and charities in a much broader context. These issues are mentioned here, but are not discussed further.

What is the Impact on the Capacity to Write Insurance?

The capacity to write insurance can be defined as making sure that promises made can be kept. This is largely accomplished through state oversight and regulation that ensures sufficient capital is available to meet obligations, either in a direct insurer's own surplus or through reinsurance, where specialized insurers provide coverage to direct insurers.

One of the greatest challenges to the insurance industry is to provide coverage at a reasonable price. For example, one element affecting the cost to consumers of insurance coverage is the existence of reinsurance coverage for CTEs. The availability of insurance products has historically been facilitated by the availability of attractively priced, low-deductible catastrophic life reinsurance, which reimbursed carriers for multiple life losses due to a single event. Catastrophic life products have allowed insurers to price for the mortality risk from disease and accidents while having a known cost, the catastrophic premium, for multiple death claims arising from some type of catastrophe.

Catastrophic reinsurance coverage has normally not been required by disability writers due to the difficulty of defining a claim and the long nature of potential claims. Determining an appropriate premium for these coverages is complicated because the true cost of a CTE may not be known for an extended period of time, adding uncertainty and risk to those products. This adds uncertainty to the disability pricing process and increases the financial risk to an insurer offering these products.

It is estimated that \$600 million to \$800 million of claims arose from group life and accidental death coverages due to the events of September 11, with catastrophic reinsurance covering over 50 percent of those claims.

The catastrophic coverages were normally made available by special risk underwriting pools or by the Lloyd's market. An underwriting firm manages the special risk underwriting pools with the risk shared among reinsurers and insurers who agree to take a share of the risk. Since September 11, the reduction in the availability of catastrophic coverage has been partly due to unwillingness of reinsurers and direct writers to take a risk share in a special risk pool where they have little control over the covered risks or the pricing.

For group life insurance, there has been a significant decrease in catastrophic reinsurance capacity since September 11 as described above. This is evident in changes in price, exclusions and limits such as:

- Increases in deductibles from \$500,000 to \$5 million or more;
- Rate increases of up to 500 percent or more;
- Decreased limits on coverage per event to \$10 – \$25 million;
- No quotes for companies with a perceived geographic concentration of risk;
- Exclusion of terrorism coverage;
- Exclusion of coverage for nuclear, biological, and chemical events.

In response to decreased catastrophic reinsurance capacity for group life and accidental death, direct insurers have explored the following alternative approaches, each of which has limitations:

- Obtaining aggregate stop-loss reinsurance that provides reimbursement for losses above a certain percentage of expected losses in a year, up to a maximum dollar amount. The direct carrier retains substantial risks (e.g., up to 140 percent of expected claims). The cost for this aggregate stop-loss coverage is often higher than the cost of pre-September 11 traditional catastrophe products.

- Establishing reinsurance purchasing cooperatives among similarly situated carriers to obtain more favorable reinsurance prices based on an improved risk profile. This is still in the concept phase and is proving difficult to develop and implement.
- Obtaining reinsurance on selected concentrated risks or quota share reinsurance, which covers a percentage of the risk. Due to the competitive pricing for large groups, the direct writers have had little extra margins to pay for the risk premium associated with sharing a portion of the risk.
- Obtaining financial reinsurance to spread losses over several years reducing the current earnings/surplus impact to the direct insurer. However, this does not resolve economic concerns because the risk is not truly transferred.
- Pooling of risk among direct carriers, including existing pools for life and accident (special pooled risk administrators) and other proposed pools for life and long-term disability. As with any pool, the challenge is to manage the pool assessments equitably.

Since so few claims have arisen from September 11 for group disability coverage, direct writers have been less focused on finding a solution for the possibility of unusual claims arising from terrorism. The disability writers have had some preliminary discussions on developing a pooling mechanism to fund CTE claims, but at this point there has not been a sense of urgency for the disability carriers to find some solution.

Direct insurers have not generally made significant changes to their pricing and underwriting practices, despite the difficulty in obtaining reasonably priced reinsurance for CTEs. State regulatory limits on the use of terrorism exclusions and competitive concerns have minimized the changes in their products and practices. However, it will be necessary for these direct insurers to appropriately recognize the risk exposure and reinsurance limitations in their product management.

A difficulty in the group life market has been to receive accurate exposure information by location. Normally the group carrier is aware of the billing address of a policyholder but does not have a record of the location of each insured. It is now common in the workers' compensation market for the employer to provide that level of detail. Group carriers will need to develop better means to track the location of their risks in order to provide a satisfactory level of data for catastrophic reinsurance.

Finally, insurance industry groups have been working with Congress to establish a federal high deductible backstop program for CTE losses to assure the availability of reasonably priced coverage. Extreme losses from terrorism risks may no longer be an insurable risk in the current global political climate, and may warrant federal intervention. The recently enacted Terrorism Risk Insurance Act of 2002 (Public Law No. 107-297,) does not include life and health coverages in the backstop program. The law does, however, authorize a study of the impact of terrorism on those lines of insurance, and the insurance industry is continuing discussions with Congress and the Administration on this issue.

What is the Impact on the Availability of Capital?

The increased risk of losses due to CTEs increases the need for capital to assure that the industry is able to meet its claim payment obligations. Although regulatory and rating agencies have not changed their risk-based capital (RBC) formulas, closer examination is to be expected even if formulas are not formally changed. There will likely be increased concern with carriers that have relatively low RBC ratios.

There are real risks to a carrier's solvency with a CTE. For example, the destruction of a building housing the majority of a client company's employees has the potential to severely impair a carrier's surplus position in the absence of reinsurance protection. There are similar solvency concerns for disability income and long-term care insurance carriers with a bioterrorism event or a "dirty bomb."

Group and Health Coverage in the Wake of September 11

At the same time that there is an increased need for capital, non-medical insurance is less attractive to potential investors. The return on their investment is threatened by increased reinsurance costs and higher retained losses from CTEs.

The higher reinsurance cost, solvency risks, increased need for capital, and potentially higher cost of capital could disproportionately affect small to mid-sized carriers who specialize in the non-medical business. Large group life carriers, who covered most of the claims arising from September 11, tend to have the largest concentrations of risks. The larger carriers have traditionally reinsured only 1 percent of the risks they cover through the purchase of excess reinsurance. Since September 11, there has been some increase in the percent of business reinsured, especially for accidental death benefits. Small carriers, who have greater need for reinsurance, may no longer be able to compete.

What is the Impact on the Cost of Coverage?

Facing the potential for increased losses due to CTEs, direct insurers have a limited number of options to manage this risk in the marketing of insurance products, i.e., pricing, underwriting, and contractual changes. The present position of many state regulators is to prohibit contractual changes limiting exposure to CTEs. Underwriting restrictions and pricing actions are the other potential risk management options that insurers may need to utilize. Alternatively, they may be forced to reduce offerings in certain markets if the returns and risks cannot be appropriately balanced. The extent to which mortality and morbidity are expected to increase, and the extent of any increase in the cost of capital will influence these decisions.

Segmentation of an insurer's portfolio of risks will be an important tool used by both direct writers and reinsurers in managing risk relative to CTEs. This will lead to examining concentration of risk by factors such as location and industry. To the extent that changes are made to pricing and underwriting practices, the market will try to match the costs within a segment to the risk assumed. This will tend to lead to higher prices, or to the extent that this balance cannot be achieved, lessened availability of coverage.

The following considerations will likely influence pricing and underwriting responses to CTE risk:

- Concentration of risk (contagion), where the risk that any particular individual will experience a loss is not independent from the risk of any other individual experiencing a loss, increases the potential risk from a CTE. This is a particular problem for insurers offering group coverage to employers, and for self-insured employer plans. An insurer will try to balance out risks by geographical areas, industries, and other parameters. Cost of coverage will increase in areas of higher perceived risk or where there are significant levels of concentration in any location. For example, an insurer may try to limit the portion of its business concentrated in certain zip codes or certain employer locations. This would be particularly true for small to medium-sized insurers.
- Direct insurers will pass along increased reinsurance costs in their products. They will continue to approach the reinsurance market as an efficient means to spread the risk of CTEs. Catastrophic reinsurance costs will remain high or continue to rise in the absence of viable catastrophic reinsurance markets which, at the current time, are limited.
- Direct insurers, to the extent that catastrophic or other types of reinsurance are unavailable to cover risk at a reasonable cost, will need to reflect a higher cost of capital as the perceived risk level increases. In certain segments of an insurer portfolio, a higher return on investment will be required for taking on added risk. Certain hazardous industries or locations will require higher prices. In some circumstances, insurers may limit sales in some segments because the cost of reinsurance or capital is prohibitive.

- Some smaller insurers may lack the financial resources to accept the risk without reinsurance protection, and may be forced to leave the market.
- Various types of insurance claims arising from experience with death, disability, and long-term care coverages will likely influence pricing and underwriting. Insurers will attempt to predict the likelihood of a CTE and its effects on insureds, such as loss of life, incidence and duration of disabilities, and the nature of disabilities. For any financial security program, these would translate into higher costs for death benefits, disability payments, and caregiver costs. These financial effects can arise as a direct result of a triggering event, or as an indirect longer-term effect such as increased stress-related claims.

