LIFE INSURANCE (A) COMMITTEE

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Dwight K. Bartlett III, Chair—Md.
Patrick E. Kelly, Vice Chair—D.C.

CONTENTS

MINUTES

The Life Insurance (A) Committee met in the New York B Ballroom of the Sheraton Hotel in New York, N.Y., at 9 a.m. on June 5, 1996. A quorum was present and Patrick E. Kelly, Vice Chair (D.C.) chaired the meeting. The following committee members or their representatives were present: Terri Vaughan (Iowa); Chris P. Krahling (N.M.); Edward Muhl (N.Y.); Jim Long (N.C.); Glenn Pomeroy (N.D.); Kerry Barnett (Ore.); and Robert E. Wilcox (Utah).

1. Report of the Annuities Working Group

Jerry Fickes (N.M) reported that the working group discussed three issues. A panel consisting of representatives from three organizations discussed the definition of annuities. The working group discussed annuities and the senior population. Concerns have been raised that seniors are being sold annuities inappropriately. He said there is definitely a lack of understanding on the part of consumers of the restrictions on annuity withdrawals. The working group will look at suitability information that is being distributed by the companies and may suggest suitability requirements similar to those for long-term care insurance. The working group will begin drafting a model law on charitable gift annuities and will have a draft to discuss at the next meeting. Upon motion duly made and seconded, the report of the Annuities Working Group was adopted (Attachment One).

2. Report of the Viatical Settlements Working Group

Tom Foley (N.D.) reported that the working group had received testimony from the viatical settlement industry that the marketplace is significantly changing, and this necessitates a review of the existing Viatical Settlements Model Act and Viatical Settlements Model Regulation. The working group also discussed the pricing of viatical settlements. Those in attendance alerted the working group to two problems they face: (1) many insurers marketing group policies will not accept an assignment for consideration, and (2) an incontestability clause is being put into the contract. The working group will

continue to monitor the NAIC models and receive input on possible changes. Upon motion duly made and seconded, the report of the Viatical Settlements Working Group was adopted (Attachment Two).

3. Report of the Genetic Testing Working Group

Dixon Larkin (Utah) said an informational seminar was held on June 3 with a spirited discussion. The working group also met in regular session and adopted a white paper to provide information to the states on the issue of genetic testing. The working group discussed whether its objectives had been met and decided there is still much to do because this is such a rapidly changing field. The group feels it is important to continue to monitor developments and to serve as a focus of information on the issue of genetic testing. Commissioner Patrick Kelly (D.C.) asked if there were any comments on the genetic testing white paper. Wendy McGoodwin (Council for Responsible Genetics) opined that the report contains numerous scientific inaccuracies and the definition of genetic testing is inadequate. Upon motion duly made and seconded, the report of the Genetic Testing Working Group was adopted (Attachment Three).

4. Report of the Synthetic GIC Working Group

Reginald Berry (D.C.) reported that the working group considered whether to move ahead with development of a model law on synthetic guaranteed interest contracts (GICs) and decided it is important to draft a model. He said the working group will interface with the Risk-Based Capital Task Force, which also is working on synthetic GICs. The working group requested assistance from technical resource advisors and received a number of offers of assistance. Upon motion duly made and seconded, the report of the Synthetic GIC Working Group was adopted (Attachment Four).

5. Report of the Life Disclosure Working Group

Commissioner Robert E. Wilcox (Utah) reported that the Life Disclosure Working Group had heard from four subgroups working on different tasks assigned to them. The Life Insurance Buyer's Guide is being revised and the only remaining issue is whether to include information about the cost indices. The current draft attached to the minutes does not include cost indices. The Variable Life Insurance Subgroup met with the Securities and Exchange Commission and the National Association of Securities Dealers to discuss the NAIC approach on illustrations. The newly formed Replacement Issues Subgroup will focus on replacements of life insurance policies. The Annuity Illustrations Subgroup received a report from its technical resource advisors and will hold an interim meeting to consider further issues. The Life Disclosure Working Group adopted a generally recognized expense table, which is referenced in the Life Insurance Illustrations Model Regulation adopted last year. The table will allow insurers more flexibility than just using actual expenses in calculating the numbers in their illustrations. A question and answer document on the Life Insurance Illustrations Model Regulation has been drafted with suggested answers to questions received from insurers and others. This document will be reviewed by the regulators and discussed further at an interim meeting. Upon motion duly made and seconded, the report of the Life Disclosure Working Group was adopted (Attachment Five).

6. Report of the Life and Health Actuarial (Technical) Task Force

Mr. Foley highlighted several items from the two days of meetings held by the task force and its working groups. He pointed out that a revision was made to the previously distributed draft of the NAIC Model Rule for Recognizing a New Mortality Table for Use in Determining Reserve Liabilities for Annuities to limit the amendments to group annuities. The task force will further consider tables for individual annuities. A subgroup looked at variations in state valuation laws and the impact on the actuarial opinion. The group proposes to use the state of domicile rules in preparing an actuarial opinion and also suggested eliminating the exemption for small companies from the filing of an actuarial opinion. States would be responsible for providing information to the NAIC about variations from the Actuarial Opinion and Memorandum Model Regulation in their state laws. The task force is continuing review of the philosophy of life nonforfeiture and expects to have an interim meeting in

September to continue its analysis. Upon motion duly made and seconded, the report of the Life and Actuarial (Technical) Task Force was adopted.

7. Any Other Matters Brought Before the Committee

Mr. Fickes said he had received a communication from Michael J. Bartholomew (American Council of Life Insurance—ACLI) who wants to present information to the NAIC about group pension and annuity business. Mr. Bartholomew said the ACLI would like to prepare for the Life Insurance (A) Committee a white paper with information about the group pension and annuity business to assist regulators. The report would contain suggestions for the appropriate type of regulation for this business. The members of the committee agreed the white paper would be helpful and welcomed the input from the ACLI.

Having no further business, the Life Insurance (A) Committee adjourned at 9:50 a.m.

Dwight K. Bartlett, Chair, Md.; Patrick E. Kelly, Vice Chair, D.C.; Terri Vaughan, Iowa; Chris P. Krahling, N.M.; Edward Muhl, N.Y.; Jim Long, N.C.; Glenn Pomeroy, N.D.; Kerry Barnett, Ore.; Robert E. Wilcox, Utah

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ATTACHMENT ONE

Annuities Working Group
of the Life Insurance (A) Committee
New York, New York
June 1, 1996

The Annuities Working Group of the Life Insurance (A) Committee met in the Royal B Ballroom of the Sheraton Hotel in New York, N.Y., at 8 a.m. on June 1, 1996. Jerry Fickes (N.M.) chaired the meeting. The following working group members or their representatives were present: Roger Strauss (Iowa); Howard Max (Md.); Tom Foley (N.D.); Kip May (Ohio); and Ted Becker (Texas).

1. Definition of an Annuity

Jerry Fickes (N.M.) reported that at the last meeting, he had requested a group of experts to come forward with recommendations at this meeting. The panel consisted of Scott Cipinko (National Alliance of Life Companies—NALC), John Booth (American Council of Life Insurance—ACLI), and Jean Rosales (American Academy of Actuaries—AAA). Mr. Cipinko said his member companies said that annuities were sold for different reasons to different people and they thought that it might be more appropriate to define annuities for specific situations. He suggested the real fear was that some people might think they have an annuity and then it would be defined in such a way as to no longer be an annuity. Mr. Booth said a number of years ago the ACLI had a group that struggled with the idea of defining annuities, but did not come to a conclusion. He suggested one all-purpose definition might tend to undermine existing state laws, and that an alternative was to have a definition to fit the situation, such as a definition for guaranty fund purposes, for taxes, for illustration purposes, and for reserves. Mr. Booth further asked if there was a problem that required developing a definition. Dr. Rosales said the AAA had been unable to come up with a definition, and that their members also had some concerns about the impact on taxes and existing annuities.

Bob Katz (Ohio) said it would be helpful to the working group to see the definitions that already existed for different purposes. Dr. Rosales responded that her group would be willing to put together a description of the types of products already being sold, and the working group agreed that this would be helpful. A preliminary definition that she had suggested to the AAA members was "a financial product that provides a series of payments and contains a mortality risk." She said her members were not comfortable with that preliminary definition because it did not include many products currently available. Mr. Booth said that this raised an interesting question: if something is not included in the definition, does that mean it is not subject to regulation? Mr. Fickes suggested that it was important to clarify whether one was defining an annuity or an annuity contract. He said the regulators were interested in looking at a product with a potential for mortality implications and a series of payments.

Bob Brown (CIGNA) pointed out that products currently sold by banks might not have rules for reserves. He suggested regulators should focus on things where there are legitimate concerns such as reserve requirements and regulate those instead of worrying about capturing every type of annuity that might exist. Dr. Rosales said one of AAA's concerns had been an unintended impact of a definition. For example, an annuity for federal tax code purposes is whatever state law says it is. Barbara Lautzenheiser (Lautzenheiser & Associates) described an annuity arrangement that was typically not covered under annuity definitions. She suggested that a continuing care retirement center where one could pay a single fee and spend a lifetime at the facility was actually an annuity where you received space instead of a dollar amount each month. Jack Evins (Texas) suggested starting with Dr. Rosales' definition and asking others to comment on what falls outside of that definition that perhaps should be included. Then the working group could address the implications of products that fall outside of the

definition and consider what government agencies should have jurisdiction over those products. A Maine regulator gave an example in her state. She said home warranty companies had previously been regulated by the real estate bureau, but that responsibility had been shifted to the insurance bureau because of the long-term promises involved. Rick Morris (N.Y.) pointed out that there will continue to be an acceleration of variations in products that might or might not be considered to be annuities. He agreed that it would be helpful to identify problems that would help regulators to determine what products they wanted to include in a definition of annuities. Dr. Rosales and Ms. Lautzenheiser agreed to work together to combine Dr. Rosales' definition and a list Ms. Lautzenheiser had prepared for the Annuity Illustrations Subgroup with more depth.

2. Discuss Annuities and the Senior Population

Mr. Evins reported that he has researched complaint records in his state and had identified a number of complaints regarding senior citizens and annuities. He said the prevailing reasons were misrepresentations and difficulty in withdrawing funds without penalty. It was obvious that many seniors did not understand the restrictions on withdrawals. Roger Strauss (Iowa) said that he had discovered in his state that the suitability factor was extremely important. He asked if it was appropriate to sell a deferred annuity to a person over a certain age. Mr. Fickes said that he found a complaint in his state where a couple had been sold a product designed to annuitize at ages 93 and 98. He agreed that most of those complaining in his state had not understood what they were buying. Howard Max (Md.) said he also had an instance where a bank CD had been rolled over into a deferred annuity for a 90-year-old, and he considered that use inappropriate. Tom Foley (N.D.) said that it might be inappropriate to sell deferred annuities to seniors over a certain age, but as long as the tax benefit remained, there would be reasons to push people into annuities. He said it was key that regulators figure out how to help people make an informed decision on whether an annuity is appropriate. Mr. Fickes said the Annuity Illustrations Subgroup was working on disclosure in general, but suggested that it was necessary to do something more specific for senior citizens, such as had been done in Medicare supplement and long-term care insurance. Mr. Evins asked insurers to submit any forms or disclosures they used to determine suitability to Carolyn Johnson (NAIC/SSO).

Mr. Katz offered to be responsible for getting a list of some of the abuses that the working group would want to look into. Mr. Fickes suggested that, after this had been distributed, the working group hold a conference call early in August to discuss the issues raised.

3. Discuss Drafting Model Law on Charitable Gift Annuities

Mr. Fickes said that a survey of the states had indicated many states did not have laws regulating charitable gift annuities, and some laws totally exempt the charities from the insurance code. He reported that the Planned Giving Council in New Mexico had been receptive to the idea that the NAIC prepare a model with limited regulation. Mr. Fickes outlined some of the considerations that would need to be included in a model law: reserve standards, a minimum level of funds for the trust, periodical examination of the trust, regulation of marketing practices and a registration requirement. Mr. Max said that Maryland did a regulation a year ago because they were receiving many more requests for registration. Charities had told the state that they did not have the services available to them of an actuary so the Maryland regulation placed the burden on the certified public accountant to state that the reserves were adequate.

Mr. Fickes agreed to take on the responsibility of preparing a first draft of a model for the members to discuss at the next meeting.

Having no further business, the Annuities Working Group adjourned at 9:50 a.m.

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ATTACHMENT TWO

Viatical Settlements Working Group of the
Life Insurance (A) Committee
New York, New York
June 2, 1996

The Viatical Settlements Working Group of the Life Insurance (A) Committee met in the New York B Ballroom of the Sheraton Hotel in New York, N.Y., at 8 a.m. on June 2, 1996. Tom Foley (N.D.) chaired the meeting. The following working group members or their representatives were present: Michael Bownes (Ala.); Carol Ostapchuk (Fla.); Ron Kotowski (Ill.); Lester Dunlap (La.); Paul Boucher (N.Y.); Tom Jacks (N.C.); John Crawford (Okla.); Mary Alice Bjork (Ore.); Rhonda Myron (Texas); Dixon Larkin (Utah); and Eleanor Perry (Vt.).

1. Hear Comments on Changes to Model Law and Regulation

Tom Foley (N.D.) said the first item of business was to hear comments on potential amendments to the Viatical Settlements Model Act and the Viatical Settlements Model Regulation. Bill Kelley (Viatical Association of American) said his association represented approximately 30 viatical companies doing business in the United States. The area of greatest concern to his members was the minimum discount requirement included in the model regulation. He said it was not necessary to set minimums because the marketplace has actually set higher standards for viatical settlements. Mr. Kelley said he would also like to see language added to the model act requiring insurers to be responsive to requests to process information on assignments. He also noted that some group policies have a provision prohibiting assignment for consideration.

Kenneth Klein (National Capital Benefits Corp.) said the escrow provision included in the model regulation left something to be desired. He noted that Florida recently adopted legislation that included a provision that structured the escrow account requirement correctly. He asked the working group to consider adding language similar to Florida's to better protect the viator. Mr. Klein said that New York law required that, in the event of a conversion from group to individual coverage, the insurer could not start over on the incontestability and suicide provisions, and he suggested this would be useful to add to the model. Mr. Klein also agreed with Mr. Kelley that assignment for consideration is right now the biggest problem faced by viatical settlement companies. He opined that New York may be the only state that prohibits a policy provision allowing gift assignment only.

Ron Kotowski (Ill.) asked whether this provision was in New York's viatical settlement law or elsewhere in its code. Paul Boucher (N.Y.) responded that the provision had been added in the life insurance portion of the code at the same time as it was adopted as part of the viatical settlement legislation.

Gary Choades (Viaticus) said there were some good aspects to the pricing structure: it was a simple table rather than a complex formula which was suitable for a short life expectancy. He asked that the expected premium to be paid by the viatical settlement company should be considered as part of the purchase price. Mr. Choades reiterated the comments heard earlier on the difficulty in working with some insurers. Without demonstrating why, they have prohibited assignment except as a gift. He said California had interpreted its existing law to allow an unlimited right of assignment and suggested that would he helpful to include in the model.

Scott Page (National Viatical Association) provided a document to members of the working group with suggested language for several amendments to the models. He suggested the confidentiality issue was most important. Disclosing the names of viators to the insurance department was not necessary. He also agreed that speedy transfer of information on verification of coverage and the assignment by insurers is a problem. He noted that viatical settlements were generally time-sensitive transactions. Mr. Page also suggested the addition of a requirement that insurers disclose the possibility of a viatical settlement when they send out a lapse notice. He said that this was comparable to a requirement that the viatical settlement company notify the potential viator of the possibility of an accelerated benefit from the insurer. He suggested that persons who might lapse their policy be directed to the viatical associations for further information.

David Landay (National Viator Representatives) suggested that the models distinguish between brokers representing buyers and brokers representing sellers of life insurance policies. He encouraged fair treatment for sellers because they do good for the persons attempting to viaticate a policy. Mr. Landay suggested that a pricing structure based on a complex formula would be difficult and this difficulty was exacerbated because doctors predicted different life expectancies and the company needs to factor in the potential for longer life because of new AIDS drugs. Mr. Landay predicted that if interest rates went up sharply, it would dry up the source of funds for viatical settlements until regulators adjusted the minimum returns in their regulations. Mr. Landay also said the bond and errors and omissions policy requirements were difficult requirements for small viatical settlement brokers. He suggested making forms and registration reciprocal because the current structure discouraged brokers from doing business in more than one state.

Elliott Kroll (Kroll and Tract) said that he had represented a viatical association in an amicus brief on the issue of incontestability laws. He described a policy that had been issued saying it was contestable "except in the case of fraud." He noted the case was currently on appeal and said that such a provision made it very difficult for someone to viaticate a policy. He differentiated between the tort remedy for fraud and a contractual provision such as he described. Mr. Boucher suggested this was not really a viatical settlement issue, but applied to contracts in general. Mr. Kroll agreed and asked the members of the working group to bring up this issue in other committees in a broader context.

Carol Ostapchuk (Fla.) provided highlights of Florida's recently adopted legislation. She said it had taken four years to get the bill through the legislature and reported that it was nearly identical to the NAIC model with some unique provisions added. The law adopted in Florida prohibits the department from regulating rates. She said an amendment added at the last minute provides that, if there are minor children, only 50% of the policy can be viaticated.

Mr. Kotowski reported that Illinois had also passed a viatical settlement law recently based on the NAIC model with some changes. He said Illinois would not license brokers, but placed the responsibility on the viatical settlement company. Mr. Kotowski noted that states adopting laws in more recent years had made changes and improvements to the NAIC models that should be considered by the working group.

Lester Dunlap (La.) said the Louisiana law adopted in 1995 had created one problem. He noted that the model act refers only to license revocation of providers, so Louisiana is not allowed to include reference in its regulation to suspension or revocation of the license of a broker. He said they will go back and amend the law to correct this defect.

Tom Jacks (N.C.) said few brokers are registering in his state and said it appeared that some brokers were acting without registration and his department was searching for information on those brokers. Ms. Ostapchuk reported that Florida's law contained a provision that a licensed life and health agent could act as a viatical broker without an additional registration. Mr. Dunlap said the Louisiana law required viatical settlement brokers to be licensed as insurance agents also. Mr. Kelley objected to a requirement for a broker to be licensed as an insurance agent. He said California law did not allow anyone licensed as an insurance agent to be a viatical broker, which meant that brokers had to choose between certain states where they were required to be licensed or prohibited from being licensed. Mr. Dunlap responded that being licensed as an insurance agent demonstrates a certain level of knowledge and competence. Mr. Kelley disagreed, saying that the body of knowledge necessary to be a viatical settlement broker was not the same as the knowledge needed as an insurance agent.

Eleanor Perry (Vt.) reported that a small group consisting of Mr. Dunlap, Mr. Jacks, Don Koch (Alaska) and herself considered what model amendments would be necessary to improve the ability to market viatical settlements to individuals who were not terminally ill but who might use the viatical settlement for long-term needs (Attachment Two-A).

2. Discuss Secondary Market for Viatical Settlements

Mary Alice Bjork (Ore.) reported that the securities division in Oregon was getting interested in viatical settlements. No products had been submitted for registration, but the division was aware that insurance agents were soliciting investors. Ms. Bjork said the insurance department was trying to educate agents that they might need to be licensed by the securities division. Ms. Bjork offered to provide information being sent to investors and also agreed to provide an informative newsletter article that had been prepared in Oregon. Mr. Kelley suggested that an Internet search for viatical would produce many solicitations for viatical settlement investors.

3. Report on Actuarial Study of Pricing

Mr. Foley said that in March he brought up the issue of an actuarial method of determining the appropriate discount when marketing to seniors and others who were not terminally ill. He suggested that rather than looking only at life expectancy, it would make more sense to establish mortality tables that would take into account premiums and other factors. Mark Peavy (NAIC/SSO) provided a memorandum that included an actuarial approach to a table of discounts (Attachment Two-B). He said the formula used in the memorandum was a very simplified formula that considered only two factors: the time value of money and the probability of death. He said even this simple formula involves difficult judgment calls, such as how to create the tables, how to decide which one to use, and how to determine the appropriate interest rate. He said that to get more accurate would require a more sophisticated formula reflecting more factors, and then the calculation was more complex.

Mr. Klein said that viatical settlement business now is generally persons with AIDS and said that most were encouraged to get at least three bids to obtain a higher return for their policy. He said that in the last two years, the average price paid had increased 10% due to competition. He said the viatical industry did not know how to underwrite a policy where a person might live for an additional 15 to 20 years.

Ms. Perry asked how competition would improve the market when states like Vermont had only a few licensed companies. She said it was not possible for a Vermont citizen who wanted to viaticate a policy to get a large number of bids. Rhonda Myron (Texas) said that in the few months the Texas law had been in place, they had already received 21 applications for registration. Mr. Kelley pointed out that the regulation of viatical settlement companies in Vermont is very onerous in comparison to other states and reminded the group that, if the law is so onerous that companies will not do business in the state, ill persons have not been helped by regulation.

Mr. Foley suggested the group continue consideration of issues related to the NAIC model and solicit additional comments, and he agreed to continue work on the actuarial pricing issue.

Having no further business, the Viatical Settlements Working Group adjourned at 10 a.m.

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ATTACHMENT TWO-A

Viatical Settlements Model Regulation
Report on Possible Amendments

In response to a charge from the Viatical Settlements Working Group (of the Life Insurance (A) Committee), the subgroup reviewed the Viatical Settlements Model Regulation to identify those sections of the regulation which might need to be revised, or sections which might need to be added, to reflect the use of viatical settlements in cases where life expectancy is longer than three years. This work is being undertaken to consider a response to industry statements that the market for viatical settlements is moving to the elder population, or those persons with cancer, Alzheimer's disease, or other conditions which do not have the relatively short life expectancy that has been true for persons with AIDS.

Section 1. License Requirements for Viatical Settlement Providers

We do not believe there is any part of this section which would require revision to respond to a changing market.

Section 2. License Requirements for Viatical Settlement Brokers

Although the industry has been critical of these requirements, we are not aware of any criticisms which are tied to changes in the viatical settlement market and we do not believe there is any part of this section which would require revision to respond to a changing market.

Section 3. Other Requirements for Brokers

We do not believe there is any part of this section which would require revision to respond to a changing market.

Section 4. Standards for Evaluation of Reasonable Payments

This section must be reviewed to determine what the requirements should be for "Minimum Percentage of Face Value Less Outstanding Loans Received by Viator" in the case of life expectancies longer than three years. The subcommittee recommends that this section be addressed by actuaries.

The provision that the minimum percentage may be reduced in response to a less favorable rating of the life insurer may be more important in cases where the life policy which is viaticated is not expected to be cashed in for five years or more.

Section 5. Reporting Requirement

We do not believe there is any part of this section which would require revision to respond to a changing market.

Section 6. General Rules

Parts B and C: The industry believes that greater flexibility in payment methods is particularly justified when dealing with elders or others who may be using the viatical settlement to provide a steady source of income. If the committee agrees with this position, we recommend that certain protections be added to the regulation:

* periodic payments are, by definition, annuities; and
* if the viatical settlement provider is using annuities as a payment vehicle, the viatical settlement provider must be either licensed as an insurer, or as an agent of a licensed insurer, or as a broker to sell annuities.

The committee should also determine whether the model regulation should restrict, in any fashion, the allowable annuities, e.g., fixed annuities only or are variable annuities acceptable, must the annuity provide a death benefit for the viator's beneficiaries.

Part G: Since there is probably a greater likelihood that elderly viators will be using their viatical settlement proceeds to pay nursing home, or other medical support costs, we recommend that this section be strengthened to disallow any affiliation between a viatical settlement provider and a nursing home or other care facility. We believe the possibility of conflict of interest and improper persuasion is simply too great.

Part H: We believe that the advertising standards section must be expanded if annuities are allowed as a vehicle for payment to ensure that viators are fully aware that they are selling their life insurance policies and buying annuities with the proceeds.

We believe a new section must be added to ensure that the viator is fully aware of the nature and consequences of the transaction. This need is strengthened since viatical settlement providers are planning to market the product to Alzheimer's victims, who may be legally competent, but in fact unable to make a considered decision. At the very least, we believe that viatical settlements should require the consent of any person who has power of attorney over the viator's affairs. There may be additional protections that can be built in.

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ATTACHMENT TWO-B

TO: Tom Foley, Director Life/Health and Actuary, North Dakota Department of Insurance
FROM: Mark Peavy, NAIC Life/Health Actuary
DATE: May 24, 1996
SUBJECT: Standards for Evaluation of Reasonable Payments for Viatical Settlements

At the Viatical Settlements Working Group meeting in March, you suggested that alternatives to the language in Section 4 of the NAIC's Viatical Settlements Model Regulation be explored. Section 4 now reads as follows:

Section 4. Standards for Evaluation of Reasonable Payments

In order to assure that viators receive a reasonable return for viaticating an insurance policy, the following shall be minimum discounts:

Insured's Life Expectancy	Minimum Percentage of Face Value Less Outstanding Loans Received by Viator
Less than 6 months	[80%]
At least 6 but less than 12 months	[70%]
At least 12 but less than 18 months	[65%]
At least 18 but less than 24 months	[60%]
Twenty-four months or more	[50%]

The percentage may be reduced by [5%] for viaticating a policy written by an insurer rated less than the highest [4] categories by A.M. Best, or a comparable rating by another rating agency.

A somewhat more refined estimate of the appropriate settlement can be obtained by reverting back to basic actuarial mathematics. Basic actuarial theory defines the present value at age "x" for $1 of term insurance for a period of n years as:

$$A^{1}_{x:\overline{n}|} = \sum_{t=0}^{n-1} v^{t+1}\, {}_{t}|q_x = \frac{1}{l_x} \sum_{t=0}^{n-1} v^{t+1} d_{x+t},$$

where payment is assumed to occur at the end of the year of death. If simplicity were the ultimate goal in revising Section 4, the above equation could be the basis for determining the minimum payment to viators. If a non-level death benefit were provided, the "1" which is implicit in each item of the summation would have to be changed to reflect that non-level pattern.

Obviously, life isn't so simple. First, the determination of the q_x's applicable to the viator isn't clear. Second, particularly in the first year, death may be heavily skewed toward the early part of the year, thereby suggesting that a) further refining the q_x's to reflect the probability of death within periods of less than a year or b) changing the assumed timing of the payment would be appropriate. Finally, the choice of an interest assumption is not clear, but the viator will obviously want as low a number as possible, while the viatical company will prefer a high interest assumption.

Assuming this sort of approach has some appeal, there are many further refinements which could be made to it. First, the viatical company is going to incur expenses in contracting with the viator, and therefore some initial expense allowance could be incorporated into the formula. Second, assuming the policy is not a paid-up policy, some additional allowance could be provided for the amount of premium the viatical company will have to pay to keep the policy in force. For fixed premium policies this estimate would be reasonably straightforward. For other than fixed premium plans some estimate. Also, for participating policies some estimate of the future dividends could be incorporated into the equation.

Some recognition would also need to be given for profit and risk margins. This can be done in several ways. One approach to make the assumptions regarding initial expenses, mortality and interest deliberately conservative. Alternatively, an explicit component could be added to the equations for risk and profit. This explicit component could be a percentage of the face amount of the policy, a percentage of the viatical settlement prior to the adjustment for profit and risk margin, a flat amount, or some combination of those approaches. Similar components might also be introduced for ongoing expenses incurred by the viatical company.

The above discussion does not represent the final level of complexity that could be introduced into this process. For example, explicit recognition of waiver of premium benefits could be made in order to reduce the credit the viatical company takes for future premiums. Also, projections regarding the exercising of future guaranteed insurability options could be incorporated into the formula. Furthermore, assuming provision is made to allow the viator to continue family riders in the contract, those benefits and premiums could also be reflected in the calculation of the viatical settlement.

All of the above has been focusing on the death benefits provided by the contract as the basis for the viatical settlement. Some observers have commented that there should be an explicit floor placed on the amount paid the viator related to the cash values available under the policy. Such a floor could be determined in a manner similar to Commissioners Annuity Reserve Valuation Method (CARVM) (which looks at the greatest present value of future amounts available under an annuity). In this case, projected cash values would be discounted back to the current time utilizing both mortality (unlike CARVM) and interest. Clearly, the premiums to be paid to keep the policy in force would also have to be factored into this equation. Given the relative level of premiums, benefits and cash values in most life insurance contracts, I would assume that it would be relatively rare that such a test would force an increase in the amount paid the viator. One scenario under which this minimum test might produce higher values would be if the viator was expected to live for several years and the contract provided for relatively high cash values. If this is a test that you think should be explored further, additional analysis can be done to better determine if there is a need for such a floor.

As demonstrated by the above discussion, as more aspects of the underlying life insurance contract are recognized in the calculation of the viatical settlement, the more complex the calculation of that amount becomes. Clearly there are going to have to be some tradeoffs between precision and practicality. Perhaps most importantly of all, it isn't at all clear at this point as to how an accurate assessment is going to be made of the mortality assumptions applicable to the viator.

I am looking forward to discussing these issues with you and the working group members in New York City.

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Discussion Points Relative to the Standards for the Evaluation
of Reasonable Payments for Viatical Settlements

- Current minimum discounts in the model regulation are based on percentages of the face amount which vary by life expectancy

- Basic actuarial theory can be utilized to create a formula to determine payments for viatical settlements
- There is a tradeoff between simplicity in the formula vs. reflecting all aspects of the policy
- Even a simple formula involves very difficult decisions relative to mortality and interest assumptions
- As more aspects of the policy are reflected in the formula, more judgment is introduced which may affect the accuracy of the formula and consistency with which it is applied
- Examples of policy features which could be reflected in the formula include: future premium payments, future dividends, guaranteed insurability options, waiver of premium benefits, family riders
- Examples of expenses incurred by the viatical company which could be reflected in the formula include: initial expense allowances, risk and profit margins, ongoing expenses
- An estimate of the present value of future cash values could serve as a floor for payments for viatical settlements

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ATTACHMENT THREE

Genetic Testing Working Group of the
Life Insurance (A) Committee
New York, New York
June 4, 1996

The Genetic Testing Working Group of the Life Insurance (A) Committee met in the New York B Ballroom of the Sheraton Hotel in New York, N.Y., at 2 p.m. on June 4, 1996. Dixon Larkin (Utah) chaired the meeting. The following working group members or their representatives were present: Ron Kotowski (Ill.); Robert G. Lange (Neb.); Kip May (Ohio); Mary Alice Bjork (Ore.); Birny Birnbaum (Texas); and Mary Clogston (Wash.).

1. Consider Adoption of White Paper on Genetic Testing

Mary Alice Bjork (Ore.) noted the working group has studied the issue of genetic testing for more than two years. Because the field is changing at such a rapid pace, she feels the current draft of the white paper is a summary of the subject's status at the current time. She proposed adoption of the white paper by the working group. Birny Birnbaum (Texas) commented that the white paper was less than he felt the group had hoped to produce and pointed out that the suggestions for different approaches had been left out. Dixon Larkin (Utah) noted that various state laws and federal proposals had been included to give information about what states are currently doing. Mr. Birnbaum said he thought the working group had reached consensus on two key issues: 1) if a person has knowledge of a genetic defect, the insurer should also, and 2) this should not be a carte blanche permission to the insurer to require any genetic tests it wished.

Dr. Larkin asked for comments from the audience on the paper and whether adoption at this time was appropriate. Wendy McGoodwin (Council for Responsible Genetics) said consumers will be disappointed if the report is moved forward in this form. She felt significant efforts had been made but that the report is biased in favor of insurers. Kip May (Ohio) said he had heard the same debate in Ohio. The definition of genetic testing itself could be thicker than the entire working group white paper if all the different opinions of people were included. He also agreed that adoption at this time was appropriate. Mr. Birnbaum pointed out that the definition included in the white paper was narrower than some of the definitions discussed and might obtain different results. He suggested removing the definition because the group had not actually come to any conclusions. Mr. Birnbaum made a motion to remove the definition from the white paper but there was no second to the motion. The original motion to adopt the white paper passed with Texas voting against it (Attachment Three-A).

2. Any Other Matters Brought Before the Working Group

Dr. Larkin asked what recommendation the working group should make to its parent for future activity. Mr. May suggested that the working group be disbanded. Tom Foley (N.D.) said that he had brought up the idea at the genetic testing forum held the prior day that insurance regulators had not done a good job of informing consumers about how to protect insurability and the consequences of becoming uninsurable. He thought it would be helpful for regulators to put together an informational document that could be distributed to consumers to help them understand the importance of getting coverage while they were insurable. He opined that the advances in genetic testing would exacerbate the problem. Dr. Larkin suggested that an important function of the working group was to respond to federal legislation and to funnel information on genetic testing to the NAIC. Ms. Bjork suggested that the working group recommend to the Life Insurance (A) Committee that it continue to monitor state and federal actions as well as consumer and industry concerns and to meet at the call of the chair to address issues. Then consumers and others who feel an issue is worthy of discussion can bring the issue to the chair and a meeting of the working group would be called. The working agreed to this suggestion.

Having no further business, the Genetic Testing Working Group adjourned at 2:55 p.m.

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ATTACHMENT THREE-A

White Paper on Genetic Testing

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The NAIC Life Insurance (A) Committee created Genetic Testing Working Group following the national meeting in Denver in 1994. The charge to the working group was to analyze the appropriateness of insurers using genetic testing in applications for insurance coverage. The working group conducted open hearings on genetic testing at the national NAIC meetings held in Baltimore, Minneapolis and New Orleans in 1994 and in Miami, San Antonio, St. Louis, and Philadelphia in 1995. In addition members of the working group participated in various seminars specifically addressing genetic testing held across the country. Also, the states have held hearings and developed various model laws. This paper is designed to provide a brief, easily understood, primer on genetic testing, its status and issues raised by its use; an overview of actions taken by the various states; suggestions as to possible regulatory options; and finally a compilation of the statutes enacted by the states.

Introduction

Each person has his or her own unique combination of 23 pairs of genes or chromosomes, the basic units of human heredity. These genes form the human genome. The human genome is the genetic blueprint of the human body. The code is made up of about three billion chemical "letters" or nucleotides, the chemical units that create each person's chromosomes. The genetic code is formed by combinations of only four amino acids, cytosine, tyrosine, guanine and adenine, in various combinations. These nucleotides are arranged in pairs, forming a twisting, ladder-like structure, known as a double helix, called deoxyribonucleic acid (DNA). If stretched out, each cell's genetic code would be about three feet in length.

Each cell of the human body contains the entire genetic code for an individual, consisting of about one hundred thousand genes. Genes order the production of proteins and other chemicals that go into making up the human body. When a gene is altered or mutated, the wrong message is sent to the production mechanism of the cell, which can, in turn, cause the body to malfunction, creating genetic disease. Genetic disease may be either inherited or acquired. Inherited disease arises from the chromosomes received directly from parents, as in cystic fibrosis. These diseases may be from dominant genes, requiring only a single gene from one parent. Or they may be from recessive genes, requiring a gene from each parent. Genetic disease may also arise from alteration of the genetic code after birth, an acquired disorder. Certain forms of cancer are most likely this type of disease, since the gene which controls the growth of a specific cell appears to be damaged so that the normal cell loses control, expanding locally and spreading distantly, ultimately killing the patient. Alterations to genes may also increase the likelihood of an individual developing a disease, though the disease itself is not genetic in origin.

Definition of Genetic Testing

No generally accepted term precisely defines "genetic testing." The term implies that a piece of the human genetic code is examined to determine if the chemical sequence is proper. However, this is not currently possible except in the most sophisticated laboratories. Rather, the underlying genetic code must be deciphered through indirect evidence.