Group and Health Coverage in the Wake of September 11

Summary

The world changed on September 11, 2001. The threat of CTEs has altered the insurance and employee benefit arena in many ways. In an effort to preserve capital, insurers have looked for ways to control risk. This has taken the form of higher prices, stricter underwriting requirements, and more restrictive contract provisions for reinsurance coverage. In turn, this has created greater exposure to risk for direct insurers, employers, and individuals who can no longer obtain appropriate reinsurance coverage for CTEs at a reasonable cost.

Insurers and the government need to work together to make sure that benefits promised are benefits paid. Preserving solvency through risk pools, reinsurance, and appropriate capital requirements is essential to the financial security of individuals and their employers. While CTEs are neither predictable nor preventable, their impact on financial security can be minimized through appropriate risk-sharing mechanisms that involve the partnership of all the entities that may be affected by them.

Endnotes

¹ Centers for Disease Control and Prevention, Fact Sheet: *Rapid assessment of physical injuries related to the attack on the World Trade Center — New York City, September 11, 2001*, January 10, 2002.

² The American Academy of Actuaries' Extreme Events Committee provides a broader discussion of the effects of terrorism on workers' compensation and the property/casualty insurance market in the monograph, *Terrorism Insurance Coverage in the Aftermath of September 11*, which is available on the Academy's website at <http://www.actuary.org/casual.htm>.

³ "Health Care Goes Digital: Doctors and hospitals find they can't stay offline any longer," *Wall Street Journal*, June 10, 2002.

⁴ "Inventory Data From Drugstores Could be Tip-Off to Bioterrorism," *Wall Street Journal*, November 13, 2001.

⁵ Charles D. Spencer & Associates, 2000 COBRA Survey (Chicago, Illinois: Spencer's Benefit Reports, 2000)

⁶ On November 26, 2002, President Bush signed into law the Terrorism Risk Insurance Act of 2002 (Public Law 107-297). This legislation creates a federal backstop to limit the liability of the property/casualty insurance industry in the event of a future terrorist attack.

Group and Health Coverage in the Wake of September 11

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**EDUCATION AND EXAMINATION
COMMITTEE OF THE
SOCIETY OF ACTUARIES**

Group Life Insurance

BY
THOMAS A. MCINTEER, FSA, MAAA

*Course 8
Study Notes
Health, Group Life, and
Managed Care*

GROUP LIFE INSURANCE

Course 8 - Health, Group Life, and Managed Care Study Notes

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Introduction

With the exception of very small employers (those with less than 10 employees), almost all employers in the United States offer some form of group life insurance benefits.

Today, 93,375,560 people (34% of the population of the United States) are covered by group life insurance. This percentage covered has risen significantly in the past 40 years. In 1960 only 16% of the US population had group life coverage. Ownership of individual life insurance has seen a steady decline during this same period, from 56% of the population in 1960 to just 36% in 1998. For many households, the only life insurance owned today is group life insurance.¹

¹Trends in Life Insurance Ownership Among Americans, 1999 LIMRA International

US Population Notes:

US population estimate for 2000.....274,634,000

Population between the ages of 18-65.....169,143,000

World Almanac, 1999

This study note will focus entirely on group life insurance.

Some of the reasons that employers buy group life insurance are:

- Most employers offer these benefits and it has become a fringe benefit that employees have come to expect.
- Group life programs give employees income and estate tax advantages.
- Group life benefits have cost advantages when compared to most kinds of individual insurance.
- Many times group life is issued with no individual or limited individual underwriting.

Group life insurance is typically written as annually renewal term insurance with the cost consisting of the currently expected level of claims, the insurer's expenses as well as margins for profits and contingencies. Despite the fact that the cost of term life insurance rises with the age of the insured, the cost of group life insurance typically remains fairly level over time because younger employees enter most groups while the older ones leave. This flow of new entrants tends to keep the average age of covered employees relatively stable.

Group life insurance is similar to most other forms of group insurance. Coverage is issued to a group policyholder (typically an employer but there are other legal groups, such

as associations, unions, or multiple employer trusts). Employees are given individual certificates of coverage.

This study note is divided into the following sections:

1. Policy Provisions;
2. Benefits;
3. Other Types of Coverage;
4. Taxation,
5. Underwriting, and
6. Pricing.

Group Life Insurance Policy Provisions

Basic group term life insurance contracts include provisions that relate to eligibility, continuation of coverage, conversion, portability, grace period and incontestability.

ELIGIBILITY

Most group term life plans allow permanent full-time employees to be eligible for coverage on either their first day of employment or after completing a probationary period (the period of time that an employee must satisfy before becoming eligible for benefits), such as 60 days. Employees must typically be actively-at-work on the date their coverage becomes effective. If they are not actively-at-work, then their insurance will not become effective until return to work on a full-time basis. The actively-at-work requirement also applies to any increase in the amount of insurance.

If the group life insurance is noncontributory, all employees eligible for coverage are effective according to the plan provisions. However, many plans are written on a contributory basis. With this type of plan, it is typical that all employees will not enroll. If an employee does not enroll for coverage within their eligibility period, evidence of insurability satisfactory to the insurance company may be required for the coverage to become effective. The reason for this provision is obvious. The insurance company must be protected from antiselection. However, sometimes plans are written with specific “open enrollment periods” which allow employees the opportunity to enroll during a specified period without furnishing evidence of insurability.

CONTINUATION OF INSURANCE DURING BREAKS OF EMPLOYMENT

Group life contracts describe the conditions under which coverage can be continued during breaks in service such as temporary layoffs or leaves of absence. Contracts typically allow that coverage can continue on a basis that precludes individual selection for a set period of time (such as 3 or 6 months).

CONVERSION

Group term life insurance contains provisions that allow individuals to convert all or part of their group term life insurance to an individual policy without evidence of insurability. Conversion is permitted whenever an employee's coverage terminates. The contracts typically differ on whether the termination is an individual or group termination. An individual termination occurs whenever life insurance ceases because: (1) employment terminates; (2) the employee is no longer in the class eligible for insurance; or (3) coverage terminates or reduces when the employee attains a certain age. Up to the full amount of group term life may be converted when there is an individual termination.

A group termination occurs when coverage for the entire group or an entire class of employees ceases. The conversion provisions are more restricted on group terminations. Typically the insurance must have been in effect for a set period of time before conversion is allowed and the amount that may be converted is limited (for example, \$2,000). These restricted provisions for group terminations are allowed because of the antiselection that can occur as the group life insurance is commonly replaced by a new carrier.

Group term life continues for 31 days after termination of eligibility. This is called the "conversion period". The insured coverage during the conversion period is continued without premium payment. The employee must decide whether to convert during his or her conversion period and submit a written application for the individual conversion policy within the 31 days.

Individual conversion policies are usually written on various permanent plans. Term insurance is not required to be offered. Conversion is a substantial benefit for impaired lives, those with health conditions, because the individual conversion policy cannot require evidence of insurability. Therefore, the mortality experience for the individual converted is worse than is priced for in the individual policy. This excess mortality must be accounted for and priced into the cost of claims for the group term life insurance. Often this is reflected in a "conversion charge" made by the Individual Life division of an insurance carrier to its Group Insurance division.

Portability

A new kind of continuation has begun to appear with group life insurance contracts – portability. This new provision provides for continuation for the group term life insurance when an employee's coverage terminates because of an individual termination. Portability provisions provide that group coverage can be continued even though eligibility for the original group term life has ended. Portability is provided either by establishing a class of former employees in the group life contract or by establishing a separate policy that specifically provides former employees coverage. Portability coverage is a continuation of group term life. The cost to continue group term life is much less under portability than conversion because portability allows term insurance. Portability is most common with voluntary or employee-pay-all plans. It is arguable whether the cost of the extra mortality is higher with portability or with conversion. Portability costs much less than conversion and the impaired lives can continue insurance at a much lower cost. This tends to increase the number of impaired lives electing to continue coverage. However, the marginal employees electing portability who would not elect conversion probably contain a fair number of healthy lives.

GRACE PERIOD

Under a typical grace period provision the employer has 31 days from the due date to pay each premium. Any claims incurred during this time period will be paid by the insurer provided the premium is paid.

INCONTESTABILITY

An insurer cannot contest an employee's or the group's coverage under the group plan after a set period of time (typically two years) except for non-payment of premiums. This provision is particularly important when individual employees are underwritten for coverage.

Group Term Life Benefits

The amount of basic group life coverage for both employees and their dependents is set in the benefit schedule. There are many types of benefit schedules written. Typical plan designs include the following.

- **FLAT AMOUNTS.** These provide for the same benefits (such as \$25,000) for all employees. These plans are among the simplest to rate because the amount of insurance doesn't vary between employees.
- **SALARY PLANS.** The amount of insurance is based on a multiple of compensation. Compensation can be defined in various ways. Many times, only base earnings are used. However, schedules are also written where the compensation includes bonuses and commissions.
- **SALARY BRACKET PLANS.** The salaries are grouped into brackets (such as salaries greater than or equal to \$35,000 but less than \$50,000) and each employee within that bracket is insured for a like amount.
- **CLASS PLANS.** Employees are segregated into classes (such as hourly, salaried and officers) and each class receives the same benefit.

Group term life plans that are based on earnings are most popular. These plans have the advantage of tying the amount of insurance to earnings. As earnings increase the amount of insurance is updated automatically. Since compensation typically increases with age and service longevity, these plans will generally provide for more insurance for older employees than for younger ones. This makes these plans usually more expensive than other benefit designs. These plans also cost more over time because salaries tend to increase over time due to inflation

VOLUNTARY OR OPTIONAL BENEFITS

It is becoming more and more popular for group life insurance plans to offer employees a choice to purchase layers of additional insurance on top of the basic benefits paid for by the employer. These benefits are usually on a contributory or an employee-pay-all basis. These supplemental group life benefits give employees much flexibility to design life insurance protection tailored to their individual needs and their ability to pay. Rates for these plans are usually step-rated to make these plans attractive to younger employees as well as lessen anti-selection.

Voluntary life plans feature a high degree of selection by the employee. The result is that underlying mortality that must be priced into these plans is higher than basic group life insurance where employees are not able to pick and choose. Not only can employees elect whether to participate; they can generally have several different benefit amounts that can be selected. Special underwriting techniques and policy provisions are used to lessen the employee antiselection inherent in voluntary group life plans. Plans that allow high amounts on a guarantee issue basis or plans that allow an insured to change his or her benefits without evidence of insurability are especially troublesome. This is even more pronounced when voluntary life is offered to dependents because of the absence of an actively-at-work provision.

DISABILITY BENEFITS INCLUDED WITH GROUP TERM LIFE INSURANCE PLANS

Typically group term life contracts contain disability benefits that allow coverage to be continued when an employee becomes totally disabled and is unable to remain an active full-time employee. These benefits are provided in addition to conversion. There are three basic types of provisions that provide for coverage continuation in event of disability. They are (1) Waiver of Premium; (2) Total and Permanent Disability; and (3) Extended Death Benefit.

WAIVER OF PREMIUM

This provision (by far the most common) provides that coverage will remain in force without further premium payment as long as disability begins while the insured is covered under the group plan. Coverage under this provision will continue even if the group contract terminates. Most contracts require that an employee must be totally disabled a prescribed period of time (6 or 9 months) before premium payments will be waived. Waiver provisions typically require that disability must commence before a limiting age (such as 60 or 65). Waiver benefits can continue indefinitely until death or the waiver benefit may end at a certain age (such as 70). The most common provision is that disability must commence before age 60 and the waiver of premium terminates at age 70. These age limitations serve to limit the overall cost of the group plan, as the disability provisions are typically a significant portion of the group life cost.

TOTAL AND PERMANENT DISABILITY

When an insured becomes totally disabled, a portion or the entire face amount is paid out, typically in installments (such as over 60 months). On death, any unpaid installments are paid in a lump sum. This type of disability benefit was very popular in the past, as it was probably the only form of disability protection that employers provided. Currently, Total and Permanent Disability Benefits are seen mainly in life insurance plans written to unions and they have become somewhat rare.

EXTENDED DEATH BENEFIT

This least liberal and consequently least costly common disability provision provides that the death benefit will be paid if an insured dies within a specified time period (usually one year) from their date of disability. The insured must remain continuously disabled during the extension. It is common for this provision to contain a limiting age such as 60. Premiums are not required during the extension period.

It is important for both employers and employees to understand the disability benefits contained within their group life insurance contracts. When an employee becomes disabled after the limiting age, there are no disability benefits. Most group life insurance contracts allow that premiums may be continued on disabled employees as long as they remain totally disabled. The options for the employer are then to continue to pay premiums or terminate the employee from the plan. If the employer terminates coverage, conversion is available for the employee to elect to continue insurance. It is important for the employer to realize if electing to continue to pay premiums on disabled employees, that there are actively-at-work considerations if the group coverage is replaced by a new carrier.

GROUP LIFE BENEFITS ON RETIRED EMPLOYEES

When employers first began providing group life insurance the usual practice was to terminate an employee's group life coverage upon retirement. Today however, it has become increasingly common for employers to provide some group life insurance to its retirees. Benefits for retirees are typically much less than for active employees. The benefits can either be flat amounts (such as \$10,000) or a fraction or percentage of the insurance that is provided as of the retirement date. Many times, retirees' benefits will decrease in stages until an ultimate benefit level is reached.

When death benefits are continued on retirees, costs can increase greatly for employers. This increasing cost pattern resembles that of a pension plan and raises the question of how employers should fund a post-retirement death benefit liability. Most employers simply decide to include the retirees within their group life insurance plan and just pay for the increasing costs as they occur. However, there are various ways to prefund these liabilities. Common approaches are a Retired Life Reserve (RLR) plan or a Voluntary Employees Beneficiary Association (VEBA). A VEBA is a tax-exempt entity created to fund employee benefits. They are sometimes called 501(c)(9) trusts (named for the US Internal Revenue Code section defining them). The tax treatment of group life benefits provided through these trusts in the U.S. is very analogous to group term life insurance, which is described later in this Study Note.

BENEFIT PAYMENT PROVISIONS

BENEFICIARY

The group life insurance benefit is payable to the beneficiary who is designated by the insured. State laws usually provide that the employer cannot be named as the beneficiary under an employee's group life insurance. There are generally no other restrictions concerning naming the beneficiary in most group life contracts. If payment cannot be made to the beneficiary, a *facility of payment* clause allows for payment of the life benefit to specified relative of the insured, in lieu of payments to the insured's estate.

SETTLEMENT OPTIONS

Group life insurance proceeds may be payable in a lump sum, or in other settlement options offered by the insurer. Settlement Options may include installments with or without life contingencies or a money market account.

ACCELERATED DEATH BENEFITS

These benefits (also known as "living benefits") allow group certificate holders to use their group life insurance benefits before they die under certain clearly set circumstances. These benefits were introduced in the United States in the late 1980s with individual life insurance policies. These benefits then appeared with group life insurance policies several years later. Accelerated benefits are designed to protect insureds against the devastating financial and emotional costs associated with catastrophic illness and long-term care. The features are well received in the marketplace for the additional flexibility they give life insurance as well as the additional security they bring to group insureds.

Almost all group accelerated benefit provisions accelerate their benefits based on only one qualifying condition, a terminal illness. Twelve months or less of life expectancy is the most common timeframe used although some group contracts feature a shorter time period. When group accelerated benefits were introduced many entailed an extra premium. However, over time this has become less common. Now, it has become prevalent that accelerated benefits are paid for by the insured themselves through discounting the benefit and the payment of an expense fee. Most group accelerated benefit provisions limit the amount that will be paid out early. Typically a maximum is stated as the lesser of a certain percentage (such as 50%) and a dollar amount (such as \$50,000). The remainder of the benefit is then paid to the beneficiary upon the death of the insured. Taxation of accelerated benefits was clarified in the U.S. with passage of the Health Insurance Portability and Accountability Act of 1996. Under this legislation, accelerated benefits paid to either terminally ill or chronically ill are not subject to federal income taxes. The Act uses a 24-month timeframe to define a terminal illness..

Other Types of Group Life Insurance

GROUP UNIVERSAL LIFE INSURANCE.

Group Universal Life (GUL) was developed in the mid-1980s as the group insurance equivalent to individual universal life plans. In essence, GUL is an employee-pay-all group version of individual insurance. GUL is made available to employees on a group basis. It is generally written without an employer contribution. The premium generally has three components, the term insurance cost, the cash value accumulation, and the expense charges. It is common for these elements to be bundled together in various combinations. GUL is generally not considered group term life insurance under Section 79 of the IRC. Therefore it does not enjoy some of the tax benefits of group term (\$50,000 exclusion), but it still enjoys some very favorable tax benefits. A GUL plan set up under Section 79 (if employer contributions are involved) is subject to onerous group life insurance tax provisions covering group permanent plans.

Under GUL, eligible employees can elect to participate in the plan and purchase an amount of insurance within the choices allowed by the group plan. The coverage is either characterized as “unbundled” or “bundled”. Under an unbundled plan a participating employee chooses separately the amount of coverage and the amount that goes into his or her cash value account. With a bundled approach, the insurer establishes total premiums that are sold as funding the amount of coverage desired. These target premiums are generally not sufficient to fund the benefit using guaranteed assumptions.

GUL policies are very flexible. Premiums are flexible and the amount of death benefit can also be changed.

The mortality charges applied for the term insurance portion of the plan are given in the group plan and normally increase with the employees attained age. The group term rates are typically higher than select individual term rates (because of the guarantee issue or limited underwriting typical with group policies) but generally approximate ultimate individual life mortality. The mortality rates may or may not be based on the group's own mortality experience. The interest rate paid on cash values is set periodically. Various methods are used to determine the crediting rate. There is a minimum interest set in the group policy.

GUL is life insurance under current tax law. Therefore, the cash value increases are not subject to current income taxation. The investment earnings on the cash value are only taxed when the coverage is surrendered, or the cash values are withdrawn and then only if the amount received is higher than the premiums paid. This tax-deferred inside buildup of the cash values is one of GUL's important features for employees. However, employee premium payments to GUL are on an after tax basis unlike contributions to a 401K pension plan.