In those states where legislation has been adopted addressing genetic testing, the definition has been relatively restrictive, limiting the definition to those tests which examine the genetic code or direct gene products. In addressing the issue of defining genetic testing, insurers have advocated extremely tight restrictions, limiting such testing to laboratory testing of human DNA or chromosomes. On the other side of the issue, some advocacy groups have advocated much broader definitions, including a prohibition against inquiring into the applicant's family history or even the ages or health of one's parents as a form of a genetic test.

The Task Force on Genetic Testing of the Working Group on the Ethical, Legal and Social Implications of the Human Genome Project:

> "Genetic tests" - The analysis of human DNA, chromosomes, proteins or other gene products to determine the presence of disease-related genotypes, mutations, phenotypes or karyotypes for clinical purposes. Such purposes include prediction of disease risks, identification of carriers, monitoring, diagnosis or prognosis, but do not include tests conducted purely for research.

The Working Group suggests the working definition be:

> "Genetic screening or testing" means a laboratory test of a person's genes or chromosomes for abnormalities, defects, or deficiencies, including carrier status, that are linked to physical or mental disorders or impairments, or that indicates a susceptibility to illness, disease, or other disorders, whether physical or mental, which test is a direct test for abnormalities, defects, or deficiencies, and not an indirect manifestation of genetic disorders.

CURRENT STATE OF GENETIC TESTING

Perhaps the most famous genetic project currently is the Human Genome Project. The Human Genome Project is a worldwide project initiated approximately five years ago in an attempt to analyze the human genetic code. It is anticipated that the Project will take about 15 years and cost about $3 billion. Presently, scientists estimate that they have identified genes responsible for about one half the 6,500 known inherited diseases caused by a single defective gene, including the genes responsible for cystic fibrosis and neurofibromatosis. In addition, certain genetic abnormalities have been discovered which predispose individuals to certain diseases, such as breast cancer in women who inherit the BRCA-1 abnormality or indicate a high probability of cancer in families who have a history of hereditary non-polyposis colon cancer.

The project hopes to accomplish two goals. First is to map the genome, to determine the location of each of the thousands of genes. Second is to sequence the genome, to determine the order of each of the chemical letters making up the genetic code. By achieving this, scientists hope to be able to examine an individual's genetic code to identify any abnormality that might exist in the sequence of the code and then determine how that abnormality might affect the individual by ascertaining which structure or function might be changed by the location of the abnormality on the map of the genome. To date less than 1% of the genome's 3 billion units has been sequenced or deciphered.

Most current "genetic tests" examine either gene products or macroscopic structures resulting from the action of a specific gene. Many genetic syndromes are diagnosed solely through the physical examination of the patient. Other genetic tests examine the chemicals created by the body from the genetic code, for example testing of newborns for treatable metabolic diseases such as phenylketonuria (PKU). Many states mandate such neonatal testing. Still other diseases are diagnosed by a combination of these two methods.

On a microscopic basis, chromosomes themselves may be examined to determine if is there is a cellular chromosomal abnormality, as when an amniocentesis is performed on a pregnant woman looking for Down's Syndrome connected with trisomy.

Genetic testing is of variable utility. This is particularly evident in autosomal regressive conditions, where the genetic abnormality must be inherited from both parents. For example, with cystic fibrosis two individuals who carry the single abnormal gene will not develop the disease. However, should those individuals have children together, those children carry a 25% risk of inheriting both abnormal genes and will then certainly develop the disease. Therefore carrier status is not predictive of future disability for those individuals. In autosomal dominant conditions such as Huntington's Chorea, the presence of a single gene means those individuals will develop the disease if they live long enough. These individuals are essential presymptomatic with the disease process, since the only condition under which the disease will not develop is an early death. The identification of the gene is therefore highly predictive of future disability. Intermediate between these two conditions are the complex gene-influenced conditions which have a predisposition toward the development of a disease. For example a woman who inherits the BRCA-1 abnormality has a high probability of developing breast cancer. However, about 15% will not develop the disease. Therefore, the predictive value of the genetic abnormality is of significance, but places the individual in an intermediate risk exposure, lying between the recessive and dominant genetic disorders.

The working group sought responses to several questions regarding the status of genetic testing. The first was whether insurers were currently requiring applicants to submit to genetic testing. We found that, now, insurers are not requiring genetic testing as a prerequisite to coverage. Second was whether insurers were using genetic test results from any source in underwriting. It was found that, although no insurers are now requiring genetic testing, if the results of genetic testing are in an applicant's medical record and are relevant, insurers are likely to include such results in the underwriting process.

GENETIC TESTING ISSUES

LIFE AND DISABILITY INCOME INSURANCE

Life and disability income insurance policies provide financial security to the policyholder's beneficiaries and for the benefit of the insured. By contrast, health insurance contracts provide indemnification for the cost of medical services rendered the insured.

Life and disability income insurance may be underwritten either individually or on a group basis. Both the underwriting and pricing of these policies are performed at the inception of these contracts. Usually once issued, neither the terms of nor the premiums for these individual policies can be changed regardless of changes in the nature of the insured risk or the length of

time the contract is in effect. These policies also cannot generally be terminated except for nonpayment of premium. Most life insurance policies are individual in nature. By contrast, most health insurance is provided by employer group contracts and hence, re-priced annually and can be canceled under certain circumstances.

Some group life and disability income policies have provisions allowing the modification of premiums for groups as a whole. However, an individual may not be singled out for premium increases based on health factors. Also, while policies cannot be terminated except for nonpayment of premiums, some policies do expire after a stated period.

At the end of 1993, the most recent year for which there are published statistics, life insurance in force in the United States amounted to $11,105 billion. Seventy-eight percent of all American households and 154 million Americans owned life insurance at the end of 1993. Life insurance purchases during the year totaled $1.7 trillion. Two thirds of that amount were for individual ordinary life insurance.

Of the $11,105 billion of life insurance in force at the end of 1993, 57.9& ($6,428.4 billion) was ordinary individual life insurance which continues to be the principal type of life insurance protection for Americans This type of insurance is purchased by individuals to meet individual needs. Group live insurance in force at the end of 1993 totaled $4,456.3 billion and represented 40.1% of the life insurance in force in the United States.

The process of risk classification is used primarily in underwriting individual life and disability income insurance. Through the process of risk classification and underwriting, insurance companies place applicants for coverage into groups or classes. Each class is comprised of individuals who pose the same or comparable levels of risk. All the members of the class pay the same premiums. This is how insurers attempt to achieve fairness among insureds by matching premiums to the risks presented so that all those who present the same level of risk pay the same premiums.

On one side, individuals with any type of genetic abnormality, even if that abnormality is not predictive of any increased morbidity or mortality, are concerned that they will not be able to get insurance. On the other, life and disability insurers are concerned that, if an individual has knowledge of a genetic condition which is either presymptomatic or highly dispositive to developing a disease, that individual has an increased incentive to obtain higher levels of insurance without disclosing what may be a highly predictive risk underwriting factor.

HEALTH INSURANCE

Health insurance is sold on a group and individual basis. Most major medical insurance coverage is provided on a group basis by an employer. Insurers classify risk for health insurance for groups either by the group's own claims experience, or by data from the claims experience of other similar groups in the same industry. The premium rates are also set according to these factors. Major medical coverage pays for most medical expenses incurred for hospital and physician services at a percentage of the amount billed, after a deductible has been satisfied. Many policies limit coverage to a lifetime maximum, which is rarely exhausted.

The smaller the group, the fewer people there are to spread the expense of high cost claims; therefore, insurers may medically underwrite smaller groups on an individual basis. Many states have enacted small employer laws that require insurers to accept all employees of a small employer so underwriting does not result in exclusion from the group. Some states have laws or regulations that limit or prohibit medical underwriting, impose rating restrictions which prohibit an insurer from varying rates for small groups beyond certain thresholds or limit the degree to which an insurer can vary a group's rates based upon an individual's medical history or claims experience.

Sole proprietors, small employers, and individuals applying for major medical coverage experience medical underwriting. If a person has a medical condition that the insurer determines is unacceptable because of potential high medical expenses, in most states the insurer may reject the applicant, or issue a policy that excludes the preexisting condition for some period, or may never cover the condition. For this reason many states have laws that provide major medical coverage to individuals through a state high risk pool, while a few states require an insurer, such as Blue Cross Blue Shield, to accept these individuals. Insurers reject or limit coverage according to data that demonstrates that certain medical conditions, such as diabetes and cancer, will result in medical expenses. Other types of health insurance such as long-term care insurance, Medicare supplement insurance and limited indemnity coverage are also medically underwritten. However, federal and state laws require insurers to issue Medicare supplement insurance policies to applicants the first six months they receive Medicare Part B and reach 65 years of age, regardless of individual health conditions.

Premiums for individual insurance coverage are set according to the individual's age, sex, and geographic residence because these are reliable factors that indicate claims experience and medical expenses in the area where a person resides.

With the increasing adoption of open enrollment requirements among the states, the utility of genetic information in underwriting health insurance is rapidly disappearing, since open enrollment requires the insurer to accept all applicants, regardless of health status. Despite these changes, several legislators have recently introduced legislation at the federal level to prohibit the use of genetic information in the health insurance area and to restrict the use in other insurance lines. Copies of bills currently before the Congress are attached to his paper.

AVAILABILITY OF INSURANCE COVERAGE

Health insurance is the fundamental means to health care for many people. Life insurance is a primary means to future financial security. If an individual's genetic information indicates a potentially adverse genetic condition, genetic testing could

threaten the individual's ability to obtain either coverage. In response to test results, an insurer may increase premiums, exclude coverage for a condition from coverage even if the individual is healthy, or deny insurance altogether. An individual's access to health care and future financial security may be threatened or closed.

RISK CLASSIFICATION

Risk classification is a critical element for any insurance system. It is one step in the process insurers use to classify and divide individuals into groups with similar claims experience, and to thereby gain an estimate of expected costs. By classifying the risk associated with projected claims, this procedure protects the insurer's solvency and allows individuals in the class to pay the lowest price compatible with projected costs.

Risk classification also attempts to offset the negative impact of adverse selection. Adverse selection describes a situation in which the individuals most likely to purchase insurance are those with the highest risk of incurring losses. A case study on adverse selection (also known as antiselection) appears in the March/April 1996 issue of the American Academy of Actuaries' publication, *Contingencies*.

The viability of a voluntary insurance system is dependent upon insurers' capacity to avoid or limit the impacts of adverse selection through risk classification. To do this, insurers must have access to the same material knowledge as the insurance applicant. Risk classification also promotes equity among consumers, whereby each person pays a premium commensurate with the individual's risk. For example, nonsmokers pay less in insurance premiums than smokers.

CONFIDENTIALITY

As a medical test, a genetic test becomes part of an individual's medical record. Consumers have justifiable concerns that private medical information will be circulated to persons other than the individual or his or her medical practitioner.

BURDEN OF KNOWLEDGE

Learning about a genetic condition may create a serious mental and emotional burden for an individual, depending on the condition and its likelihood or potential for injuring the individual's health. An individual has no control over the condition. Depression, hopelessness and psychological trauma are obvious concerns. Family discord arising from unknown or undiscovered hereditary conditions are possible. Finally, the knowledge may have no therapeutic value for an individual if nothing can be done to prevent or deal with the condition. The lack of therapeutic value of the testing itself, as well as of the test results, is especially troubling because the testing at the outset was not done for the individual's medical benefit or by the individual's choice, but for the economic interest of a third party, the insurer. However, it is important to note that requiring an individual to disclose genetic results from a test previously performed does not raise the burden of knowledge issue. The burden of knowledge also varies by the type of test performed. For example, informing an individual of a high cholesterol level associated with a familial syndrome is different from revealing that an individual may be at risk for developing a life-threatening condition later in life.

DISCRIMINATION

A perfectly healthy individual who has a potentially adverse genetic condition (if such an individual may be properly described as "perfectly healthy") may be the object of discrimination by insurers, employers and others if these parties know about the genetic condition before taking some specified action. Similarly, an individual who has this knowledge, while others do not, may behave differently when buying insurance or taking other actions. Essentially, the individual runs the risk of being negatively stereotyped or categorized regardless of the individual's current health, though insurance involves, by its very nature, the sorting of individuals into risk classes. In any case, the question arises about whether or not knowledge of a genetic condition will result in unfair categorization.

EFFECT ON CURRENT POLICYHOLDERS

A policyholder who learns of a genetic condition will recognize that a change in employment may threaten health care and future economic security. The individual's freedom to move from one job to another and the freedom to move from one type of coverage to another may be circumscribed. The individual's employment may even be threatened. Finally, a healthy person with a potentially serious genetic condition may be treated unnecessarily as having a chronic, fatal disease.

Regulatory Options

When the working group originally met, there was substantial discussion over the possible development of a model act or regulation. This substantial discussion resulted in substantial disagreement regarding the advisability, necessity and even the capability of the working group to come to agreement on such a model.

Appendix
Survey of State Legislation
State Positions on The Issue of
Genetic Testing for Insurance Coverage

STATE	CITATION	COVERAGE	PROVISIONS
Arizona	§ 20-448	Life and Health	It is an unfair trade practice to consider a genetic condition in determining rates, terms or conditions of a life or health insurance policy or to reject an application for coverage based on a genetic condition unless claims experience or actuarial projections establish substantial differences in claims are likely to result from the genetic condition.
California	Ins. § 10140	Health	No insurer shall refuse to issue or sell or renew any policy of health insurance or charge a higher premium solely because the person carries a gene which may be associated with disability in that person or the person's offspring.
	§§ 10146 to 10149.1		Establishes standards for underwriting life and health insurance on the basis of genetic characteristics.
	§ 10123.35		Additional penalties and remedies with respect to violation of provisions relating to discrimination on basis of genetic characteristics apply to self-insured welfare benefit plan.
Colorado	§ 10-3-1104.7	Health, disability income, long-term care	Prohibits health and disability underwriters from seeking genetic information or using it to deny health insurance, group disability or long-term care insurance.
Florida	§§ 626.9706, 626.9707	Life and health; sickle-cell trait	No life or health insurer shall refuse to issue and deliver any policy of insurance solely because the person has sickle-cell trait.
Georgia	§§ 33-54-1 to 33-54-8	Health	Prohibits use of any information obtained from genetic testing to deny access to health insurance.
Hawaii	*SB 299 pending (1995)*	Health	*May not use results of genetic test to decide whether to insure for health insurance or in determination of rates or any other aspect of health insurance. Does not apply to life insurance, as long as rates are reasonably related to risk involved.*
Louisiana	R.S. 22:652.1	Life and health; sickle-cell trait	No insurer shall refuse to provide a policy of life insurance or health insurance solely because the applicant has sickle-cell trait.
Maryland	48A § 223	Genetic discrimination; life	Insurer may not refuse to insure or make or permit any differential in ratings for life insurance solely because the applicant has a genetic trait which is harmless within itself unless there is actuarial justification for it.
Minnesota	§ 72A.139	Health	May not require a genetic test or consider results of a test in determining eligibility for health insurance coverage, establishing premiums, or limiting coverage. Life insurers should obtain informed consent before testing and should recommend counseling.
Montana	§ 33-18-206	Genetic discrimination; all lines	The rejection of an application or determination of rates based on a genetic condition is unfair discrimination unless the applicant's medical condition and history and either claims experience or actuarial projections establish that substantial differences in claims are likely to result from the genetic condition.
New Hampshire	§§ 141-H:1 to 141-H:6	Health	Health insurer may not require genetic testing or condition provision of health insurance on results of a genetic test. May not consider in determination of rates. Does not apply to life, disability income or long-term care insurance.
North Carolina	§ 58-58-25	Life; sickle-cell trait	Insurer shall not refuse to issue or deliver any policy of life insurance solely by reason of the fact that their person possesses sickle cell trait or hemoglobin C trait, nor shall the policy carry a higher premium rate or charge by reason of the fact of the insured possesses the trait.
Ohio	§§ 1742.42 to 1742.43, 3901.491 to 3901.501	Health	Insurers and HMOs shall not consider any information obtained from genetic testing in processing individual or group health insurance applications. Statute effective until the year 2004.

STATE	CITATION	COVERAGE	PROVISIONS
Oregon	§ 746.135	Hospital or medical expense coverage	Requires informed consent before testing DNA. May not use results of testing to reject, deny, limit, cancel, refuse to renew, increase the rates, or otherwise affect any policy covering hospital or medical expenses.
Pennsylvania	*Senate Resolution 6 pending (1995)* *HB 1662 pending (1995)*	Health	*Encourages insurers to place a two-year moratorium on the practice of denying individuals insurance coverage due to genetic abnormalities while Dept. of Health conducts a study.* *Prohibits health insurers from discriminating based on genetic characteristics.*
Tennessee	§ 56-7-207	Life; sickle-cell trait	Insurer shall not refuse to issue or deliver any policy of life insurance solely by reason of the fact that the person to be insured possesses sickle cell trait or hemoglobin C trait.
Virginia	§ 38.2-508.4	Health	Insurer may not terminate, restrict, limit or otherwise apply conditions on coverage of an individual; cancel or refuse to renew; exclude; impose a waiting period; or establish a different rate for coverage on the basis of the results of genetic information. Information obtained from genetic screening or testing is confidential. Statute expires on July 1, 1998.
Wisconsin	§ 631.89	Health	Insurer may not require or request any individual or a member of the individual's family to obtain a genetic test. Shall not condition the provision of insurance coverage or health care benefits on whether a genetic test has been performed or on what the test results are. Does not apply to life insurance or income continuation insurance. If life or income continuation insurers do obtain genetic testing information, they are under the same information use restrictions as the insurers mentioned above.

Note: Every effort has been made to provide correct and complete information. For further information, consult the statutes listed.

ARIZONA

§ 20-448 Unfair discrimination

A. No person shall make or permit any unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for any contract of life insurance or of life annuity or in the dividends or other benefits payable thereon, or in any other of the terms and conditions of the contract.

B. No person shall make or permit any unfair discrimination respecting hemophiliacs or between individuals of the same class and of essentially the same hazard in the amount of premium, policy fees or rates charged for any policy or contract of disability insurance or in the benefits payable thereunder, or in any of the terms or conditions of the contract, or in any other manner whatever. The provisions of this subsection regarding hemophiliacs shall not apply to any policy or subscription contract which provides only benefits for specific diseases or for accidental injuries or which provides only indemnity for blood transfusion services or replacement of whole blood products, fractions or derivatives.

C. As to kinds of insurance other than life and disability, no person shall make or permit any unfair discrimination in favor of particular persons, or between insureds or subjects of insurance having substantially like insuring, risk and exposure factors, or expense elements, in the terms or conditions of any insurance contract, or in the rate or amount of premium charged therefor. This subsection shall not apply as to any premium or premium rate in effect pursuant to chapter 2, article 4 of this title (rate laws, fire and casualty).

D. No insurer shall refuse to consider an application for life or disability insurance on the basis of a genetic condition, developmental delay or developmental disability.

E. The rejection of an application or the determining of rates, terms or conditions of a life or disability insurance contract on the basis of a genetic condition, developmental delay or developmental disability constitutes unfair discrimination, unless the applicant's medical condition and history and either claims experience or actuarial projections establish that substantial differences in claims are likely to result from the genetic condition, developmental delay or developmental disability.

F. As used in this section:

1. "Developmental delay" means a delay of at least one and one-half standard deviations from the norm.
2. "Developmental disability" is as defined in section 36-551.
3. "Genetic condition" means a specific chromosomal or single-gene genetic condition.

CALIFORNIA

Ins § 10140 Discrimination prohibited; violations

Text of section operative until January 1, 2002

(a) No admitted insurer, licensed to issue life or disability insurance, shall fail or refuse to accept an application for that insurance, to issue that insurance to an applicant therefor, or issue or cancel that insurance, under conditions less favorable to the insured than in other comparable cases, except for reasons applicable alike to persons of every race, color, religion, national origin, ancestry, or sexual orientation. Race, color, religion, national origin, ancestry, or sexual orientation shall not, of itself, constitute a condition or risk for which a higher rate, premium, or charge may be required of the insured for that insurance.

(b) Except as otherwise permitted by law, no admitted insurer, licensed to issue disability insurance policies for hospital, medical, and surgical expenses, shall fail or refuse to accept an application for that insurance, fail or refuse to issue that insurance to an applicant therefor, cancel that insurance, charge a higher rate or premium for that insurance, or offer or provide different terms, conditions, or benefits, or place a limitation on coverage under that insurance, on the basis of a person's genetic characteristics that may, under some circumstances, be associated with disability in that person or that person's offspring. This subdivision shall not apply to life and disability income policies issued or delivered on or after January 1, 1995, that are contingent upon review or testing for other diseases or medical conditions.

(c) No discrimination shall be made in the fees or commissions of agents or brokers for writing or renewing a policy of disability insurance, other than disability income, on the basis of a person's genetic characteristics that may, under some circumstances, be associated with disability in that person or that person's offspring.

(d) It shall be deemed a violation of subdivision (a) for any insurer to consider sexual orientation in its underwriting criteria or to utilize marital status, living arrangements, occupation, gender, beneficiary designation, zip codes or other territorial classification within this state, or any combination thereof for the purpose of establishing sexual orientation or determining whether to require a test for the presence of the human immunodeficiency virus or antibodies to that virus, where that testing is otherwise permitted by law. Nothing in this section shall be construed to alter, expand, or limit in any manner the existing law respecting the authority of insurers to conduct tests for the presence of human immunodeficiency virus or evidence thereof.

(e) This section shall not be construed to limit the authority of the commissioner to adopt regulations prohibiting discrimination because of sex, marital status, or sexual orientation or to enforce these regulations, whether adopted before or on or after January 1, 1991.

(f) "Genetic characteristics" as used in this section shall have the same meaning as defined in Section 10147.

(g) This section shall remain in effect only until January 1, 2002, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2002, deletes or extends that date.

Ins § 10140.1 Disclosure of genetic test results: violations

(a) This section shall apply to the disclosure of genetic test results contained in an applicant or enrollee's medical records by an admitted insurer licensed to issue life or disability insurance, except life and disability income policies issued or delivered on or after January 1, 1995, that are contingent upon review or testing for other diseases or medical conditions.

(b) Any person who negligently discloses results of a test for a genetic characteristic to any third party, in a manner that identifies or provides identifying characteristics, of the person to whom the test results apply, except pursuant to a written authorization, as described in subdivision (g), this shall be assessed a civil penalty in an amount not to exceed one thousand dollars ($1,000) plus court costs, as determined by the court, which penalty and costs shall be paid to the subject of the test.

(c) Any person who willfully discloses the results of a test for a genetic characteristic to any third party, in a manner that identifies or provides identifying characteristics of the person to whom the test results apply, except pursuant to a written authorization, as described in subdivision (g), shall be assessed a civil penalty in an amount not less than one thousand dollars ($1,000) and no more than five thousand dollars ($5,000 plus court costs, as determined by the court, which penalty and costs shall be paid to the subject of the test.

(d) Any person who willfully or negligently discloses the results of a test for a genetic characteristic to a third party, in a manner that identifies or provides identifying characteristics of the person to whom the test results apply, except pursuant to a written authorization, as described in subdivision (g), that results in economic, bodily, or emotional harm to the subject of the test, is guilty of a misdemeanor punishable by a fine not to exceed ten thousand dollars ($10,000).

(e) In addition to the penalties listed in subdivisions (b) and (c), any person who commits any act described in subdivision (b) or (c) shall be liable to the subject for all actual damages, including damages for economic, bodily, or emotional harm which is proximately caused by the act.

(f) Each disclosure made in violation of this section is a separate and actionable offense.

(g) The applicant's "written authorization," as used in this section, shall satisfy the following requirements:

(1) Is written in plain language.

(2) Is dated and signed by the individual or a person authorized to act on behalf of the individual.

(3) Specifies the types of persons authorized to disclose information about the individual.

(4) Specifies the nature of the information authorized to be disclosed.

(5) States the name or functions of the persons or entities authorized to receive the information.

(6) Specifies the purposes for which the information is collected.

(7) Specifies the length of time the authorization shall remain valid.

(8) Advises the person signing the authorization of the right to receive a copy of the authorization. Written authorization is required for each separate disclosure of the test results, and the authorization shall set forth the person or entity to whom the disclosure would be made.

(h) This section shall not apply to disclosures required by the Department of Health Services necessary to monitor compliance with Chapter 1.5 (commencing with Section 150) of Part 1 of Division 1 of, and Sections 289.7 and 309 of, the Health and Safety Code, nor to disclosures required by the Department of Corporations necessary to administer and enforce compliance with Section 1374.7 of the Health and Safety Code.

Ins § 10140.5 Penalties for violations

(a) In addition to any other remedy permitted by law, the commissioner shall have the administrative authority to assess penalties specified in this section against life or disability insurers for violations of Section 10140.

(b) Any life or disability insurer that violates Section 10140 is liable for administrative penalties of not more than two thousand five hundred dollars ($2,500) for the first violation and not more than five thousand dollars ($5,000) for each subsequent violation.

(c) Any life or disability insurer that violates Section 10140 with a frequency that indicates a general business practice or commits a knowing violation of that section, is liable for administrative penalties of not less than fifteen thousand dollars ($15,000) and not more than one hundred thousand dollars ($100,000) for each violation.

(d) An act or omission that is inadvertent and that results in incorrect premium rates being charged to more than one subscriber shall be a single violation for the purpose of this section.

Ins § 10146 Purpose

The purposes of this article are to establish standards regarding unfair discrimination among individuals of the same class in the underwriting of life or disability income insurance on the basis of tests of a person's genetic characteristics; to establish minimum standards for determining insurability which are sufficiently reliable to be used for life and disability income insurance risk classification and underwriting purposes; to require the maintenance of strict confidentiality of personal information obtained through a test of a person's genetic characteristics; and to require informed consent before insurers underwrite on the basis of a test of a person's genetic characteristics. This article and Sections 10140 and 10143 shall constitute the exclusive requirements for insurers' practices relating to genetic characteristics or to tests thereof.

Ins § 10147 Definitions

As used in this article:

(a) "Disability income insurance" means insurance against loss of occupational earning capacity arising from injury, sickness, or disablement, and includes insurance which provides benefits for overhead expenses of a business or profession when the insured becomes disabled.

(b) "Genetic characteristics" means any scientifically or medically identifiable gene or chromosome, or alteration thereof, which is known to be a cause of a disease or disorder, or determined to be associated with a statistically increased risk of development of a disease or disorder that is presently not associated with any symptoms of any disease or disorder.

(c) "Life or disability income insurer" means an insurer licensed to transact life insurance or disability income insurance in this state or a fraternal benefit society licensed in this state.

(d) "Policy" means (1) a life insurance policy or a disability income insurance policy delivered in this state, or (2) a certificate of life insurance benefits or disability income insurance benefits, issued under a group life or disability income insurance policy and delivered in this state by a life or disability income insurer or a fraternal benefits society, regardless of the location of the group master policy.

(e) "Test of a person's genetic characteristics" means a laboratory test which is generally accepted in the scientific and medical communities for the determination of the presence or absence of genetic characteristics.

Ins § 10148 Written consent

No insurer shall require a test for the presence of a genetic characteristic for the purpose of determining insurability other than in accordance with the informed consent, and privacy protection provisions of this article and Article 6.6 (commencing with Section 791) of Chapter 1 of Part 2 of Division 1. Notwithstanding any other provision of law, this constitutes the exclusive requirements for informed consent, and privacy protection for that testing.

(a) An insurer that requests an applicant to take a genetic characteristic test shall obtain the applicant's written informed consent for the test. Written informed consent shall include a description of the test to be performed, including its purpose, potential uses, and limitations, the meaning of its results, procedures for notifying the applicant of the results, and the right to confidential treatment of the results.

(b) The insurer shall notify an applicant of a test result by notifying the applicant or the applicant's designated physician. If the applicant tested has not given written consent authorizing a physician to receive the test results, the applicant shall be urged, at the time the applicant is informed of the test results, to contact a health care professional.

(c) The commissioner shall develop and adopt standardized language for the informed consent disclosure form required by this section to be given to any applicant for life or disability income insurance who takes a test for a genetic characteristic.

(d) A life or disability income insurer shall not require a person to undergo a test of the person's genetic characteristics unless the cost of the test is paid by the insurer.

(e) No policy shall limit benefits otherwise payable if loss is caused or contributed to by the presence or absence of genetic characteristics, except to the extent and in the same fashion as the insurer limits coverage for loss caused or contributed to by other medical conditions presenting an increased degree of risk.

(f) Nothing in this chapter shall limit an insurer's right to decline an application or enrollment request for a life or disability income insurance policy, charge a higher rate or premium for such a policy, or place a limitation on coverage under such a policy, on the basis of manifestations of any disease or disorder.

(g) No discrimination shall be made in the fees or commissions of agents or brokers writing or renewing a life or disability income policy on the basis of a test of that person's genetic characteristics.

Ins § 10149.1 Disclosure of test results

(a) This section shall apply to the disclosure of the results of a test for a genetic characteristic requested by an insurer pursuant to this article.

(b) Any person who negligently discloses results of a test for a genetic characteristic to any third party, in a manner which identifies or provides identifying characteristics of the person to whom the test results apply, except pursuant to a written authorization, as described in subdivision (g), or except as provided in this article or in Sections 1603.1 and 1603.3 of the Health and Safety Code, shall be assessed a civil penalty in an amount not to exceed one thousand dollars ($1,000) plus court costs, as determined by the court, which penalty and costs shall be paid to the subject of the test.

(c) Any person who willfully discloses the results of a test for a genetic characteristic to any third party, in a manner which identifies or provides identifying characteristics of the person to whom the test results apply, except pursuant to a written authorization, as described in subdivision (g), or except as provided in this article or in Sections 1603.1 and 1603.3 of the Health and Safety Code, shall be assessed a civil penalty in an amount not less than one thousand dollars ($1,000) and no more than five thousand dollars ($5,000) plus court costs, as determined by the court, which penalty and costs shall be paid to the subject of the test.

(d) Any person who willfully or negligently discloses the results of a test for a genetic characteristic to a third party, in a manner which identifies or provides identifying characteristics of the person to whom the test results apply, except pursuant to a written authorization, as described in subdivision (g), or except as provided in this article or in Sections 1603.1 and 1603.3 of the Health and Safety Code, which results in economic, bodily, or emotional harm to the subject of the test, is guilty of a misdemeanor punishable by imprisonment in a county jail for a period not to exceed one year, by a fine of not to exceed ten thousand dollars ($10,000), or by both that fine and imprisonment.

(e) Any person who commits any act described in subdivision (b) or (c) shall be liable to the subject for all actual damages, including damages for economic, bodily, or emotional harm which is proximately caused by the act.

(f) Each disclosure made in violation of this section is a separate and actionable offense.

(g) The applicant's "written authorization," as used in this section, applies only to the disclosure of test results by a person responsible for the care and treatment of the person subject to the test. Written authorization is required for each separate disclosure of the test results, and shall include to whom the disclosure would be made.

Ins § 10123.35 Disclosure of genetic test results: violations

(a) This section shall apply to the disclosure of genetic test results contained in an applicant or enrollee's medical records by a self-insured welfare benefit plan.

(b) Any person who negligently discloses results of a test for a genetic characteristic to any third party, in a manner that identifies or provides identifying characteristics, of the person to whom the test results apply, except pursuant to a written authorization, as described in subdivision (g), shall be assessed a civil penalty in an amount not to exceed one thousand dollars ($1,000) plus court costs, as determined by the court, which penalty and costs shall be paid to the subject of the test.

(c) Any person who willfully discloses the results of a test for a genetic characteristic to any third party, in a manner that identifies or provides identifying characteristics of the person to whom the test results apply, except pursuant to a written authorization, as described in subdivision (g), shall be assessed a civil penalty in an amount not less than one thousand dollars ($1,000) and no more than five thousand dollars ($5,000) plus court costs, as determined by the court, which penalty and costs shall be paid to the subject of the test.

(d) Any person who willfully or negligently discloses the results of a test for a genetic characteristic to a third party, in a manner that identifies or provides identifying characteristics of the person to whom the test results apply, except pursuant to a written authorization, as described in subdivision (g), that results in economic, bodily, or emotional harm to the subject of the test, is guilty of a misdemeanor punishable by a fine not to exceed ten thousand dollars ($10,000).

(e) In addition to the penalties listed in subdivisions (b) and (c), any person who commits any act described in subdivision (b) or (c) shall be liable to the subject for all actual damages, including damages for economic, bodily, or emotional harm which is proximately caused by the act.

(f) Each disclosure made in violation of this section is a separate and actionable offense.

(g) The applicant's "written authorization," as used in this section, shall satisfy the following requirements:

(1) Is written in plain language.

(2) Is dated and signed by the individual or a person authorized to act on behalf of the individual.

(3) Specifies the types of persons authorized to disclose information about the individual.

(4) Specifies the nature of the information authorized to be disclosed.

(5) States the name or functions of the persons or entities authorized to receive the information.

(6) Specifies the purposes for which the information is collected.

(7) Specifies the length of time the authorization shall remain valid.

(8) Advises the person signing the authorization of the right to receive a copy of the authorization. Written authorization is required for each separate disclosure of the test results, and the authorization shall set forth the person or entity to whom the disclosure would be made.

(h) This section shall not apply to disclosures required by the Department of Health Services necessary to monitor compliance with Chapter 1.5 (commencing with Section 150) of Part 1 of Division 1 of, and Sections 289.7 and 309 of, the Health and Safety Code, nor to disclosures required by the Department of Corporations necessary to administer and enforce compliance with Section 1374.7 of the Health and Safety Code.

COLORADO

§ 10-3-1104.7 Genetic testing—declaration—definitions—limitations—on disclosure of information—liability—legislative—declaration

(1) The general assembly hereby finds and determines that recent advances in genetic science have led to improvements in the diagnosis, treatment, and understanding of a significant number of human diseases. The general assembly further declares that:

(a) Genetic information is the unique property of the individual to whom the information pertains;

(b) Any information concerning an individual obtained through the use of genetic techniques may be subject to abuses if disclosed to unauthorized third parties without the willing consent of the individual to whom the information pertains;

(c) To protect individual privacy and to preserve individual autonomy with regard to the individual's genetic information, it is appropriate to limit the use and availability of genetic information;

(d) The intent of this statute is to prevent information derived from genetic testing from being used to deny access to health care insurance, group disability insurance, or long-term care insurance coverage.

(2) For the purposes of this section:

(a) "Entity" means any sickness and accident insurance company, health maintenance organization, nonprofit hospital, medical-surgical and health service corporation, or other entity that provides health care insurance, group disability insurance, or long-term care insurance coverage and is subject to the jurisdiction of the commissioner of insurance.

(b) "Genetic testing" means any laboratory test of human DNA, RNA, or chromosomes that is used to identify the presence or absence of alterations in genetic material which are associated with disease or illness. "Genetic testing" includes only such tests as are direct measures of such alterations rather than indirect manifestations thereof.

(3) (a) Information derived from genetic testing shall be confidential and privileged. Any release, for purposes other than diagnosis, treatment, or therapy, of genetic testing information that identifies the person tested with the test results released requires specific written consent by the person tested.

(b) Any entity that receives information derived from genetic testing may not seek, use, or keep the information for any nontherapeutic purpose or for any underwriting purpose connected with the provision of health care insurance, group disability insurance, or long-term care insurance coverage.