Participating employees may withdraw cash values and they may also take loans against their cash values within the terms defined by the group policy. Upon termination of employment, participating employees may continue their coverage by making premium payments directly to the insurance company. At retirement, employees can typically use their accumulated cash values to provide some sort of paid-up life insurance.

Since GUL is a group product, it typically will feature guarantee issue or limited individual underwriting. The type and extent of underwriting will generally depend on the amount of insurance being requested, the size of the group and the percentage participating.

GROUP ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

It is very common for group term life insurance to be sold with accompanying AD&D insurance. The face amount of the AD&D insurance is typically the amount of group term life, although many plans are sold where the AD&D is for a different amount. AD&D insurance is very inexpensive. It is well received by the younger employees since statistically, many of their deaths are caused by accidents.

The face amount of AD&D is referred to the principal sum. The full principal sum is paid if an insured employee dies as a result of an accident. There are percentages of the principal sum that are paid for various combinations of dismemberments. AD&D is usually written to cover both occupational and nonoccupational accidents (24 hour coverage). The loss (either death or dismemberment) must occur within a prescribed period of time from the accident (such as 90 days)

AD&D has its own set of exclusions that generally don't apply to group term life. Common AD&D policy language excludes losses caused by:

- Suicide or attempted suicide
- War or acts of war
- Disease or body infirmity or mental infirmity
- Medical or surgical treatment
- Infections other than those caused by accident
- Airplane crash when serving as a member of the crew

DEPENDENT GROUP LIFE INSURANCE

Dependent group life insurance is frequently offered to groups along with employee group life coverage. Dependents covered are the insured's spouse and dependent children. The benefit is typically a flat amount with the children's amount frequently graded by age. An employee generally cannot elect dependent life insurance unless they are covered by the plan themselves. Benefit amounts are usually low, although larger amounts on spouses are sometimes offered under voluntary group life plans. Many states limit the amount of dependent life insurance that can be written.

Eligibility requirements for dependents vary by state, but generally match those for health coverage. Sometimes newborn children may not be eligible until they reach a specified age such as 14 days. Coverage generally continues only while the employee's group life remains in force. There may often be a conversion privilege with dependent coverage. Disability provisions such as waiver of premium do not cover the dependent. However, if the employee is covered under a waiver of premium provision, the dependent's premium may be waived under the terms of the group contract upon the employee's disability.

Dependent life insurance is almost always employee-pay-all. This is partly due to tax considerations. However, employers can provide small benefits (less than \$2,000 per life) without imputed income being generated. When the dependent insurance benefits are small, employee contributions are often on a flat rate basis. When more than modest amounts are available, it is more common to see step rates that vary by age. Sometimes the step rates will vary by the employee's age rather than the spouse's age, which simplifies administration and enrollment.

SURVIVOR INCOME INSURANCE

This insurance provides for payment of a monthly income to an eligible survivor of an employee who dies while insured. The essential idea is to relate the death benefits more closely to the insured employee's needs. These types of benefits are also written as ancillary benefits within pension plans. Benefits are typically a percentage of the employee's monthly income. An example would be 25% of the employee's salary to the spouse and 10% for each dependent child with a total limit of 50%. However, flat benefit amounts (such as \$500 per month) can be written. Benefits are usually paid for a limited benefit period such as the earlier of: 10 years; the spouse attains age 65; or when the spouse remarries. The commuted value of benefits (present value) must be determined to price this benefit. The calculation requires assumptions on interest, number and ages of dependents, mortality, remarriage, and salary. Manual claim rates can then be applied to the commuted values. This commuted value is also used to calculate any imputed income under Section 79.

Although the concept of Survivor Income Insurance is quite logical, this type of benefit has not been widely accepted by both employers and employees. Consequently, little of this is currently sold in the United States.

Taxation of Group Term Life Insurance

Basic Group Term Life Insurance. At one time, tax rules concerning group term life were relatively simple. Over the years, these rules have become more and more complex.

Group term life insurance is one of the many benefits employers provide that receives favorable income tax treatment within the Internal Revenue Code (IRC). The IRC provides that all or some of the employer's cost of providing group life benefits are not included in the employee's gross income for federal income tax purposes. Group life benefits are also not considered gross income to the beneficiaries. Furthermore the costs of these benefit programs are typically deductible by the employer as ordinary and necessary business expenses.

The U.S. federal income taxation of group term life insurance is governed mainly by Section 79 of the IRC. In fact, many group term plans are called "Section 79 Plans". In order to secure the tax advantages of Section 79, a group life insurance plan must comply with the federal tax law definition of group term life insurance, this definition may differ from general definitions and also from definitions contained within many of the state's insurance laws.

A plan is considered to be group term life insurance for purposes of Section 79 if it meets the following conditions: (1) the plan must provide a general death benefit that is excludable from gross income for federal income tax purposes; (2) the plan must be provided to a group of employees as compensation for personal services; (3) the insurance must be provided under a policy carried directly or indirectly by the employer; and (4) the amount of insurance provided by the plan must be computed under a formula that precludes individual selection. Furthermore, there are additional regulations that apply to groups of less than 10 employees. These small group plans have the additional requirements that: (1) it is provided for all full-time employees; and (2) the amount of insurance must be computed as either a uniform percentage of compensation or on the basis of coverage brackets under which the coverage does not exceed 2 1/2 times the next lower bracket and the coverage in the highest bracket cannot be more than 10 times the coverage in the

lowest bracket. Another special requirement for groups of less than 10 is that while eligibility for the amount of coverage may be based on individual evidence of insurability, such evidence must be determined solely by medical questionnaires completed by employees; a physical examination may not be required. Voluntary information provided may not be used for the basis of rate determination.

An employer may provide up to \$50,000 of group term life insurance protection each year without cost to the employees. Generally, the taxable value of any group term life in excess of the \$50,000 exclusion amount is determined under a table (Table I) provided by the Internal Revenue Service. The Service adopted a new Table in 1999 to become effective on July 1, 1999. This new table featured significant reductions in the Table I cost and there were special transition rules implemented. However, many employers implemented the new Table as soon as possible due to its lowering of employee's taxable income. The primary reason that the Table was lowered was because the underlying data used to calculate the value used a 50/50 split by sex. The prior Table was calculated using a much higher weight on male mortality, which is much higher than female mortality.

The taxable value (imputed income) in excess of the excludable amount is calculated on a monthly basis. The calculation of this value takes the following four steps:

1. Determine the total amount of group term life insurance for each month of the taxable year
2. Subtract \$50,000 from each month's coverage.
3. Multiply this monthly amount by the appropriate rate from Table I
4. Sum these monthly costs and subtract any employee contributions for the year, if any.

THE TABLE I RATES EFFECTIVE (7/1/99)

**Uniform Premiums for \$1,000 of Group Term Life Protection
Rate Applicable to Cost of group-Term Life Insurance
Provided After June 30,1999**

5-Year Age Bracket for One-Month Period	Cost per \$1,000 of Protection
Under 25	\$0.05
25 to 29	0.06
30 to 34	0.08
35 to 39	0.09
40 to 44	0.10
45 to 49	0.15
50 to 54	0.23
55 to 59	0.43
60 to 64	0.66
65 to 69	1.27
70 and above	2.06

There are three exceptions where the cost of group term life, even for amounts greater than \$50,000 is tax exempt:

1. When the insured is a former employee who has terminated his employment and has become permanently disabled.
2. If a charitable organization is designated as the beneficiary – but no charitable contributions deduction is allowed for such a designation.
3. The employer is the beneficiary – this is contrary to most states' laws governing group insurance.

TAXATION OF VOLUNTARY GROUP LIFE PLANS

The federal income tax implications of voluntary group life plans depends on whether the plan is maintained as a Section 79 plan. If the plan is considered a Section 79 plan, the optional amounts and the employee contributions are combined with those under any basic term life insurance to calculate the appropriate imputed income. Prior to the reduction of the Table I cost in 1999 this treatment produced an undesirable result. The old Table I costs were, many times, higher than many voluntary group life plans' rates. This caused the imputed income to be higher than the corresponding credit for the contribution. Employers had an incentive to consider their plan outside of Section 79.

To be considered outside of Section 79, a voluntary group life insurance plan must meet the following conditions:

- It must be employee-pay-all with no direct or indirect employer subsidies.
- The voluntary group life rates must not straddle the Table I cost (that is, all rates must be equal or below, or alternatively, equal or above Table I rates).
- The voluntary life's financial treatment must be independent of the employer's basic life plan.

When the new Table I was implemented in 1999, the tax treatment of many voluntary life plans markedly changed. The Table I rate reductions were so significant, the new Table I produced costs that were less than many plans' voluntary life rates. When the Table I costs are less than the actual rates, it is beneficial to keep the voluntary plan under Section 79 because the imputed value is less than the offset for the employee's contribution.

TAXATION OF GROUP AD&D INSURANCE

There are no imputed income issues with AD&D coverage comparable to Section 79. All benefits paid under an AD&D policy are received by the beneficiary income tax free.