(4) Notwithstanding the provisions of subsection (3) of this section, in the course of a criminal investigation or a criminal prosecution, and to the extent allowed under the federal or state constitution, any peace officer, district attorney, or assistant attorney general, or a designee thereof, may obtain information derived from genetic testing regarding the identity of any individual who is the subject of the criminal investigation or prosecution for use exclusively in the criminal investigation or prosecution without the consent of the individual being tested.

(5) Notwithstanding the provisions of subsection (3) of this section, any research facility may use the information derived from genetic testing for scientific research purposes so long as the identity of any individual to whom the information pertains is not disclosed to any third party; except that the individual's identity may be disclosed to the individual's physician if the individual consents to such disclosure in writing.

(6) This section does not limit the authority of a court or any party to a parentage proceeding to use information obtained from genetic testing for purposes of determining parentage pursuant to section 13-25-126, C.R.S.

(7) This section does not limit the authority of a court or any party to a proceeding that is subject to the limitations of part 5 of article 64 of title 13, C.R.S., to use information obtained from genetic testing for purposes of determining the cause of damage or injury.

(8) This section does not limit the authority of the state board of parole to require any offender who is involved in a sexual assault to submit to blood tests and to retain the results of such tests on file as authorized under section 17-2-201(5)(g), C.R.S.

(9) This section does not limit the authority granted the state department of public health and environment, the state board of health, or local departments of health pursuant to section 25-1-122, C.R.S.

(10) This section does not apply to the provision of life insurance or individual disability insurance.

(11) Any violation of this section is an "unfair practice," as defined in section 10-3-1104(1), and is subject to the provisions of sections 10-3-1106 to 10-3-1113.

(12) Any individual who is injured by an entity's violation of this section may recover in a court of competent jurisdiction the following remedies:

(a) Equitable relief, which may include a retroactive order, directing the entity to provide health insurance, group disability insurance, or long-term care insurance coverage, whichever is appropriate, to the injured individual under the same terms and conditions as would have applied had the violation not occurred; and

(b) An amount equal to any actual damages suffered by the individual as a result of the violation.

(13) The prevailing party in an action under this section may recover costs and reasonable attorney fees.

FLORIDA

§ 626.9706 Life insurance discrimination based on sickle-cell trait

(1) No insurer authorized to transact insurance in this state shall refuse to issue and deliver any policy of life insurance solely because the person to be insured has the sickle-cell trait.

(2) No life insurance policy issued and delivered in this state shall carry a higher premium rate or charge solely because the person to be insured has the sickle-cell trait.

§ 626.9707 Disability insurance discrimination based on sickle-cell trait

(1) No insurer authorized to transact insurance in this state shall refuse to issue and deliver in this state any policy of disability insurance, whether such policy is defined as individual, group, blanket, franchise, industrial, or otherwise, which is currently being issued for delivery in this state and which affords benefits and coverage for any medical treatment or service authorized and permitted to be furnished by a hospital, clinic, health clinic, neighborhood health clinic, health maintenance organization, physician, physician's assistant, nurse practitioner, or medical service facility or personnel solely because the person to be insured has the sickle-cell trait.

(2) No disability insurance policy issued or delivered in this state shall carry a higher premium rate or charge solely because the person to be insured has the sickle-cell trait.

GEORGIA

§ 33-54-1 Purpose of provisions

The General Assembly finds and determines that recent advances in genetic science have led to improvements in the diagnosis, treatment, and understanding of a significant number of human diseases. The General Assembly further finds and declares that:

(1) Genetic information is the unique property of the individual tested;

(2) The use and availability of information concerning an individual obtained through the use of genetic testing techniques may be subject to abuses if disclosed to unauthorized third parties without the willing consent of the individual tested;

(3) To protect individual privacy and to preserve individual autonomy with regard to an individual's genetic information, it is appropriate to limit the use and availability of genetic information; and

(4) The intent of this chapter is to prevent accident and sickness insurance companies, health maintenance organizations, managed care organizations, and other payors from using information derived from genetic testing to deny access to accident and sickness insurance.

§ 33-54-2 "Genetic testing"; "insurer"

As used in this chapter, the term:

(1) "Genetic testing" means laboratory tests of human DNA or chromosomes for the purpose of identifying the presence or absence of inherited alterations in genetic material or genes which are associated with a disease or illness that is asymptomatic at the time of testing and that arises solely as a result of such abnormality in genes or genetic material. For purposes of this chapter, genetic testing shall not include routine physical measurements; chemical, blood, and urine analysis; tests for abuse of drugs; and tests for the presence of the human immunodeficiency virus.

(2) "Insurer" means an insurer, a fraternal benefit society, a nonprofit medical service corporation, a health care corporation, a health maintenance corporation, or a self-insured health plan not subject to the exclusive jurisdiction of the Employee Retirement Income Security Act of 1974, 29 U.S.C. Section 1001, et seq.

§ 33-54-3 Written consent for testing and disclosure of results

(a) Except as otherwise provided in this chapter, genetic testing may only be conducted to obtain information for therapeutic or diagnostic purposes. Genetic testing may not be conducted without the prior written consent of the person to be tested.

(b) Information derived from genetic testing shall be confidential and privileged and may be released only to the individual tested and to persons specifically authorized by such individual to receive the information. Any insurer that possesses information derived from genetic testing may not release the information to any third party without the explicit written consent of the individual tested. Information derived from genetic testing may not be sought by any insurer as defined in Code Section 33-54-2.

§ 33-54-4 Utilization of test results

Any insurer that receives information derived from genetic testing may not use the information for any nontherapeutic purpose.

§ 33-54-5 Use of results in legal proceedings

Notwithstanding the provisions of Code Sections 33-54-3 and 33-54-4, information derived from genetic testing regarding the identity of any individual who is the subject of a criminal investigation or a criminal prosecution may be disclosed to appropriate legal authorities conducting the investigation or prosecution. The information may be used during the course of the investigation or prosecution with respect to the individual tested without the consent of such individual.

§ 33-54-6 Testing for research purposes; information disclosure

Notwithstanding the provisions of Code Sections 33-54-3 and 33-54-4, any research facility may conduct genetic testing and may use the information derived from genetic testing for scientific research purposes so long as the identity of any individual tested is not disclosed to any third party, except that the individual's identity may be disclosed to the individual's physician with the consent of the individual.

§ 33-54-7 Applicability of provisions

This chapter shall not apply to a life insurance policy, disability income policy, accidental death or dismemberment policy, Medicare supplement policy, long-term care insurance policy, credit insurance policy, specified disease policy, hospital indemnity policy, blanket accident and sickness policy, franchise policy issued on an individual basis to members of an association, limited accident policy, health insurance policy written as a part of workers' compensation equivalent coverage, or other similar limited accident and sickness policy.

§ 33-54-8 Legal procedure; violation of genetic testing laws

(a) Any violation of this chapter by an insurer shall be unfair trade practice subject to the provisions of Article 1 of Chapter 6 of this title, and a violation of this chapter by any other person shall be an unfair practice and shall be subject to the provisions of Part 2 of Article 15 of Chapter 1 of Title 10, the "Fair Business Practices Act of 1975." In addition, any individual who is harmed as a result of a violation of this chapter shall have a cause of action against the person whose violation caused the harm.

(b) Any insurer that is found in violation of the provisions of this chapter by a court of competent jurisdiction is liable to the individual injured by the violation in an amount equal to any actual damages suffered by the individual. In the alternative, the court may issue an order directing the insurer to provide accident and sickness insurance to the injured individual under the same terms and conditions as would have applied had the violation not occurred.

(c) The court shall award costs and reasonable attorney's fees to any individual who is successful in enforcing the provision of this chapter.

LOUISIANA

R.S. 22:652.1 Life or disability insurance; discrimination based on "severe disability" or sickle cell trait prohibited

A. No insurance company shall charge unfair discriminatory premiums, policy fees or rates for, or refuse to provide any policy or contract of life insurance, life annuity, or policy containing disability coverage for a person solely because the applicant therefor has a severe disability, unless the rate differential is based on sound actuarial principles or is related to actual experience. No insurance company shall unfairly discriminate in the payments of dividends, other benefits payable under a policy, or in any of the terms and conditions of such policy or contract solely because the owner of the policy or contract has a severe disability.

B. "Severe disability," as used in this Section, means any disease of, or injury to, the spinal cord resulting in permanent and total disability, amputation of any extremity that requires prosthesis, permanent visual acuity of twenty/two hundred or worse in the better eye with the best correction, or a peripheral field so contracted that the widest diameter of such field subtends an angular distance no greater than twenty degrees, total deafness, inability to hear a normal conversation or use a telephone without the aid of an assertive device, or persons who have developmental disabilities, including but not limited to autism, cerebral palsy, epilepsy, mental retardation, and other neurological impairments.

C. Nothing in this Section shall be construed as requiring an insurance company to provide insurance coverage against a severe disability which the applicant or policyholder has already sustained.

D. No insurance company shall charge unfair discriminatory premiums, policy fees or rates for, or refuse to provide any policy or contract of life insurance, life annuity, or policy containing disability coverage for a person solely because the applicant therefor has sickle cell trait. No insurance company shall unfairly discriminate in the payments of dividends, other benefits payable under a policy, or in any of the terms and conditions of such policy or contract solely because the insured of the policy or contract has sickle cell trait. Nothing in this Subsection shall prohibit waiting periods, preexisting conditions, or dreaded disease rider exclusions, or any combination thereof, if they do not unfairly discriminate.

MARYLAND

§ 48A § 223 Unfair discrimination: life, health, and annuity contracts

(a) (1) No person shall make or permit any unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for any contract of life insurance or of life annuity or in the dividends or other benefits payable thereon, or in any other of the terms and conditions of such contract.

(2) (i) Notwithstanding any other provisions in this section, an insurer may not make or permit any differential in ratings, premium payments or dividends for life insurance and annuity contracts for any reason based on the blindness or other physical handicap or disability of an applicant or policyholder.

(ii) Actuarial justification for the differential may be considered for a physical handicap or disability other than blindness or hearing impairment.

(3) An insurer may not refuse to insure or make or permit any differential in ratings, premium payments, or dividends in connection with life insurance and life annuity contracts solely because the applicant or policyholder has the sickle-cell trait, thalassemia-minor trait, hemoglobin C trait, Tay-Sachs trait, or any genetic trait which is harmless within itself, unless there is actuarial justification for it.

(b) (1) No person shall make or permit any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy fees, or rates charged for any policy or contract of health insurance or in the benefits payable thereunder, or in any of the terms, or conditions of such contract, or in any other manner whatever.

(2) Notwithstanding any other provisions in this section, an insurer may not make or permit any differential in ratings, premium payments or dividends for any reason based on the sex of an applicant or policyholder unless there is actuarial justification for the differential.

(3) (i) Notwithstanding any other provisions in this section, an insurer may not make or permit any differential in ratings, premium payments or dividends for health insurance contracts for any reason based on the blindness or other physical handicap or disability of an applicant or policyholder.

(ii) Actuarial justification for the differential may be considered for a physical handicap or disability other than blindness or hearing impairment.

(4) An insurer may not make or permit any differential in ratings, premium payments, or dividends in connection with a health insurance contract solely because the applicant or policyholder has the sickle-cell trait, thalassemia-minor trait, hemoglobin C trait, Tay-Sachs trait, or any genetic trait which is harmless within itself, unless there is actuarial justification for it.

MINNESOTA

§ 72A.139 Genetic discrimination act

Subdivision 1. Name and citation. This section shall be known and may be cited as the "genetic discrimination act."

Subdivision. 2. Definitions.

(a) As used in this section, "commissioner" means the commissioner of commerce for health plan companies and other insurers regulated by that commissioner and the commissioner of health for health plan companies regulated by that commissioner.

(b) As used in this section, a "genetic test" means a presymptomatic test of a person's genes, gene products, or chromosomes for the purpose of determining the presence or absence of a gene or genes that exhibit abnormalities, defects, or deficiencies, including carrier status, that are known to be the cause of a disease or disorder, or are determined to be associated with a statistically increased risk of development of a disease or disorder. "Genetic test" does not include a cholesterol test or other test not conducted for the purpose of determining the presence or absence of a person's gene or genes.

(c) As used in this section, "health plan" has the meaning given in section 62Q.01, subdivision 3.

(d) As used in this section, "health plan company" has the meaning given in section 62Q.01, subdivision 4.

(e) As used in this section, "individual" means an applicant for coverage or a person already covered by the health plan company or other insurer.

Subdivision 3. Prohibited acts; health plan companies. A health plan company, in determining eligibility for coverage, establishing premiums, limiting coverage, renewing coverage, or any other underwriting decision, shall not, in connection with the offer, sale, or renewal of a health plan:

(1) require or request an individual or a blood relative of the individual to take a genetic test;

(2) make any inquiry to determine whether an individual or a blood relative of the individual has taken or refused a genetic test, or what the results of any such test were;

(3) take into consideration the fact that a genetic test was taken or refused by an individual or blood relative of the individual; or

(4) take into consideration the results of a genetic test taken by an individual or a blood relative of the individual.

Subdivision 4. Application. Subdivisions 5, 6, and 7 apply only to a life insurance company or fraternal benefit society requiring a genetic test for the purpose of determining insurability under a policy of life insurance.

Subdivision 5. Informed consent. If an individual agrees to take a genetic test, the life insurance company or fraternal benefit society shall obtain the individual's written informed consent for the test. Written informed consent must include, at a minimum, a description of the specific test to be performed; its purpose, potential uses, and limitations; the meaning of its results; and the right to confidential treatment of the results. The written informed consent must inform the individual that the individual should consider consulting with a genetic counselor prior to taking the test and must state whether the insurer will pay for any such consultation. An informed consent disclosure form must be approved by the commissioner prior to its use.

Subdivision 6. Notification. The life insurance company or fraternal benefit society shall notify an individual of a genetic test result by notifying the individual or the individual's designated physician. If the individual tested has not given written consent authorizing a physician to receive the test results, the individual must be urged, at the time that the individual is informed of the genetic test result described in this subdivision, to contact a genetic counselor or other health care professional.

Subdivision 7. Payment for test. A life insurance company or fraternal benefit society shall not require an individual to submit to a genetic test unless the cost of the test is paid by the life insurance company or fraternal benefit society.

Subdivision 8. Enforcement. A violation of this section is subject to the investigative and enforcement authority of the commissioner, who shall enforce this section.

MONTANA

§ 33-18-206 Unfair discrimination

(1) No person shall make or permit any unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for any contract of life insurance or of life annuity or in the dividends or other benefits payable thereon or in any other of the terms and conditions of such contract.

(2) No person shall make or permit any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy fees, or rates charged for any policy or contract of disability insurance or in the benefits payable thereunder or in any of the terms or conditions of such contract or in any other manner whatever.

(3) An insurer may not refuse to consider an application for life or disability insurance on the basis of a genetic condition, developmental delay, or developmental disability.

(4) The rejection of an application or the determining of rates, terms, or conditions of a life or disability insurance contract on the basis of genetic condition, developmental delay, or developmental disability constitutes unfair discrimination unless the applicant's medical condition and history and either claims experience or actuarial projections establish that substantial differences in claims are likely to result from the genetic condition, developmental delay, or developmental disability.

(5) As used in this section, the following definitions apply:

(a) "Developmental delay" means a delay of at least 1 1/2 standard deviations from the norm.

(b) "Developmental disability" means the singular of developmental disabilities as defined in 53-20-202.

(c) "Genetic condition" means a specific chromosomal or single-gene genetic condition.

NEW HAMPSHIRE

§ 141-H:1 Definitions In this chapter:

I. "Disability income insurance" means insurance intended to protect against loss of occupational earning capacity arising from injury, sickness or disablement, including insurance that provides benefits for overhead expenses or purchase of a business or profession when the insured becomes disabled.

II. "Employment" means work performed by an employee for an employer for remuneration.

III. "Employment agency" has the meaning given in RSA 354-A:2, VIII.

IV. "Genetic testing" means a test, examination or analysis which is generally accepted in the scientific and medical communities for the purpose of identifying the presence, absence or alteration of any gene or chromosome, and any report, interpretation or evaluation of such a test, examination or analysis, but excludes any otherwise lawful test, examination or analysis that is undertaken for the purpose of determining whether an individual meets reasonable functional standards for a specific job or task.

V. "Health insurance" means any arrangement with any entity which pays medical claims on behalf of an individual, an employee or dependents, including any such arrangement evidenced by a hospital or medical policy or certificate, hospital or medical service plan or contract, or health maintenance organization group or individual subscriber contract, or self insurance plan or contract, or other evidence of coverage, except for the purposes of this chapter, "health insurance" shall not mean life, disability income, or long-term care insurance.

VI. "Individual" means a human being.

VII. "Labor organization" has the meaning given in RSA 354-A:2, X.

VIII."Licensing agency" means a unit of government which is authorized to grant, deny, renew, revoke, suspend, annul, withdraw, or amend an occupation license.

IX. "Life insurance" means insurance in which the risk contemplated is the death of a particular individual upon which event the insurer pays a stipulated sum, or the type of insurance defined in RSA 401:1, III.

X. "Long-term care insurance" means the types of insurance defined in RSA 415-D:3, V.

XI. "Person" includes a human being, an association or organization, a trust, corporation and partnership.

§ 141-H:2 Standards; permissible disclosure

I. Except as otherwise provided in this chapter, no individual or member of the individual's family shall be required to undergo genetic testing as a condition of doing business with another person.

II. Except as required to establish paternity under RSA 522, or as required to test newborns for metabolic disorders under RSA 132:10-a, or as required for purposes of criminal investigations and prosecutions, or as is necessary to the functions of the office of chief medical examiner, no genetic testing shall be done in this state on any individual or anywhere on any resident of this state based on bodily materials obtained within this state, without the prior written and informed consent of the individual to be tested. The results of any such test shall be provided only to those persons approved in writing by the individual. No person shall refuse to perform genetic testing, or to arrange for genetic testing to be performed, or to do business with an individual, solely because the individual to be tested refuses to consent to providing the test results to some or all persons.

III. Except as provided in paragraph II, no person shall disclose to any other person that an individual has undergone genetic testing, and no person shall disclose the results of such testing to any other person, without the prior written and informed consent of the individual.

§ 141-H:3 Use in employment situations

I. No employer, labor organization, employment agency or licensing agency shall directly or indirectly:

(a) Solicit, require or administer genetic testing relating to any individual as a condition of employment, labor organization membership or licensure.

(b) Affect the terms, conditions or privileges of employment, labor organization membership or licensure or terminate the employment, labor organization membership or licensure of any individual based on genetic testing.

II. Except as provided in paragraph IV of this section, no person shall sell or otherwise provide to an employer, labor organization, employment agency or licensing agency any genetic testing relating to an employee, labor organization member or licensee or to a prospective employee, labor organization member or licensee.

III. Any agreement between an employer, labor organization, employment agency or licensing agency and an individual offering employment, labor organization membership, licensure or any pay or benefit to that individual in return for taking a genetic test is prohibited.

IV. This section shall not prohibit the genetic testing of an employee who requests to undergo genetic testing and who provides written and informed consent to genetic testing for any of the following purposes:

(a) Investigating a workers' compensation claim under RSA 281-A.

(b) Determining the employee's susceptibility or level of exposure to potentially toxic chemicals or potentially toxic substances in the workplace, if the employer does not terminate the employee, or take any other action that adversely affects any term, condition or privilege of the employee's employment, as a result of genetic testing.

V. This section shall not prohibit or limit genetic testing for evidence of insurability with respect to life, disability income, or long-term care insurance under the terms of an employee benefit plan.

§ 141-H:4 Health insurance prohibitions

A health insurer in connection with providing health insurance shall not:

I. Require or request directly or indirectly any individual or a member of the individual's family to undergo genetic testing.

II. Require or request directly or indirectly any individual to reveal whether the individual or a member of the individual's family has undergone genetic testing or the results of the testing, if undergone by the individual or a member of the individual's family.

III. Condition the provision of health insurance coverage or health care benefits on whether an individual or a member or the individual's family has undergone genetic testing or the results of the testing, if undergone by the individual or a member of the individual's family.

IV. Consider in the determination of rates or any other aspect of health insurance coverage or health care benefits provided to an individual whether an individual or a member of the individual's family has underdone genetic testing or the results of the testing, if undergone by the individual or a member of the individual's family.

§ 141-H:5 Prohibited use by certain insurers

I. Except as provided in paragraph II of this section, the provisions of this chapter shall not apply to the provision of life insurance, disability income insurance, or long-term care insurance.

II. A person in the business of providing life, disability income, or long-term care insurance who obtains information with respect to any genetic testing of an individual or a member of the individual's family shall not use that information in writing a type of insurance coverage other than life, disability income, or long-term care insurance.

§ 141-H:6 Civil actions

An aggrieved individual may bring a civil action under this chapter and, if successful, shall be awarded special or general damages of not less than $1,000 for each violation, and costs and reasonable legal fees.

NORTH CAROLINA

§ 58-58-25 Discrimination against sickle cell trait or hemoglobin C trait prohibited

No insurance company licensed in this State pursuant to the provisions of Articles 1 through 64 of this Chapter shall refuse to issue or deliver any policy of life insurance authorized thereunder solely by reason of the fact that the person to be insured possesses sickle cell trait or hemoglobin C trait; nor shall any such policy issued and delivered in this State carry a higher premium rate or charge by reason of the fact that the person to be insured possesses said traits. The term "sickle cell trait" is defined as the condition wherein the major natural hemoglobin components present in the blood of the individual are hemoglobin A (normal) and hemoglobin S (sickle hemoglobin) as defined by standard chemical and physical analytic techniques, including electrophoresis, and the proportion of hemoglobin A is greater than the proportion of hemoglobin S or one natural parent of the individual is shown to have only normal hemoglobin components (hemoglobin A, hemoglobin A2, hemoglobin F) in the normal proportions by standard chemical and physical analytic tests. The term "hemoglobin C trait" is defined as the condition wherein the major natural hemoglobin components present in the blood of the individual are hemoglobin A (normal) and hemoglobin C as defined by standard chemical and physical analytic techniques, including electrophoresis, and the proportion of hemoglobin A is greater than the proportion of hemoglobin C or one natural parent of the individual is shown to have only normal hemoglobin components (hemoglobin A, hemoglobin A2, hemoglobin F) in the normal proportions by standard chemical and physical analytic tests.

OHIO

§ 3901.491 Use of genetic screening information prohibited

(A) As used in this section:

(1) "Genetic screening or testing" means a laboratory test of a person's genes or chromosomes for abnormalities, defects, or deficiencies, including carrier status, that are linked to physical or mental disorders or impairments, or that indicate a susceptibility to illness, disease, or other disorders, whether physical or mental, which test is a direct test for abnormalities, defects, or deficiencies, and not an indirect manifestation of genetic disorders.

(2) "Insurer" means any person authorized under Title XXXIX of the Revised Code to engage in the business of sickness and accident insurance.

(3) "Sickness and accident insurance" means sickness and accident insurance under Chapter 3923. of the Revised Code excluding disability income insurance and excluding supplemental policies of sickness and accident insurance.

(B) Upon the repeal of section 3901.49 of the Revised Code by Sub. H.B. No. 71 of the 120th General Assembly, no insurer shall do either of the following:

(1) Consider, in a manner adverse to an applicant or insured, any information obtained from genetic screening or testing conducted prior to the repeal of section 3901.49 of the Revised Code in processing an application for an individual or group policy of sickness and accident insurance, or in determining insurability under such a policy;

(2) Inquire, directly or indirectly, into the results of genetic screening or testing conducted prior to the repeal of section 3901.49 of the Revised Code, or use such information, in whole or in part, to cancel, refuse to issue or renew, or limit benefits under, a sickness and accident insurance policy.

(C) Any insurer that has engaged in, is engaged in, or is about to engage in a violation of division (B) of this section is subject to the jurisdiction of the superintendent of insurance under section 3901.04 of the Revised Code.

§ 3901.50 Self insurers prohibited from using genetic screening

Text of section repealed effective February 9, 2004

(A) As used in this section:

(1) "Genetic screening or testing" means a laboratory test of a person's genes or chromosomes for abnormalities, defects, or deficiencies, including carrier status, that are linked to physical or mental disorders or impairments, or that indicate a susceptibility to illness, disease, or other disorders, whether physical or mental, which test is a direct test for abnormalities, defects, or deficiencies, and not an indirect manifestation of genetic disorders.

(2) "Self-insurer" means any government entity providing coverage for health care services on a self-insurance basis.

(B) No self-insurer, in processing an application for coverage under a plan of self-insurance or in determining insurability under such a plan, shall do any of the following:

(1) Require an individual seeking coverage to submit to genetic screening or testing;

(2) Take into consideration, other than in accordance with division (F) of this section, the results of genetic screening or testing;

(3) Make any inquiry to determine the results of genetic screening or testing;

(4) Make a decision adverse to the applicant based on entries in medical records or other reports of genetic screening or testing.

(C) In developing and asking questions regarding medical histories of applicants for coverage under a plan of self-insurance, no self-insurer shall ask for the results of genetic screening or testing or ask questions designed to ascertain the results of genetic screening or testing.

(D) No self-insurer shall cancel or refuse to provide or renew coverage for health care services based on the results of genetic screening or testing.

(E) No self-insurer shall establish or modify a plan of self-insurance in this state that limits benefits based on the results of genetic screening or testing.

(F) A self-insurer may consider the results of genetic screening or testing if the results are voluntarily submitted by an applicant for coverage or renewal of coverage and the results are favorable to the applicant.

(G) A violation of this section is an unfair and deceptive act or practice in the business of insurance under sections 3901.19 to 3901.26 of the Revised Code.

§ 3901.501 Use of genetic screening information prohibited

(A) As used in this section:

(1) "Genetic screening or testing" means a laboratory test of a person's genes or chromosomes for abnormalities, defects, or deficiencies, including carrier status, that are linked to physical or mental disorders or impairments, or that indicate a susceptibility to illness, disease, or other disorders, whether physical or mental, which test is a direct test for abnormalities, defects, or deficiencies, and not an indirect manifestation of genetic disorders.

(2) "Self-insurer" means any government entity providing coverage for health care services on a self-insurance basis.

(B) Upon the repeal of section 3901.50 of the Revised Code by Sub. H.B. No. 71 of the 120th general assembly, no self-insurer shall do either of the following:

(1) Consider, in a manner adverse to an applicant or insured, any information obtained from genetic screening or testing conducted prior to the repeal of section 3901.50 of the Revised Code in processing an application for coverage under a plan of self-insurance or in determining insurability under such a plan;

(2) Inquire, directly or indirectly, into the results of genetic screening or testing conducted prior to the repeal of section 3901.50 of the Revised Code, or use such information, in whole or in part, to cancel. refuse to provide or renew, or limit benefits under, a plan of self-insurance.

(C) Any self-insurer that has engaged in, is engaged in, or is about to engage in a violation of division (B) of this section is subject to the jurisdiction of the superintendent of insurance under section 3901.04 of the Revised Code.

§ 1742.42 Prohibition from using genetic screening

Text of section effective until February 9, 2004

(A) As used in this section, "genetic screening or testing" means a laboratory test of a person's genes or chromosomes for abnormalities, defects, or deficiencies, including carrier status, that are linked to physical or mental disorders or impairments, or that indicate a susceptibility to illness, disease, or other disorders, whether physical or mental, which test is a direct test for abnormalities, defects, or deficiencies, and not an indirect manifestation of genetic disorders.

(B) No health maintenance organization, in processing an application for coverage for health care services under an individual or group health maintenance organization contract or in determining insurability under such a contract, shall do any of the following:

(1) Require an individual seeking coverage to submit to genetic screening or testing;

(2) Take into consideration, other than in accordance with division (F) of this section, the results of genetic screening or testing;

(3) Make any inquiry to determine the results of genetic screening or testing;

(4) Make a decision adverse to the applicant based on entries in medical records or other reports of genetic screening or testing.

(C) In developing and asking questions regarding medical histories of applicants for coverage under an individual or group health maintenance organization contract, no health maintenance organization shall ask for the results of genetic screening or testing or ask questions designed to ascertain the results of genetic screening or testing.

(D) No health maintenance organization shall cancel or refuse to issue or renew coverage for health care services based on the results of genetic screening or testing.

(E) No health maintenance organization shall deliver, issue for delivery, or renew an individual or group contract in this state that limits benefits based on the results of genetic screening or testing.

(F) A health maintenance organization may consider the results of genetic screening or testing if the results are voluntarily submitted by an applicant for coverage or renewal of coverage and the results are favorable to the applicant.

(G) A violation of this section is an unfair and deceptive act or practice in the business of insurance under sections 3901.19 to 3901.26 of the Revised Code.

Note—Section three of 1993 H 71, eff. 2-9-94, reads:

(A) There is hereby created the Task Force on Genetic Testing in Health Insurance.

(B) The Task Force shall be composed of the following:

(1) The Superintendent of Insurance or his representative

(2) The Director of Health or his representative

(3) Two members of the Senate appointed by the President of the Senate

(4) Two members of the House of Representatives appointed by the Speaker of the House of Representatives

(5) Six members appointed by the Speaker of the House of Representatives, one of whom shall be a consumer representative, one of whom shall be a representative of an Ohio health care advocacy organization that is exempt from taxation under section 501(c)(3) of the "Internal Revenue Code of 1986," 100 Stat. 2085, 26 U.S.C.A. 501, as amended, one of whom shall be a hospital representative, one of whom shall be an insurance underwriter, one of whom shall he an insurance medical director, and one of whom shall be a geneticist. The geneticist shall be appointed from a list of five names submitted by insurers doing business in Ohio. If the Speaker of the House is not satisfied with the names submitted, the insurers shall submit additional names until he makes the appointment.

(6) Six members appointed by the President of the Senate, one of whom shall be a consumer representative, one of whom shall be a representative of an Ohio health care advocacy organization that is exempt from taxation under section 501(c)(3) of the "Internal Revenue Code of 1986," 100 Stat. 2085, 26 U.S.C.A. 501, as amended, one of whom shall be a hospital representative, one of whom shall be an insurance underwriter, one of whom shall be an insurance medical director, and one of whom shall be a geneticist. The geneticist shall be appointed from a list of five names submitted by the Ohio health care advocacy organizations described in division (B)(6) of this section. If the President of the Senate is not satisfied with the names submitted, the organizations shall submit additional names until he makes the appointment.

Vacancies shall be filled in the same manner as original appointments.

(C) Within 30 days after the effective date of this act, the Speaker of the House of Representatives and the President of the Senate shall make their respective appointments to the Task Force.

(D) The Superintendent of Insurance shall serve as chairman, and in his absence his representative shall serve as chairman. He shall also designate a person from his staff to serve as secretary.

(E) The Task Force shall conduct a comprehensive study of genetic screening and testing as they relate to the medical underwriting of health benefit plans, including sickness and accident insurance, other than disability income insurance, health maintenance organization benefit plans, and other health benefit plans and programs in Ohio. The study shall include, but is not limited to, the following:

(1) A review of all complaints filed with the Department of Insurance regarding substandard rating or rejections, or both, by such health benefit plans based on genetic screening or testing results.

(2) A review of the use of genetic screening or testing required to be taken by applicants residing in Ohio during calendar years 1992 and 1993 as part of the medical underwriting processes of health benefit plan providers, including insurers doing the business of sickness and accident insurance, other than disability income insurance, health maintenance organizations, and other health benefit plan and program providers in Ohio.

(3) A review of the health benefit plan provider use of results of genetic screening or testing previously administered to applicants, including how health benefit plan providers use the results of previously administered genetic screenings or testings as part of the application process.

(4) A review of the impact that increasingly sophisticated and reliable medical screenings and testings, including genetic screening and testing, have had on the proportion of applications for health benefit plans that have been accepted on a standard basis, rated on a substandard basis, or rejected.

(5) A review of the alternative sources of health benefit plan coverage for persons residing in Ohio who are denied access to conventional health benefit plans due to their high risk health conditions, including a survey of sickness and accident insurers to determine the number of persons accepted for health benefit plan coverage under the open enrollment provisions of Am. Sub. H.B. 478 of the 119th General Assembly, a survey of health maintenance organizations to determine the number of persons accepted for health benefit plan coverage under the open enrollment provisions of Chapter 1742. of the Revised Code, a survey of every mutual insurance company that merged or consolidated with a hospital service association to determine the number of persons accepted for health benefit plan coverage under the open enrollment provisions of section 3941.53 of the Revised Code, and a determination of the number of Ohio residents who are covered by health benefit plans that require no medical underwriting in the application process, including, but not limited to, group sickness and accident insurance, other than disability income insurance, health maintenance organization plans, multiple employer welfare arrangements, self- funded plans, Medicare, and Medicaid.

(6) A review of genetic screenings or testings conducted annually by medical care providers in Ohio, including, with respect to calendar years 1993 and 1994, the identification of the genetic screenings or testings available that are reliable predictors of adverse health conditions and the approximate cost range for each, the number of genetic screenings or testings administered in Ohio, the types of genetic screenings or testings administered in Ohio, and the percentage of each type of screening or testing that produced adverse results.

(F) The Superintendent of Insurance shall provide all research, technical, clerical, and other staff assistance needed by the Task Force in carrying out its duties. To help defray the costs incurred by the Superintendent, in providing such assistance, assessments, totaling in the aggregate not more than two hundred fifty thousand dollars, may be levied by and at the discretion of the Superintendent of Insurance on the health benefit plan providers described in division (E)(2) of this section. All assessments levied under this division shall be paid into the state treasury to the credit of the Department of Insurance Operating Fund created under section 3901.021 of the Revised Code. In addition, the departments, universities, agencies, and officers of this state shall cooperate with the Task Force to the fullest possible extent, including providing such facilities or data as may be available.

(G) The Task Force shall issue a final report to the Governor and the General Assembly, including any recommendations, not later than December 31, 1995. Upon issuance of the final report, the Task Force shall cease to exist.

§ 1742.43 Use of genetic screening information prohibited

(A) As used in this section, "genetic screening or testing" means a laboratory test of a person's genes or chromosomes for abnormalities, defects, or deficiencies, including carrier status, that are linked to physical or mental disorders or impairments, or that indicate a susceptibility to illness, disease, or other disorders, whether physical or mental, which test is a direct test for abnormalities, defects, or deficiencies, and not an indirect manifestation of genetic disorders.

(B) Upon the repeal of section 1742.42 of the Revised Code by Sub. H.B. No. 71 of the 120th General Assembly, no health maintenance organization shall do either of the following:

(1) Consider, in a manner adverse to an applicant or insured, any information obtained from genetic screening or testing conducted prior to the repeal of section 1742.42 of the Revised Code in processing an application for coverage for health care services under an individual or group contract or in determining insurability under such a contract;

(2) Inquire, directly or indirectly, into the results of genetic screening or testing conducted prior to the repeal of section 1742.42 of the Revised Code, or use such information, in whole or in part, to cancel, refuse to issue or renew, or limit benefits under, an individual or group contract.

(C) Any health maintenance organization that has engaged in, is engaged in, or is about to engage in a violation of division (B) of this section is subject to the jurisdiction of the superintendent of insurance under section 3901.04 of the Revised Code.

OREGON

§746.135 Genetic testing

(1) If an insurance provider asks an applicant for insurance to take a genetic test in connection with an application for insurance, the use of the test shall be revealed to the applicant and the provider shall obtain the specific authorization of the applicant using a form prescribed by rules of the Health Division.

(2) An insurance provider may not use a favorable genetic test as an inducement to purchase insurance.

(3) An insurance provider may not use genetic information to reject, deny, limit, cancel, refuse to renew, increase the rates of, affect the terms and conditions of or otherwise affect any policy for hospital or medical expenses.

(4) For purposes of this section, "genetic information," "genetic test" and "insurance provider" have those meanings given in ORS 659.700.