FLEXIBLE BENEFIT PLANS

A cafeteria plan (or flexible spending arrangement – FSA) is an employer provided plan where employees can select two or more benefits consisting of cash and “qualified benefits”. Under these plans, employers reduce the employee's compensation by the amount contributed toward “qualified” benefits. Flexible Benefit Plans were first written in the earlier 1980s. The plans are governed by Section 125 of the Internal Revenue Code. A cash benefit not only includes cash, but a benefit, which may be purchased with after-tax dollars. Group term life insurance on dependents is an example of a cash benefit. A “qualified” benefit is one, which is not includable in the income of the employee. A cafeteria plan can offer group term life insurance, including coverage that is includable in income (coverage in excess of the \$50,000 exemption given in Section 79). With the advent of the new Table I (effective 1999), it can be advantageous to give employees the opportunity to purchase voluntary group term life insurance within a cafeteria plan rather than purchasing those benefits with after-tax dollars. This is because the value assigned by Table I is frequently lower than the actual cost of the voluntary group life program. The taxes on the imputed income can be lower than the taxes on the premiums.

NONDISCRIMINATION REQUIREMENTS OF GROUP TERM LIFE INSURANCE

Section 79 provides that a plan may not exclude from the employee's net income, premium on the first \$50,000 of group term life coverage for "key employees" when the plan discriminates either with respect to eligibility or with respect to the benefits. A key employee in a discriminatory plan must include the higher of the actual cost or the specified uniform premium Table I cost in his or her taxable income. Employees who are not "key employees" may exclude the cost of the first \$50,000 of coverage even if the plan is discriminatory. The term "key employee" has a similar meaning as it does with various rules concerning qualified pension plans.

EMPLOYER DEDUCTION

The premiums paid by an employer for group term insurance on employees are deductible for the employer. This is so even if the plan discriminates in favor of key employees.

DEATH PROCEEDS

The death benefit of any group life insurance is received by the beneficiary income tax free.

ESTATE TAXATION

Group term life insurance is included in a deceased employee's estate at his or her death if the employee had any rights in the policy at the time of death, even when another person or a trust is the beneficiary of the life insurance. The IRS has ruled that that an insured employee can remove the proceeds of group term life insurance on his or her life from the gross estate by absolutely assigning all of his or her incidents of ownership to another. This is allowable provided the proceeds are not payable to the insured's estate and the group master contract and applicable state law permits such an assignment. Because of these relatively favorable estate tax rules, many employees with large potential estates absolutely assign their group term life to another.

GIFT TAXATION

When an absolute assignment is made of group term life insurance, the employee is considered to be making a gift of the value of the group term life insurance to the person or entity to which the insurance is assigned. For group term life, this gift is considered to be made each year of the assignment. Gift tax rules apply.

Underwriting Group Life Insurance

Underwriting group life insurance can be generally divided into two separate topics: (1) the legal requirements under state and other regulating jurisdiction insurance laws; (2) the insurer's own underwriting standards (risk selection).

Under most laws, the coverage must be issued to an eligible group. Examples of eligible groups include, single employer groups, governmental entities, associations, union groups, and multi-employer trusts. Each type of group must have certain distinct characteristics to be considered eligible. In addition groups must meet minimum size requirements. Laws also specify certain participation requirements for group life insurance. Laws also have specific requirements concerning both the eligibility and benefits that may be offered as dependent group life insurance.

Risk selection standards are very broad and vary substantially between insurers. Some factors that must be evaluated for group life insurance are: industry, contribution level, eligibility, participation level, benefit schedule, prior experience, past rate history, and individual underwriting information.

INDUSTRY

Different industries have different mortality characteristics that influence their experience. Many times this is reflected as a SIC factor which is part of the manual rate or by automatic declination of coverage for certain industries. These different mortality patterns are caused not only by the occupational risks but also by the different underlying mortality of various groups of people employed in a given industry.

CONTRIBUTION LEVEL

The most desirable group life plans from a risk standpoint are non-contributory. All participants are covered when they become eligible, producing the best spread of risk. Under contributory plans, all or portion of the cost is borne by the insured employees. Therefore, employees have the opportunity to decline to

participate. This creates a chance for antiselection. The underwriter must assess both the amount of contribution required and the percentage of eligible employees electing coverage to determine risk.

ELIGIBILITY

Eligibility requirements need to be clearly defined. Normally, full time employees (for example, those working at least 30 hours per week) are eligible for coverage. Dependents eligible for dependent life insurance generally include spouses and unmarried children up to a specified age. Retirees are sometimes eligible for group term life insurance. There are special concerns from a risk standpoint in covering retirees. Mortality is higher for retirees than it is for active employees of the same age.

PARTICIPATION LEVEL

75% participation is required in many state statutes. Even when not required by law, 75% may be required to assure an adequate spread of risk. Higher participation yields a better spread of risk. This can be reflected in lower premium rates. Employees who refuse coverage and later apply are considered late applicants. It is customary to require evidence of insurability for all late applicants.

BENEFIT SCHEDULE

A benefit schedule with a low variance of benefit amounts is a lower risk plan. Schedules that feature a large spread between high and low amounts do not spread risk as well as tighter schedules. Age reductions are key benefit design features that serve to lower risk. This is due to the steeply increasing mortality at the higher ages. There are specific federal rules concerning age discrimination that apply to age-based benefit reductions (ADEA). Age reductions must be cost justified.

PRIOR EXPERIENCE

On the largest cases, the expected mortality can be developed solely from the case's past experience. However, very few cases have enough credibility where this can be done. Credibility rating, where the group's experience is combined with their manual expected claims is typically done for most large cases. The more credible a group's own experience, the more weight is given the group's actual experience in developing the charged rate.

PAST RATE HISTORY

Many underwriters will want to review the rate history on a group to assess risk. Generally the rate history is needed to fully understand the prior experience. It is also worthwhile to compare any potential manual rate with the prior rates to validate that no mistake has been made in calculating any potential rate.

INDIVIDUAL UNDERWRITING INFORMATION

Group life insurance is generally offered without evidence of insurability. However, some level of individual health underwriting is generally required for: high individual amounts of coverage; late entrants, for small groups (i.e., less than 10 employees); some associations and multiple employer plans; and certain voluntary plans. The guarantee issue amount or non-medical amount is determined based on underwriting criteria. Individual health underwriting usually consists of an individual completing a health questionnaire, giving information about his or her current state of health and medical history. Depending on the information requested, the insurer might require additional information. The level of individual underwriting done within a group will affect the overall expected level of claims and can be factored into the underwriters overall risk assessment.

Pricing Group Life Insurance

The pricing of group term life insurance is dependent on the expected claims, the expenses associated with the product and the insurer's margins for risk and profit. The most significant portion of the final rate is the development of the expected claim cost.

Typically group life insurance rates are expressed as an average monthly premium rate per \$1,000 of coverage. This average premium rate will be calculated by summing the mortality costs of the different lives composing the group. Age and sex distinct rates are typically used. Even though age and sex distinct rates are used, the composite rate that is typically charged is the same for each \$1,000 of insurance regardless of the insured's age or sex for other than voluntary (employee-pay-all) plans.

Insurers develop a manual-rating table for use in pricing. This manual table will be either based on premiums or claims. Manual premium methodologies calculate a group's cost as the sum of the manual premiums for the insureds. Adjustments can be taken for group size, industry, average volume, or any other trait considered appropriate. Manual claim methods calculate a group's cost as a sum of expected claims. Once the expected claims are calculated the appropriate expenses, risk, profit and margins are added. On larger groups that are credible, the claim rate may be calculated as a combination of the case's manual claim rate and its own experience. Manual claims methods can also adjust the group's cost for traits such as industry, participation, etc.

A manual claim table for group life insurance is very difficult to develop. It is very hard for most insurers to procure appropriate group mortality experience. With individual life insurance, accurate characteristics on all insureds is available and can be analyzed. In group insurance, detailed information about individuals is often not recorded or tracked. Many groups are self administered for billing purposes. The employer reports aggregate volumes each month calculating their own bills. It is difficult for even large group insurers to obtain usable exposure data on which to base proper mortality studies. To develop a manual claim table, most insurers must rely on studies published by the Society of Actuaries, along with their own experience and the use of population statistics

When using these published studies, special care must be taken to recognize the inherent limitations in the data. Typical limitations will include the type of disability provision inherent in the experience, the measurement of accidental deaths, the amount of data that does not have a sex distinction, no indicators on whether insureds are individually underwritten, the amount of antiselection contained within the data and improvements in mortality.

Manual claim costs must also include any cost of reinsurance as well as the costs of providing conversions.

SOCIETY OF ACTUARIES GROUP MORTALITY STUDIES

The main source of group mortality data is the intercompany study produced by the Society of Actuaries. The latest study was published in 1995. It used data submitted for the period 1985 – 1989. This study differed from previous studies in the following ways:

- The report gave experience by amounts as well as by lives.
- Experience was submitted for 8 different disability provisions and then combined and published for 4 different provisions.
- Actual to tabular (expected) ratios were calculated, with tabular taken to be the actual experience from the prior 1975-1979 study.

18 different companies contributed data but not all contributing companies were able to submit data by lives and amounts. The report used data from just 13 of the companies. The total death exposure included in the report was for 19.3 million lives and over \$602 billion in force.

The four disability categories that were calculated were:

- No disability provision or one-year extended benefit.
- Premium payment continued.
- Waiver of premium with maximum disability age of both 60 and 65.
- Mixed and other (this included Total and Permanent Disability as well as any other cash benefit).

Experience was published separately for Males; Females; Sex Unknown; and All Sexes Combined.

The overall actual to tabular ratio for total claims was 84.7% when measured by lives and 71.5% when measured by amounts. This result is significant. Mortality is 20% lower when calculated by amount than when calculated by lives. Various

economic theories have been proposed to explain this rather pronounced difference. The tabular ratio by lives is consistent with a 1-2% increase improvement per year since the actual and tabular (prior study) values are 10 years apart. This kind of improvement is considered reasonable.

POPULATION STATISTICS

Population statistics are difficult to use to predict group life mortality. Death rates in the general population tend to be higher than mortality levels in most group plans. There are a number of reasons for this.

Generally, there is a continual flow of healthy individuals into a group, while aged and substandard lives tend to be removed from group exposure. New employees are typically healthy; many employers require a physical examination as a condition for employment. Actively-at-work provisions are required and some individual underwriting is done.

However, population statistics can be very useful in estimating annual improvements in mortality, determining ratios between different sexes and ages, and in developing rates for dependents and retirees. It is important to recognize that retiree mortality is very different than actively-at-work mortality for those covered at the older ages.

INSURER EXPERIENCE

The best data can sometimes be obtained from a carrier's own experience. However, only the largest of group carriers in the country have a block of business where this is completely valid.

However, even for a smaller carrier, the relationship between an insurer's actual experience and a published tabular result is very valuable to evaluate current underwriting effectiveness and overall business practices. It is also good information to establish marketing focus and to help design profitable products.

CHANGES IN MORTALITY

It is generally accepted that mortality is improving at an overall rate of 1-2% per year. This is an important assumption in rating group life insurance because most data is relatively old before it is made available. For example, in the year 2000 the Society of Actuaries most recent experience report will be based on data that is 13 years old. This is a definite problem for group life actuaries. An overall improvement assumption could be seriously flawed.

To illustrate this, the following table (from the 1995 SOA Experience Report) gives the following actual to tabular ratios for the probability death (measured by lives).

Central Age	Male	Female
17	37.8	52.6
22	67.1	91.1
27	95.2	121.0
32	98.6	138.3
37	99.6	105.3
42	82.9	82.1
47	68.1	85.1
52	60.6	67.3
57	68.8	79.5
62	60.6	79.5
67	64.7	80.2
72	71.2	82.2
Overall	77.2	90.0

This result corresponds to the 84.7 overall ratio given earlier. Notice how different these ratios are by age and sex. Over the ten-year period 1975-1979 to 1985-1989 mortality improved significantly more for males than females and particularly for males over age 50.

The impact of new developments in medical technology on mortality needs to be considered. While new treatments for many illnesses are likely to increase longevity, many times death claims are replaced with disability claims.

MANUAL CLAIM COST ADJUSTMENTS

An overall claim table needs further adjustments for group specific traits such as industry, contribution, benefit, effective date, disability provision, and the level of individual underwriting.

INDUSTRY FACTORS

It is well documented that different industries exhibit varying levels of group mortality. The typical method to adjust for industry is to multiply the composite manual claim rate by an industry factor. Factors are usually assigned by Standard Industry Classification (SIC) Code and typically from a discount of 30% for select industries for groups such as consulting firms to a 50% load for hazardous industries such as firefighters. Industry data and actual to tabular ratios are calculated for various SIC's within the Society of Actuaries experience reports.

CONTRIBUTION

A non-contributory plan, where the employer pays the full cost generally will get the lowest rate. This is because antiselection is minimized. When contributions are required from employees, there will typically be a rate load to account for the opposite.

When contributions are required, they will be based on a composite rate or step rate. With composite rate, older employees pay the same rate as the younger ones. This increases the amount of anti selection, because the younger, healthier employees having to subsidize the older employees, will drop out particularly if they can meet underwriting requirements to get coverage elsewhere. Antiselection for contributory plans is lessened when the contributions are based on age such as 5-year step rates. This approach is more equitable to all employees.

BENEFIT

It was documented in the 1996 SOA Experience Report that mortality is lower when measured by volume than it is when measured by lives. This is because employees insured for higher amounts exhibit better mortality than those insured for lower amounts. Many insurers will give a volume discount within their manual rates to account for this risk parameter.

EFFECTIVE DATE

Most group rating formulas calculate an insured's age by subtracting the employee's year of birth from the current year. This makes the age appropriate for July 1 effective dates. Most rating schemes have factors that are less than 1 for the early part of the year (when employees are a bit younger) and a factor greater than 1 for the latter part of the year. Typically these factors range from plus 2% to minus 2%.

DISABILITY PROVISION

Most manual rating formulas will assume the insurer's standard disability provision. Specific adjustments must be made whenever a non-standard provision must be rated.

INDIVIDUAL UNDERWRITING

Plans that feature individual underwriting exhibit markedly lower mortality costs in the time period immediately afterward. The effect of the underwriting will lessen gradually as the mortality evolves to some ultimate level. It is appropriate to adjust the manual claim cost for the corresponding level of underwriting. Turnover within the group becomes an important risk parameter because it determines the ongoing effectiveness of the individual underwriting.

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Chapter Five: Group Life Insurance Benefits

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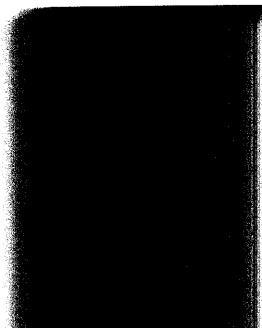
CHAPTER FIVE

GROUP LIFE INSURANCE BENEFITS

Michael J. Thompson

Group life insurance benefits began in 1911. The initial focus of group life insurance was on basic group term life insurance, with benefits being either flat amounts or related to earnings or position. There was no selection of amounts by individual insureds, and insurance was only available on the life of the employee. Premiums were charged to the employer using a composite rate for the group, in order to keep the administration simple.

The types of group life insurance benefits have gradually broadened to more closely meet the needs of employees and their dependents. While traditional basic group term life insurance is still the most common form of group life insurance, more tailored coverage has gradually been offered with the following types of benefits:

- Supplemental/Optional Life Insurance
 - Dependent Life Insurance
 - Accidental Death and Dismemberment Insurance
 - Survivor Income Benefits
 - Group Permanent Insurance
 - Group Universal Life Insurance
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A description of the types of group life insurance plans and plan provisions and related tax and statutory considerations associated with each of these benefits is outlined in the balance of this chapter. There is also a brief description of group creditors life insurance.

GROUP TERM LIFE INSURANCE

Types of Plans

Basic group term life insurance plans are designed to minimize selection risk and provide a common base of insurance for the covered group of employees. Typical plan designs include the following:

- Flat dollar plans, such as \$10,000 for all employees.
- Multiple of earnings plans, such as 2 times earnings. This is the most common type of plan design.
- Salary bracket plans, such as the plan in the following table.

Salary	Life Insurance Amount
Up to \$20,000	\$20,000
\$20,001 - \$40,000	\$40,000
\$40,001 - \$60,000	\$60,000
\$60,001 - \$80,000	\$80,000
\$80,001, and over	\$100,000

- Position plans, such as the plan shown in the following table.

Position	Life Insurance Amount
Hourly Employees	\$ 25,000
Non-officer Management	\$50,000
Officers	\$100,000

The need for life insurance is generally less at higher ages, while the cost is substantially higher. For this reason, age or retirement reduc-

tions in amounts of insurance are frequently included. A typical age reduction might reduce the life insurance multiple of earnings from 200% to 130% at age 65, with further reductions at advanced ages and on retirement.

Plan Provisions

Basic group term life insurance includes plan provisions relating to eligibility, continuity of coverage, and benefit payment. The following discussion describes the provisions prevalent in most plans.

Eligibility Provisions

- The eligible class of insureds usually includes an actively-at-work requirement which requires that an employee be actively at work at his job before the life insurance becomes effective.
- Employee contributions may be required, but generally a 75% minimum participation requirement must be met. The minimum participation requirement may be a function of both underwriting constraints and statutory considerations.
- Amounts above the non-medical maximum require evidence of insurability before insurance is effective.

Continuity of Coverage Provisions

- The insured has a conversion privilege upon termination of employment or membership in the eligible class. The insured may convert to an individual life insurance policy, with a face amount up to the lost coverage, at standard individual policy rates based on the age at time of conversion. This privilege is intended to provide continuity of coverage. A more limited conversion right is available if the group insurance for an insured's class ends due to termination or amendment of the policy. If the insured dies within a specified period (usually 31 days) after ceasing to be covered, the amount that could have been converted is payable on death.
- One of the following disability provisions may be included:
 - Waiver of Premium. Group term life insurance is continued without premium payment when an employee be-

comes totally disabled, while insured is less than age 60 or 65, and is continuously disabled until death.

- Total and Permanent Disability. When an insured become totally and permanently disabled, this provision typically provides a benefit on a monthly installment basis, equal to all or a portion of the life insurance benefit. On death, the original death benefit would be reduced by any disability installments made.
- Extended Death Benefit. Under this provision, the death benefit is paid if an insured's insurance terminates prior to age 60 and dies within a year of the termination date, while being continuously and totally disabled from the termination date to the date of death.