TENNESSEE

56-7-207 Sickle cell and hemoglobin C

(a) No insurance company which has been qualified and authorized to do business in this state pursuant to the provisions of chapter 2 of this title shall refuse to issue or deliver any policy of life insurance authorized thereunder solely by reason of the fact that the person to be insured possesses sickle cell trait or hemoglobin C trait.

(b) As used in this section:

(1) "Hemoglobin C trait" means the condition wherein the major natural hemoglobin components present in the blood of the individual are hemoglobin A (normal) and hemoglobin C as defined by standard chemical and physical analytic techniques, including electrophoresis; and the proportion of hemoglobin A is greater than the protection of hemoglobin C or one (1) natural parent of the individual is shown to have only normal hemoglobin components (hemoglobin A, hemoglobin A2, hemoglobin F) in the normal proportions by standard chemical and physical analytic tests; and

(2) "Sickle cell trait" means the condition wherein the major natural hemoglobin components present in the blood of the individual are hemoglobin A (normal) and hemoglobin S (sickle hemoglobin) as defined by standard chemical and physical analytic techniques, including electrophoresis; and the proportion of hemoglobin A is greater than the proportion of hemoglobin S or one (1) natural parent of the individual is shown to have only normal hemoglobin components (hemoglobin A, hemoglobin A2, hemoglobin F) in the normal proportions by standard chemical and physical analytic tests.

VIRGINIA

§ 38.2-508.4. Genetic information privacy.

A. As used in this section:

"Genetic characteristic" means any scientifically or medically identifiable gene or chromosome, or alteration thereof, which is known to be a cause of a disease or disorder, or determined to be associated with a statistically increased risk of development of a disease or disorder, and which is asymptomatic of any disease or disorder.

"Genetic information" means information about genes, gene products, or inherited characteristics that may derive from an individual or a family member.

B. No person proposing to issue, re-issue, or renew any policy, contract, or plan of accident and sickness insurance defined in Section 38.2-109, but excluding disability income insurance, issued by any (i) insurer providing hospital, medical and surgical or major medical coverage on an expense incurred basis, (ii) corporation providing a health services plan, or (iii) health maintenance organization providing a health care plan for health care services shall, on the basis of any genetic information obtained concerning an individual or on the individual's request for genetic services, with respect to such policy, contract, or plan:

1. Terminate, restrict, limit, or otherwise apply conditions to coverage of an individual or restrict the sale to an individual;

2. Cancel or refuse to renew the coverage of an individual;

3. Exclude an individual from coverage;

4. Impose a waiting period prior to commencement of coverage of an individual;

5. Require inclusion of a rider that excludes coverage for certain benefits and services; or

6. Establish differentials in premium rates for coverage.

In addition, no discrimination shall be made in the fees or commissions of an agent or agency for an enrollment, a subscription, or the renewal of an enrollment or subscription of any person on the basis of a person's genetic characteristics which may, under some circumstances, be associated with disability in that person or that person's offspring.

C. Notwithstanding any other provisions of law, all information obtained from genetic screening or testing conducted prior to the repeal of this section shall be confidential and shall not be made public nor used in any way, in whole or in part, to cancel, refuse to issue or renew, or limit benefits under any policy, contract or plan subject to the provisions of this section.

§ 38.2-613. Disclosure limitations and conditions.

A. An insurance institution, agent, or insurance-support organization shall not disclose any personal or privileged information about an individual collected or received in connection with an insurance transaction unless the disclosure is:

1. With the written authorization of the individual, provided:

a. If the authorization is submitted by another institution, agent, or insurance-support organization, the authorization meets the requirements of § 38.2-606; or

b. If the authorization is submitted by a person other than an insurance institution, agent, or insurance-support organization, the authorization is:

(1) Dated,

(2) Signed by the individual; or

(3) Obtained one year or less prior to the date a disclosure is sought pursuant to this subdivision; or

2. To a person other than an insurance institution, agent, or insurance-support organization, provided the disclosure is reasonably necessary:

a. To enable that person to perform a business, professional or insurance function for the disclosing insurance institution, agent, or insurance-support organization, and that person agrees not to disclose the information further without the individual's written authorization unless the further disclosure:

(1) Would otherwise be permitted by this section if made by an insurance institution, agent, or insurance-support organization; or

(2) Is reasonably necessary for that person to perform its function for the disclosing insurance institution, agent, or insurance-support organization; or

b. To enable that person to provide information to the disclosing insurance institution, agent, or insurance-support organization for the purpose of:

(1) Determining an individual's eligibility for an insurance benefit or payment; or

(2) Detecting or preventing criminal activity, fraud, material misrepresentation, or material nondisclosure in connection with an insurance transaction; or

3. To an insurance institution, agent, or insurance-support organization, or self-insurer, provided the information disclosed is limited to that which is reasonably necessary:

a. To detect or prevent criminal activity, fraud, material misrepresentation, or material nondisclosure in connection with insurance transactions; or

b. For either the disclosing or receiving insurance institution, agent or insurance-support organization to perform its function in connection with an insurance transaction involving the individual; or

4. To a medical-care institution or medical professional for the purpose of (i) verifying insurance coverage or benefits, (ii) informing an individual of a medical problem of which the individual may not be aware or (iii) conducting an operations or services audit, provided only that information is disclosed as is reasonably necessary to accomplish the foregoing purposes; or

5. To an insurance regulatory authority; or

6. To a law-enforcement or other government authority:

a. To protect the interests of the insurance institution, agent or insurance-support organization in preventing or prosecuting the perpetration of fraud upon it; or

b. If the insurance institution, agent, or insurance-support organization reasonably believes that illegal activities have been conducted by the individual; or

c. Upon written request of any law-enforcement agency, for all insured or claimant information in the possession of an insurance institution, agent, or insurance-support organization which relates an ongoing criminal investigation, such insurance institution, agent, or insurance-support organization shall release such information, including, but not limited to, policy information, premium payment records, record of prior claims by the insured or by another claimant, and information collected in connection with an insurance company's investigation of an application or claim. Any information released to a law-enforcement agency pursuant to such request shall be treated as confidential criminal investigation information and not be disclosed further except as provided by law. Notwithstanding any provision in this chapter, no insurance institution, agent, or insurance-support organization shall notify any insured or claimant that information has been requested or supplied pursuant to this section prior to notification from the requesting law-enforcement agency that its criminal investigation is completed. Within ninety days following completion of any such criminal investigation, the law-enforcement agency making such a request for information shall notify any insurance institution, agent, or insurance-support organization from whom information was requested that the criminal investigation has been completed.

7. Otherwise permitted or required by law; or

8. In response to a facially valid administrative or judicial order, including a search warrant or subpoena; or

9. Made for the purpose of conducting actuarial or research studies, provided:

a. No individual may be identified in any actuarial or research report; and

b. Materials allowing the individual to be identified are returned or destroyed as soon as they are no longer needed, and

c. The actuarial or research organization agrees not to disclose the information unless the disclosure would otherwise be permitted by this section if made by an insurance institution, agent, or insurance-support organization; or

10. To a party or a representative of a party to a proposed or consummated sale, transfer, merger, or consolidation of all or part of the business of the insurance institution, agent, or insurance-support organization, provided:

a. Prior to the consummation of the sale, transfer, merger, or consolidation only such information is disclosed as is reasonably necessary to enable the recipient to make business decisions about the purchase, transfer, merger, or consolidation, and

b. The recipient agrees not to disclose the information unless the disclosure would otherwise be permitted by this section if made by an insurance institution, agent, or insurance-support organization; or

11. To a person whose only use of such information will be in connection with the marketing of a product or service, provided:

a. No medical-record information, privileged information, or personal information relating to an individual's character, personal habits, mode of living, or general reputation is disclosed, and no classification derived from the information is disclosed,

b. The individual has been given an opportunity to indicate that he does not want personal information disclosed for marketing purposes and has given no indication that he does not want the information disclosed, and

c. The person receiving such information agrees not to use it except in connection with the marketing of a product or service; or

12. To an affiliate whose only use of the information will be in connection with an audit of the insurance institution or agent or the marketing of an insurance product or service, provided the affiliate agrees not to disclose the information for any other purpose or to unaffiliated persons; or

13. By a consumer reporting agency, provided the disclosure is to a person other than an insurance institution or agent; or

14. To a group policyholder for the purpose of reporting claims experience or conducting an audit of the insurance institution's or agent's operations or services, provided the information disclosed is reasonably necessary for the group policyholder to conduct the review or audit; or

15. To a professional peer review organization for the purpose of reviewing the service or conduct of a medical-care institution or medical professional; or

16. To a governmental authority for the purpose of determining the individual's eligibility for health benefits for which the governmental authority may be liable; or

17. To a certificate holder or policyholder for the purpose of providing information regarding the status of an insurance transaction; or

18. To a lienholder, mortgagee, assignee, lessor or other person shown on the records of an insurance institution or agent as having a legal or beneficial interest in a policy of insurance, provided that:

a. No medical record information is disclosed unless the disclosure would be permitted by this section; and

b. The information disclosed is limited to that which is reasonably necessary to permit such person to protect his interest in the policy.

B. 1. No person proposing to issue, re-issue, or renew any policy, contract, or plan of accident and sickness insurance defined in Section 38.2-109, but excluding disability income insurance, issued by any (i) insurer providing hospital, medical and surgical or major medical coverage on an expense incurred basis, (ii) corporation providing a health services plan, or (iii) health maintenance organization providing a health care plan for health care services shall disclose any genetic information about an individual or a member of such individual's family collected or received in connection with any insurance transaction unless the disclosure is made with the written authorization of the individual.

2. For the purpose of this subsection, "genetic information" means information about genes, gene products, or inherited characteristics that may derive from an individual or a family member.

3. Agents and insurance support organizations shall be subject to the provisions of this subsection to the extent of their participation in the issue, re-issue, or renewal of any policy, contract, or plan of accident and sickness insurance defined in Section 38.2-109, but excluding disability income insurance.

Section 2. That the provisions of Section 38.2-508.4 shall expire on July 1, 1998.

WISCONSIN

§ 631.89 Genetic tests

(1) In this section, "genetic test" means a test using deoxyribonucleic acid extracted from an individual's cells in order to determine the presence of a genetic disease or disorder or the individual's predisposition for a particular genetic disease or disorder.

(2) An insurer, or a county, city, village or school board that provides health care services for individuals on a self-insured basis, may not do any of the following:

(a) Require or request directly or indirectly any individual or a member of the individual's family to obtain a genetic test.

(b) Require or request directly or indirectly any individual to reveal whether the individual or a member of the individual's family has obtained a genetic test or what the results of the test, if obtained by the individual or a member of the individual's family, were.

(c) Condition the provision of insurance coverage or health care benefits on whether an individual or a member of the individual's family has obtained a genetic test or what the results of the test, if obtained by the individual or a member of the individual's family, were.

(d) Consider in the determination of rates or any other aspect of insurance coverage or health care benefits provided to an individual whether an individual or a member of the individual's family has obtained a genetic test or what the results of the test, if obtained by the individual or a member of the individual's family, were.

(3) (a) Subsection (2) does not apply to an insurer writing life insurance coverage or income continuation insurance coverage.

(b) An insurer writing life insurance coverage or income continuation insurance coverage that obtains information under sub. (2)(a) or (b) may not do any of the following:

1. Use the information contrary to sub. (2)(c) or (d) in writing a type of insurance coverage other than life or income continuation for the individual or a member of the individual's family.

2. Provide for rates or any other aspect of coverage that is not reasonably related to the risk involved.

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Federal Proposals

Several proposals are pending before Congress. Sections of two bills to be considered by a joint conference committee (H.R. 3160 and S. 1028) deal with genetic testing and health insurance. In addition, S. 1416, H.R. 2748 and S. 1600 are bills introduced to limit the use of genetic testing.

104TH CONGRESS, 2D SESSION

H.R. 3160

To amend the Internal Revenue Code of 1986 to improve portability and continuity of health insurance coverage in the group and individual markets, to combat waste, fraud and abuse in health insurance and health care delivery, to promote the use of medical savings accounts, to improve access to long-term care services and coverage, to simplify the administration of health insurance, to reform medical liability, and for other purposes.

SEC. 101. PORTABILITY OF COVERAGE FOR PREVIOUSLY COVERED INDIVIDUALS.

(a) CREDITING PERIODS OF PREVIOUS COVERAGE TOWARD PREEXISTING CONDITION RESTRICTIONS.—Subject to the succeeding provisions of this section, a group health plan, and an insurer or health maintenance organization offering health insurance coverage in connection with a group health plan, shall provide that any preexisting condition limitation period (as defined in subsection(b)(2)) is reduced by the length of the aggregate period of qualified prior coverage (if any, as defined in subsection (b)(3)) applicable to the participant or beneficiary as of the date of commencement of coverage under the plan.

(b) DEFINITIONS AND OTHER PROVISIONS RELATING TO PREEXISTING CONDITIONS.—

(1) PREEXISTING CONDITION.—

(A) IN GENERAL.—For purposes of this subtitle, subject to subparagraph (B), the term "preexisting condition" means a condition, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period ending on the day before—

(i) the effective date of the coverage of such participant or beneficiary, or

(ii) the earliest date upon which such coverage could have been effective if there were no waiting period applicable, whichever is earlier.

(B) TREATMENT OF GENETIC INFORMATION.—For purposes of this section, genetic information shall not be considered to be a preexisting condition, so long as treatment of the condition to which the information is applicable has not been sought during the 6-month period described in subparagraph (A).

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SEC. 103. PROHIBITING EXCLUSIONS BASED ON HEALTH STATUS AND PROVIDING FOR ENROLLMENT PERIODS.

(a) PROHIBITION OF EXCLUSION OF PARTICIPANTS OR BENEFICIARIES BASED ON HEALTH STATUS.—

(1) IN GENERAL.—A group health plan, and an insurer or HMO offering health insurance coverage in connection with a group health plan, may not exclude an employee or his or her beneficiary from being (or continuing to be) enrolled as a participant or beneficiary under the terms of such plan or coverage based on health status (as defined in section 191(c)(6)).

(2) CONSTRUCTION.—Nothing in this subsection shall be construed as preventing the establishment of preexisting condition limitations and restrictions to the extent consistent with the provisions of this subtitle.

(b) PROHIBITION OF DISCRIMINATION IN PREMIUM CONTRIBUTIONS OF INDIVIDUAL PARTICIPANTS OR BENEFICIARIES BASED ON HEALTH STATUS.—

(1) IN GENERAL.—A group health plan, and an insurer or HMO offering health insurance coverage in connection with a group health plan, may not require a participant or beneficiary to pay a premium or contribution which is greater than such premium or contribution for a similarly situated participant or beneficiary solely on the basis of the health status of the participant or beneficiary.

* * * * *

(6) HEALTH STATUS.—The term "health status" includes, with respect to an individual, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), or disability.

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IN THE SENATE OF THE UNITED STATES—104th Cong., 1st Sess.

S. 1028

To provide increased access to health care benefits, to provide increased portability of health care benefits, to provide increased security of health care benefits, to increase the purchasing power of individuals and small employers, and for other purposes.

* * * * *

(A) a health plan issuer offering a group health plan may not decline to offer whole group coverage to a group purchaser desiring to purchase such coverage; and

(B) an employee health benefit plan or a health plan issuer offering a group health plan may establish, under the terms of such plan, eligibility, enrollment, or premium contribution requirements for individual participants or beneficiaries, except that such requirements shall not be based on health status, medical condition, claims experience, receipt of health care, medical history, evidence of insurability, genetic information, or disability.

* * * * *

(f) LIMITATIONS ON COOPERATIVE ACTIVITIES.—A health plan purchasing cooperative shall not—

(1) perform any activity relating to the licensing of health plan issuers;

(2) assume financial risk directly or indirectly on behalf of members of a health plan purchasing cooperative relating to any group health plan or individual health plan;

(3) establish eligibility, enrollment, or premium contribution requirements for individual participants or beneficiaries based on health status, medical condition, claims experience, receipt of health care, medical history, evidence of insurability, genetic information, or disability;

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104th CONGRESS, 1ST SESSION

S. 1416

To establish limitation with respect to the disclosure and use of genetic information, and for other purposes.

SECTION 1. SHORT TITLE.

This Act may be cited as the "Genetic Privacy and Nondiscrimination Act of 1995".

SECTION 2. FINDINGS AND PURPOSES.

(a) FINDINGS. Congress finds the following:

(1) The DNA molecule contains information about an individual's probable medical future.

(2) Genetic information is uniquely private and personal information that should not be disclosed without the authorization of the individual.

(3) The improper disclosure of genetic information can lead to significant harm to the individual, including stigmatization and discrimination in areas such employment, education, health care and insurance.

(4) An analysis of an individual's DNA provides information not only about an individual, but also about the individual's parents, siblings and children.

(5) Current legal protections for genetic information, tissue samples and DNA samples are inadequate to protect genetic privacy, and require further attention.

(6) Laws for the collection, storage and use of identifiable DNA samples and private genetic information obtained from those samples are needed both to protect individual privacy and to permit legitimate genetic research.

(b) PURPOSES. It is the purpose of this Act to—

(1) define the rights of individuals whose genetic information is disclosed;

(2) define the circumstances under which an individual's genetic information may be disclosed; and

(3) protect against discrimination by an insurer or employer based upon an individual's genetic information.

SECTION 3. DEFINITIONS.

As used in this Act:

(1) DNA. The term "DNA" means deoxyribonucleic acid.

(2) DNA SAMPLE. The term "DNA sample" means any human biological specimen from which DNA can be extracted, or the DNA extracted from such specimen.

(3) EMPLOYER. The term "employer" has the same meaning given such term in section 3(d) of the Fair Labor Standards Act of 1938 (29 U.S.C. 203(d)).

(4) GENETIC INFORMATION. The term "genetic information" means the information about genes, gene products or inherited characteristics that may derive from an individual or a family member.