Benefit Payment Provisions

- The life insurance is payable to the beneficiary who is designated by the insured. If a beneficiary has not been designated, the insurance is paid to the insured's estate. In general, the employer may not be named as beneficiary. A facility of payments provision allows for payment of the life benefit to specified persons related to the insured, in lieu of payments to the estate.
- On death, several settlement options may be available to the beneficiary including a lump sum, a monthly installment or a money market account.
- A living benefits provision allows a limited payout of the death benefit prior to death if the insured becomes terminally ill with a limited number of months to live. Typical plans provide for a payout of 25% or 50% of the face amount, often limited to \$25,000 or \$50,000.

Federal Income Tax Implications

Employer-provided group term life insurance is covered under Section 79 of the Internal Revenue Code. Section 79 generally imputes income to the insured on amounts of insurance over \$50,000. The imputed income is determined as follows:

- The Table I rate (found in regulations related to Section 79) for the insured's attained age is multiplied by the total amount of group term life insurance in excess of \$50,000.
- Any employee contributions are then subtracted from the calculated amount.

The following example illustrates the calculation:

- Total amount of group term life insurance: \$125,000
- Insured's age: 50
- Table I monthly rate per \$1,000 for an insured age 50: .48
- Employee monthly contribution per \$1,000: .25
- Table I cost of group term life insurance over \$50,000:

$$(75,000/1,000) \times .48 \times 12 = \$432$$

- Employee contributions:

$$(125,000/1,000) \times .25 \times 12 = \$375$$

- Imputed income:

$$\$432 - \$375 = \$57$$

A further provision of Section 79 is that if the employer-provided group term life insurance plan is discriminatory in favor of "key employees," then the imputed income for the key employees is based on the higher of Table I rates and actual cost, and the \$50,000 exclusion does not apply. Death benefits payable under group term life insurance are received tax-free by the beneficiary.

Statutory Considerations

Any group term life plan design must consider applicable state law. Some common state laws governing group term life insurance may include the following provisions:

- Requirements which preclude plans which permit individual selection of amount.

- Maximum employee contribution requirement.
- Minimum participation requirement.

While not an insurance law, the Age Discrimination in Employment Act (ADEA) also requires that age reductions be cost justified.

Various other statutes or regulations may be in effect, based on National Association of Insurance Commissioners model laws or regulations. These are discussed further in the chapter on state regulation.

GROUP SUPPLEMENTAL LIFE PLANS

Types of Plans

Supplemental or optional life plans provide additional insurance beyond basic group term life, and can be on either an employee-pay-all or employer subsidized basis. Generally, employee-pay-all optional life plans are written on a step-rated basis, with rates varying over 5-year age brackets. Supplemental plans with rates flat by age tend to be on an employer subsidized basis, due to selection concerns. The amounts of insurance available are usually a flat amount (such as \$25,000, \$50,000, or \$100,000), or multiples of earnings (such as 1 times, or 2 times earnings). Typically, as many as 3 to 5 options may be included.

Plan Provisions

Plan provisions for supplemental or optional life insurance are the same as basic group term life insurance with the following potential differences:

- If a disability provision is included, it would usually be limited to waiver of premium.
- Minimum participation requirements tend to be more liberal (lower) than for basic group term life, such as 50% rather than 75%.
- The optional life insurance might be offered subject to limited medical evidence, perhaps with a short-form questionnaire of 4 or 5 questions.

Federal Income Tax Implications

If the supplemental or optional life plan is maintained under Section 79, the optional amounts of insurance and employee contributions are taken together with those under the basic group term life insurance in applying the Section 79 imputed income calculation. This may produce an undesirable result if the optional life rates are employee-pay-all and less than Table I rates, since the employee may receive imputed income from the supplemental coverage equal to the difference between the Table I cost and the "optional life cost," even if the coverage is entirely employee-paid. In this instance it may be desirable to provide optional life insurance "outside of Section 79."

For optional life insurance to be considered outside of Section 79, the following conditions should be met:

- It must be employee-pay-all with no direct or indirect employer subsidies.
- All the optional life rates should be at or below Table I rates. (Alternatively, all rates could be at or above Table I rates. However, if this condition were met, it would probably be more beneficial to keep the plan under Section 79.)
- The optional life's financial treatment must be independent of the employer-provided plan.

An alternative approach to keeping an optional life plan outside Section 79 (supported by some IRS private letter rulings) may be to provide the optional life plan through a Voluntary Employees' Beneficiary Association (VEBA). Under this approach, the employer's involvement in the program becomes much more restricted.

An optional life plan provided outside of Section 79 is not considered an employer-provided group term life insurance plan, and does not generate imputed income.

Statutory Considerations

While the same state laws governing basic group term life insurance apply to supplemental or optional life insurance, it is worthwhile pointing out how these laws have generally been interpreted.

- Laws “precluding individual selection of amount” have generally been interpreted as not precluding offering an employee a limited number of selections under each of which an employee is entitled to a specific dollar or multiple of earnings amount of insurance.
- Maximum employee contribution requirements have been viewed in the aggregate where step rate contributions have applied.
- Minimum participation requirements apply to all group term life insurance provided through an employer. Consequently, if the basic group term plan meets a statutory 75% minimum participation requirement, then all the group term life insurance provided through that employer meets the minimum participation requirements (even if less than 75% participate in the supplemental or optional life insurance plan).

GROUP ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE

Types of Plans

Group AD&D insurance is typically offered as a companion coverage to group term life insurance. The AD&D benefit is payable if an employee dies as the result of accident. One half of the benefit is also payable if the employee loses a member, which is a hand, a foot or the sight of an eye. If more than one member is lost in an accident then the full AD&D benefit is payable. However, no more than the face amount is payable for all losses due to one accident.

The AD&D face amount is typically equal to the basic group life insurance face amount. Optional amounts of AD&D may also be offered on an employee-paid basis. The coverage may be either non-occupational (only covering accidents not related to work) or 24-hour. Typically the loss must occur within a specified period after the accident. Voluntary AD&D benefits may also provide coverage to other family members.

Plan Provisions

Eligibility Provisions

Group AD&D eligibility provisions are generally the same as those for the underlying group term life insurance. Where optional amounts are available, no medical evidence requirements apply.

Continuity of Coverage Provisions

A conversion privilege is generally not available with AD&D. Coverage generally ceases on termination of employment.

Benefit Payment Provisions

Common exclusions applicable to AD&D include losses resulting from the following:

- Suicide or attempted suicide.
- War or acts of war.
- Disease or bodily or mental infirmity, or medical or surgical treatment thereof.
- Infections other than a pyogenic infection occurring through and at the time of an accidental cut or wound
- Travel or flight in an aircraft as a pilot, student pilot or as an officer or member of the crew.

The named beneficiary receives the accidental death benefit under AD&D, while the dismemberment benefit is payable to the employee.

Other benefit enhancements have recently become available, including additional benefits for:

- Seat belt use
- Spouse re-education
- Hearing loss
- Hospital indemnity
- Child education

Federal Income Tax Implications

There is no imputed income for AD&D coverage comparable to Section 79.

DEPENDENT GROUP LIFE INSURANCE

Types of Plans

Dependent group life insurance is designed to provide a lump sum benefit to the employee in the event of death of a covered dependent. This coverage is only available when employee group life insurance is in force.

Historically, the typical dependent group life insurance plan offered a flat amount of insurance on the spouse and children, such as that illustrated in the following table:

Coverage On	Coverage
Spouse	\$5,000
Each Child 6 Months or over	\$2,000
Each Child under 6 Months	\$500

Where limited amounts of insurance are provided, employee contributions are typically on a flat-rate (no differences by age) basis. Recently there has been an increased prevalence of higher amounts of dependent coverage being available, particularly on the spouse. There may also be a limited number of benefit amount options available on the spouse. Where higher amounts of dependent life coverage are available, the amounts are generally limited to some percentage of the employee's group term insurance, such as 50% of the employee's group term life insurance, or some multiple of the employee's salary. The coverage is typically employee-pay-all, although it may be employer subsidized.

Where higher amounts of spousal coverage are permitted, it is more common to see step rates applied to this coverage. The step rates may be based on the employee's age, rather than the spouse's age, for ease of administration.

Plan Provisions

Eligibility Provisions

Subject to state requirements, the eligibility rules for dependents are usually the same as for health coverage, except that newborn children may not be eligible until they reach a specified age such as 14 days.

A dependent's deferment provision may apply, which provides that the effective date of coverage on a dependent who is currently confined for medical treatment in an institution or at home is deferred until the dependent is medically released from that confinement.

In addition, where higher amounts of spousal coverage are offered, they may be subject to completion of a medical evidence questionnaire, and proof of insurability.

Continuity of Coverage Provisions

Coverage generally continues only while the employee's group term life coverage continues. However, dependent coverage usually ends when the employee retires, even if the group term life insurance continues. A conversion privilege may be offered for the spouse's coverage. No disability provision is provided.

Benefit Payment Provisions

The beneficiary for dependents group life insurance is usually the employee, and benefits are typically payable in a lump sum.

Federal Income Tax Implications

If the amounts of dependent group life insurance available are less than \$2,000, then the insurance is considered *de minimis* generates no imputed income.

Where the amounts of dependent group life insurance available exceed \$2,000 then Section 132 imputes income on the employee based on the Table 1 cost of the entire amount of dependents group life insurance, less any employee contributions. However, if this amount is less than the value of \$2,000 of dependents group life insurance using Table 1 cost, then there is no imputed income.

Statutory Considerations

Some states establish a maximum amount of insurance which may be provided on dependents (spouse or children), or place restrictions on children's eligibility. Some states require a conversion right for children who attain limiting ages.

SURVIVOR INCOME BENEFITS

Types of Plans

Survivor income benefits provide a monthly payment to the employee's spouse and children on the employee's death. The benefit is typically a percentage of the employee's monthly earnings, and is intended to more closely meet the needs of the employee's surviving dependents. An example of such a benefit plan would be (a) a spouse benefit of 25% of the employee's monthly earnings, and (b) a children's benefit of 15% of those earnings.

The duration of the monthly benefit varies by plan. A typical spouse benefit is payable to the earliest of remarriage, attainment of a limiting age such as 62, or death. A typical children's benefit is payable to age 19, or age 23 if still a full-time student.

Plan Provisions

Survivor income benefit plan provisions for eligibility and continuity of coverage are similar to group basic term life insurance, with the following potential differences:

- The conversion privilege applies to the commuted value (the present value) of the monthly survivor benefit.
- The disability provision is limited to a waiver of premium provision.

Benefit payment provisions are established by the plan and may include the following:

- **Guaranteed Benefit Period.** A period for which the benefit is payable, regardless of the surviving spouse's death or remarriage.
- **Maximum Benefit Period.** Benefits are not paid beyond a maximum number of years, such as ten, or a limiting age, such as 62.
- **Remarriage Provision.** Benefits may or may not cease on remarriage.
- **Dowry Provision.** A lump sum benefit may be payable on the remarriage of the spouse, to reduce the incentive not to remarry.
- **Social Security Offset.** Some plans may provide for an offset of Social Security survivor benefits.
- **Last Survivor Provision.** Benefits may be defined by the composition of the remaining eligible survivors. A level last survivor benefit would pay the same amount regardless of how many survivors are eligible. A joint and 2/3 last survivor would provide a benefit to a spouse alone or child(ren) alone which is 2/3 of the benefit while both are eligible.

Survivor income benefits are usually paid to the employee's spouse if eligible, otherwise in equal shares to the children.

Federal Income Tax Implications

The commuted value (present value) of the survivor income benefits is combined with other group term life insurance in applying the Section 79 imputed income calculation. In addition, only a portion of the benefits are considered tax-free life insurance benefits, with the balance being considered taxable income. The portion of benefits which is excluded from taxable income is the ratio of the present value of the survivor income benefits (using the reserve basis interest rate) to the expected amount of survivor income benefits (using a 0% interest rate for discounting).

GROUP PERMANENT LIFE INSURANCE

Types of Plans

Although once more popular, group permanent life insurance is rarely provided today, largely because of the tax limitations discussed below. The following outlines the types of plans which may be available:

Single-Premium Group Paid-Up Life Insurance

A level death benefit is provided for a fixed premium, based on attained age. This product may be used by an employer to “buy-out” a retiree life insurance benefit, thus avoiding the need for future premium payments. It generally includes a level face amount and growing cash value.

Group Ordinary Life Insurance

This is the group counterpart to individual whole life insurance generally with a fixed life insurance amount, level premiums and a growing cash value.

Group Term and Paid-Up Plans

This coverage provides level insurance similar to group ordinary coverage. This coverage, however, splits the coverage into a combination of group paid-up life insurance paid by the employee and corresponding decreasing group term life insurance paid by the employer. The total face amount (term plus paid-up) is maintained according to the employer’s prescribed plan.

Plan Provisions

Plan provisions for group permanent life insurance are similar to group term life insurance with the following potential differences:

- No continuity-of-coverage provisions are necessary for group paid-up insurance.

- The disability provision is usually limited to waiver of premium on the term portion of group term and paid-up insurance.
- The conversion privilege is limited to the face amount less cash value for group ordinary life insurance.

Tax Considerations

Employer-provided group permanent life insurance benefits are subject to onerous tax treatment under Section 79. Essentially, since Section 79 imputes income to an employee based on a formula using conservative interest and mortality assumptions, the imputed taxable income for group permanent life insurance can be substantially *greater* than the economic value provided to the employee using the cash values defined in the policy. Employee-pay-all group permanent life insurance may be excludable from Section 79 and not generate any imputed income under the following conditions:

- The insurer sells the insurance directly to the employee, who pays the full cost.
- The employer's participation is limited to such functions as selection of insurer and type of insurance, providing the insurer with lists of employees and use of premises, and collecting premiums.
- The insurer or employer does not condition the sale on the purchase of other obligations.

GROUP UNIVERSAL LIFE INSURANCE

Types of Plans

Group universal life (GUL) insurance plans were developed in the mid-1980's as the group insurance counterpart to individual universal life plans started in the late 1970's. In general, they consist of two components, namely term life insurance and a side fund which accumulates with interest, to provide tax-favored savings and long-

term life insurance protection. Spousal insurance may also be included under GUL policies.

The death benefit under GUL plans is defined as the sum of the term life insurance component plus the side fund component. The term life insurance component can be designed similarly to an optional life plan (a multiple of salary or a flat amount) with the side fund being added on. This results in an increasing death benefit. Alternatively, the overall GUL death benefit (term plus side fund) can be a level benefit, with the term amount decreasing as the side fund grows.

The GUL premium may be credited to the fund net of premium tax and expense charges. The term costs can then be charged to the fund, with the balance accumulating with interest. The GUL premium may be determined flexibly, with the minimum amount allowable being enough to satisfy the cost of the term insurance element, and the maximum amount being defined by the GUL policy in order to ensure the life insurance internal revenue code definition is met. A target premium may be defined as the amount necessary to fund a given level death benefit, assuming the current interest crediting rate. The cost of term insurance, or term costs, are typically based on either one-year or five-year step rates, and subject to change annually. In addition, a schedule of maximum term costs may be included in the GUL policy.

The credited interest rate for the side fund is generally based on prevailing market conditions, and is adjusted annually. There may also be a guaranteed minimum credited interest rate included in the GUL policy.

Plan Provisions

Eligibility provisions for GUL are similar to group supplemental or optional life plans. GUL may provide for continuity of coverage through some combination of the following approaches:

- A waiver of premium disability provision may apply to the term portion of the premium.
- A portability provision may apply where employees can continue coverage at termination or retirement, on a premium-paying basis.

- The fund may convert to paid-up insurance on retirement or termination. The paid-up insurance would generally include a cash value of its own.
- Coverage may continue on a non-premium paying basis, with the fund paying the term costs as long as it is sufficient.
- A conversion privilege may be provided. The amount convertible may be limited to the total GUL death benefit (term plus fund) prior to termination, less any paid-up insurance purchasable by the fund.

The death benefit payment provisions are similar to group term life insurance. In addition, all or a portion of the fund may be paid out as a surrender or a policy loan. As a surrender, the amount is directly deducted from the fund. As a policy loan, the amount continues to be considered part of the fund earning interest, but an offsetting policy loan interest charge is assessed. On death, any outstanding loans and interest charges are deducted from the death benefit otherwise payable.

Federal Income Tax Implications

The tax implications of group universal life insurance are very favorable, provided it is maintained outside of Section 79. They include the following features:

- The interest on the fund accumulates on a tax-deferred basis.
- Cash surrender of the fund is taxable on the gain on surrender, which is the excess of the cash surrender over the total GUL premiums paid. Consequently, interest accumulations are only taxable to the degree they exceed the term costs plus premium tax and expense charges.
- The total death benefit (term plus fund) is payable tax free to the beneficiary.

A GUL plan may be maintained outside of Section 79 similarly to group permanent life plans. A GUL plan provided under Section 79 (if employer contributions are involved) is subject to the onerous group permanent life insurance tax provisions discussed earlier.

Another concern is that if the fund exceeds a defined limit in relation to the face amount, then the plan may become a modified endowment contract, under the tax laws, resulting in less favorable taxation. In order to satisfy the definition of life insurance, Section 7702 of the Internal Revenue Code requires the policy to satisfy either the cash value accumulation test or both the guideline level premium and cash value corridor tests which are defined in that section of the code.

GROUP CREDIT LIFE INSURANCE

A variation on group life insurance is group credit life insurance, which provides a death benefit equal to the unpaid consumer debt of the insured. The creditor (usually a bank) is both the group policyholder as well as the beneficiary of the policy. The amount of insurance is tied directly to the debtor's account balance. The premium is generally paid by the debtor, usually as a component of the cost of servicing the debt. However, dividends payable under the policy are paid to the creditor. This feature can make group credit life insurance very profitable to the creditor, and consequently can lead to potential marketing abuses.

There is considerable regulation of group credit life insurance. Many states have promulgated maximum rates in order to avoid excessive charges being made, in order to maximize dividends to the creditor at the expense of the debtor.