(5) GENETIC TEST. The term "genetic test" means a test for determining the presence or absence of genetic characteristics in an individual, including tests of nucleic acids such as DNA, RNA and mitochondria DNA, chromosomes or proteins in order to diagnose a genetic characteristic.

(6) INSURER. The term "insurer" means an insurance company, health care service contractor, fraternal benefit organization, insurance agent, third party administrator, insurance support organization or other person subject to regulation under State insurance laws. Such term includes self-funded health plans and health plans regulated under the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.).

(7) SECRETARY. The term "Secretary" means the Secretary of Health and Human Services.

SECTION 4. REQUIREMENTS FOR DISCLOSURE OF GENETIC INFORMATION.

(a) PROHIBITION.

(1) IN GENERAL. Except as provided in paragraph (2), regardless of the manner in which genetic information was received, or of the source of such information, including information received from an individual, an entity may not disclose or be compelled (by subpoena or any other means) to disclose genetic information about an individual unless such disclosure is specifically authorized by the individual involved or the legal representative of the individual through a written authorization which includes a description of the information being disclosed, the name of the individual or entity to whom the disclosure is being made, and the purpose of the disclosure.

(2) EXCEPTIONS. Notwithstanding paragraph (1), genetic information concerning an individual may be disclosed if such disclosure—

(A) is authorized under Federal or State criminal laws relating to identification of individuals, or as is necessary for the purpose of a criminal or death investigation, a criminal or juvenile proceeding, an inquest, or a child fatality review by a multidisciplinary child abuse team;

(B) is required under the specific order of a Federal or State court;

(C) is authorized under Federal or State law for the purpose of establishing paternity;

(D) is for the purpose of furnishing genetic information relating to a decedent to the blood relatives of the decedent for the purpose of medical diagnosis; or

(E) is for the purpose of identifying bodies.

(b) APPLICATION OF SECTION. The prohibitions of this section shall apply to any redisclosure by any entity after another entity has disclosed the genetic information.

SECTION 5. PROHIBITION ON CERTAIN EMPLOYMENT PRACTICES.

(a) DISCRIMINATION AS TO RIGHTS OR BENEFITS. No employer may seek to obtain, obtain, or use the genetic information of an employee or a prospective employee, or require a genetic test of an employee or prospective employee, to distinguish between or discriminate against or restrict any right or benefit otherwise due or available to the employee or prospective employee.

(b) ENFORCEMENT. The powers, remedies, and procedures set forth in sections 705 through 709 of the Civil Rights Act of 1964 shall by the powers, remedies, and procedures this section provides to any person alleging a violation of this section.

SECTION 6. REQUIREMENTS RELATING TO INSURERS

(a) GENERAL PROHIBITION. An insurer offering health insurance may not use genetic information to reject, deny, limit, cancel, refuse to renew, increase the rates of, or otherwise affect health insurance.

(b) PROHIBITION ON INDUCEMENT. With respect to a genetic test conducted in accordance with subsection (c), an insurer may not use such a genetic test as an inducement for the purchase of insurance.

(c) PERMISSIBILITY OF TESTS. If an insurer requests that an applicant for insurance (other than an applicant for heath insurance) take a genetic test in connection with an application for insurance, the use of the results of such test shall be disclosed to the applicant and the insurer shall obtain the specific written authorization of the applicant for such disclosure.

(d) APPLICATION. This section shall apply only to insurance policies issued on or after the date of enactment of this Act, and to the renewal of policies issued before, on, or after such date of enactment.

SECTION 7. FURTHER RECOMMENDATION BY THE NATIONAL BIOETHICS ADVISORY COMMISSION.

Not later than August 31, 1996, the National Bioethics Advisory Commission shall prepare and submit to the appropriate committees of Congress a report containing recommendations on—

(1) the development and implementation of standards to provide increased protection for the collection, storage, and use of identifiable DNA samples and genetic information obtained from those samples; and

(2) the development and implementation of appropriate standards for the acquisition and retention of genetic information in all settings, including appropriate exceptions.

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104th CONGRESS, 1ST SESSION

H.R. 2748

To prohibit insurance providers from denying or canceling health insurance coverage, or varying the premiums, terms, or conditions for health insurance coverage on the basis of genetic information or a request forgenetic services, and for other purposes.

SECTION 1. SHORT TITLE.

This Act may be cited as the "Genetic Information Nondiscrimination in Health Insurance Act of 1995".

SECTION 2. PROHIBITION OF HEALTH INSURANCE DISCRIMINATION ON THE BASIS OF GENETIC INFORMATION.

(a) IN GENERAL. An insurance provider may not deny or cancel health insurance coverage, or vary the premiums, terms, or conditions for health insurance coverage, for an individual or a family member of an individual—

(1) on the basis of genetic information; or

(2) on the basis that the individual or family member of an individual has requested or received genetic services.

(b) LIMITATION ON COLLECTION AND DISCLOSURE OF INFORMATION—

(1) IN GENERAL. An insurance provider may not request or require an individual to whom the provider provides health insurance coverage, or an individual who desires the provider to provide health insurance coverage, to disclose to the provider genetic information about the individual or family member of the individual.

(2) REQUIREMENT OF PRIOR AUTHORIZATION. An insurance provider may not disclose genetic information about an individual without the prior written authorization of the individual or legal representative of the individual. Such authorization is required for each disclosure and shall include an identification of the person to whom the disclosure would be made.

(c) ENFORCEMENT.

(1) PLANS OTHER THAN EMPLOYEE HEALTH BENEFIT PLANS. The requirements established under subsections (a) and (b) shall be enforced by the State insurance commissioner for the State involved or the official or officials designated by the State, except that in no case shall a State enforce such requirements as they relate to employee health benefit plans.

(2) EMPLOYEE HEALTH BENEFIT PLANS. With respect to employee health benefit plans, the Secretary shall enforce the requirements established under subsections (a) and (b) in the same manner as provided for under sections 502, 504, 506, and 510 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132, 1134, 1136, and 1140).

(3) PRIVATE RIGHT OF ACTION. A person may bring a civil action.

(A) to enjoin any act or practice which violates subsection (a) or (b),

(B) to obtain other appropriate equitable relief (i) to redress such violations, or (ii) to enforce any such subsections, or

(C) to obtain other legal relief, including monetary damages.

(4) JURISDICTION. State courts of competent jurisdiction and district courts of the United States have concurrent jurisdiction of actions under this subsection. The district courts of the United States shall have jurisdiction, without respect to the amount in controversy or the citizenship of the parties, to grant the relief provided for in paragraph (3) in any action.

(5) VENUE. For purposes of this subsection the venue provisions of section 1391 of title 28, United States Code, shall apply.

(6) REGULATIONS. The Secretary may promulgate such regulations as may be necessary or appropriate to carry out this section.

(d) APPLICABILITY.

(1) PREEMPTION OF STATE LAW. A State may establish or enforce requirements for insurance providers or health insurance coverage with respect to the subject matter of this section, but only if such requirements are more restrictive than the requirements established under subsections (a) and (b).

(2) RULE OF CONSTRUCTION. Nothing in this section shall be construed to affect or modify the provisions of section 514 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144).

(3) CONTINUATION. Nothing in this section shall be construed as requiring a group health plan or an employee health benefit plan to provide benefits to a particular participant or beneficiary.

(e) DEFINITIONS. For purposes of this Act:

(1) EMPLOYEE HEALTH BENEFIT PLAN. The term "employee health benefit plan" means any employee welfare benefit plan, governmental plan, or church plan (as defined under paragraphs (1), (32), and (33) of section 3 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002)) that provides or pays for health insurance coverage (such as provider and hospital benefits) whether—

(A) directly;

(B) through a group health plan; or

(C) otherwise.

(2) FAMILY MEMBER. The term "family member" means, with respect to an individual, another individual related by blood to that individual.

(3) GENETIC INFORMATION. The term "genetic information" means information about genes, gene products, or inherited characteristics.

(4) GENETIC SERVICES. The term "genetic services" means health services to obtain, assess, and interpret genetic information for diagnostic and therapeutic purposes, and for genetic education and counseling.

(5) GROUP HEATH PLAN. The term "group health plan" has the meaning given such term in section 607 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1167), and includes a multiple employer welfare arrangement (as defined in section 3 (40) of such Act) that provides health insurance coverage.

(6) HEALTH INSURANCE COVERAGE. The term "health insurance coverage" means a contractual arrangement for the provision of a payment of health care, including—

(A) a group health plan; and

(B) any other health insurance arrangement, including any arrangement consisting of a hospital or medical expense incurred policy or certificate, hospital or medical service plan contract, or health maintenance organization subscriber contract.

(7) INDIVIDUAL HEALTH PLAN. The term "individual health plan" means any health insurance coverage offered to individuals that is not a group health plan.

(8) INSURANCE PROVIDER. The term "insurance provider" means an insurer or other entity providing health insurance coverage.

(9) PERSON. The term "person" includes corporations, companies, associations, firms, partnerships, societies, and joint stock companies, as well as individuals.

(10) SECRETARY. The term "Secretary" means the Secretary of Labor.

(11) STATE. The term "State" means nay of the 50 States, the District of Columbia, Puerto Rico, the Northern Marinana Islands, the Virgin Islands, American Samoa, and Guam.

(f) TECHNICAL AMENDMENT. Section 508 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1138) is amended by inserting "and under the Genetic Insurance Nondiscrimination in Health Insurance Act of 1995" before the period.

(g) EFFECTIVE DATE. This section shall apply to health insurance coverage offered or renewed on or after the end of the 90-day period beginning on the date of the enactment of this Act.

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104th CONGRESS, 2D SESSION

S. 1600

To establish limitations on health plans with respect to genetic information, and for other purposes.

SECTION 1. SHORT TITLE.

This Act may be cited as the "Genetic Fairness Act of 1996".

SECTION 2. DEFINITIONS.

As used in this Act:

(1) FAMILY MEMBER. The term "family member" means, with respect to an individual, another individual related by blood to that individual or an spouse or adopted child of the individual or a spouse or adopted child of the individual.

(2) GENETIC INFORMATION. The term "genetic information" means the information about genes, gene products or inherited characteristics that may be derived from an individual or a family member.

(3) GENETIC SERVICES. The term "genetic services" means health services provided to obtain, assess, and interpret genetic information for diagnostic and therapeutic purposes, and for genetic education and counseling.

(4) GENETIC TEST. The term "genetic test" means a procedure that is generally accepted in the scientific and medical communities and that is performed for the purposes of identifying the presence, absence, or alternation of any gene or chromosome.

(5) HEALTH PLAN. The term "health plan" means—

(A) a group health plan (as such term is defined in section 607 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1167), and a multiple employer welfare arrangement (as defined in section 3(40) of such Act) that provides health insurance coverage; or

(B) any contractual arrangement for the provision of a payment for health care, including any health insurance arrangement or any arrangement consisting of a hospital or medical expense incurred policy or certificate, hospital or medical service plan contract, or health maintenance organization subscriber contract.

(6) INSURER. The term "insurer" means

(A) an insurance company, health care service contractor, fraternal benefit organization, insurance agent, third party administrator, insurance support organization or other person subject to regulation under State health insurance laws;

(B) a managed care organization; or

(C) an employee welfare benefit plan regulated under the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.).

(7) SECRETARY. The term "Secretary" means the Secretary of Health and Human Services.

SECTION 3. PROHIBITIONS

(a) GENETIC INFORMATION. An insurer offering a health plan may not—

(1) terminate, restrict, limit, or otherwise apply conditions to coverage of an individual or family member under the plan, or restrict the sale of the plan to an individual or family member;

(2) cancel or refuse to renew the coverage of an individual or family member under the plan;

(3) deny coverage or exclude an individual or family member from coverage under the plan;

(4) impose a rider that excludes coverage for certain benefits and services under the plan;

(5) establish differentials in premium rates or cost sharing for coverage under the plan; or

(6) otherwise discriminate against an individual or family member in the provision of health care;

on the basis of any genetic information concerning and individual or family member or on the basis of an individual's or family member's request for or receipt of genetic services.

(b) GENETIC TESTS. An insurer offering a health plan may not require an applicant for coverage under the plan, or an individual or family member who is presently covered under the plan, to be the subject of a genetic test or to be subjected to questions relating to genetic information.

(c) NOTICE OF RIGHTS. An insurer offering a health plan shall, in the enrollment information provided by the insurer concerning such plan, provide an enrollee with a written statement disclosing the rights of the enrollee under this Act. Such statement shall be in a form and manner that is noticeable to and understandable by an average enrollee.

(d) ENFORCEMENT.

(1) PLANS OTHER THAN EMPLOYEE WELFARE BENEFIT PLANS. The requirements established under subsections (a), (b), and (c) shall be enforced by the State insurance commissioner for the State involved or the official or officials designated by the State, except that in no case shall a State enforce such requirements as they relate to employee welfare benefit plans.

(2) EMPLOYEE WELFARE BENEFIT PLANS. With respect to employee welfare benefit plans, the Secretary shall enforce the requirements established under subsections (a), (b) and (c) in the same manner as provided for under sections 502, 504, 506, and 510 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132, 1134, 1136, and 1140).

(3) PRIVATE RIGHT OF ACTION. A person may, after that person has exhausted all available administrative remedies, bring a civil action—

(A) to enjoin any act or practice which violates subsection (a), (b), or (c);

(B) to obtain other appropriate equitable relief—

(i) to redress such violations; or

(ii) to require the Secretary of Health and Human Services to enforce any such subsections, or

(C) to obtain other legal relief, including monetary damages.

(4) JURISDICTION. State courts of competent jurisdiction and district courts of the United States have concurrent jurisdiction of actions under this subsection. The district courts of the United States shall have jurisdiction, without respect to the amount in controversy or the citizenship of the parties, to grant the relief provided for in paragraph (3) in any action.

(5) VENUE. For purposes of this subsection the venue provisions of section 1391 of title 28, United States Code, shall apply.

(6) REGULATIONS. The Secretary may promulgate such regulations as may be necessary or appropriate to carry out this section.

SECTION 4. EFFECTIVE DATE

This Act shall apply to any health plan offered or renewed on or after the end of the 90-day period beginning on the date of the enactment of this Act.

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Consumer Position Paper
Genetic Testing: A Tool for Doctors, Not For Insurers
Council for Responsible Genetics

The science of genetics holds great promise. New genetic discoveries have the potential to improve medical care for millions of Americans. Legitimate medical uses of genetic testing are beneficial and should be encouraged. But there is no role for genetic testing—or the use of predictive genetic information—in the insurance context.

Life, health, and disability insurers should not be permitted to require or request that applicants undergo genetic testing as a condition of obtaining or retaining insurance.

Life, health, and disability insurers should not be permitted to use genetic information to reject, deny, limit, cancel, refuse to renew, increase the rates of, affect the terms or conditions of, or otherwise affect an insurance policy or contract.

Scientists working with the Council for Responsible Genetics have identified over 200 cases in which *healthy* individuals were denied insurance or employment on the basis of predictive genetic information. Unfortunately, the same technology that can be used to help doctors identify and treat illness is also being misused to discriminate against people perceived to be at risk for future ill health.

Genetic Tests Are of Limited Predictive Ability

Genetic tests do not function as the proverbial crystal ball, enabling their users to look into the future. Genes can tell us only part of the story about why some people get sick and others do not. Many genetic tests predict, with limited accuracy, that a disease will become manifest at an undetermined time in the future. In some cases, individuals who carry copies of a disease-linked gene never develop any symptoms of the disease. In other cases, the severity of the individual's experience of the disease varies widely. Individuals with sickle cell anemia and cystic fibrosis, for example, may have debilitating cases of these conditions, or may have relatively mild forms with few medical complications. Unfortunately, these relatively healthy individuals are often treated by insurers as if they had a chronic, fatal and costly illness. While these individuals may not feel ill or impaired, they face discrimination and stigmas associated with illness in our society.

The Threat of Genetic Discrimination Compromises Quality Medical Care

Fear of genetic discrimination can undermine whatever benefits might be derived from new developments in genetic testing technology. Already, some consumers are avoiding genetic testing for fear that the test results will be used against them. The threat of discrimination compromises their ability to take full advantage of their medical options. In some cases, this means that they will miss out on early diagnosis, treatment or even prevention. In many cases, an early diagnosis of a genetic condition can lead to treatments which can delay the onset of symptoms and minimize those symptoms when they do appear. If consumers avoid taking advantage of available medical options out of fear of discrimination, they are likely to suffer more serious—and more expensive—health problems in the long run.

Genetic Conditions are Already Reflected in Actuarial Tables

Insurance companies claim they will go bankrupt if forced to insure people at risk for genetic diseases. This claim is hard to take seriously. Unlike infectious diseases, genetic conditions exist at a fairly stable incidence in our society. There is no epidemic of genetic conditions. Thus, they are already reflected in the actuarial tables used by insurers to establish rates. It is misleading for insurers to suggest that their financial solvency will be jeopardized if they are obligated to insure people at risk for genetic conditions. In fact, insurers have always insured people at risk for genetic conditions. Previously, however, it was not possible to identify those people at risk for genetic conditions before they became ill with the disorder. There is no reason for insurers to begin to use this new predictive information now, merely because it is available. Early identification of risk status may actually lead to insurer cost savings as a result of preventative care and longer life spans during which premiums can be collected.

Genetic Testing Creates a Burden of Knowledge

If insurance applicants are required to undergo genetic testing as a condition of obtaining insurance, consumers will be obliged to obtain unwanted information about their genetic inheritance. This "burden of knowledge" in turn may create feelings of hopelessness and may lead to serious psychological traumas. In many cases, the identification of a gene associated with a particular disease is of no therapeutic value to the consumer. There is a general consensus in the medical community that coercive medical interventions represent a gross violation of medical ethics. This is doubly true when the medical intervention offers no benefit to the patient, and merely serves the interests of some third party such as an insurance company. The decision to undergo testing for highly sensitive genetic information must be entirely in the hands of the consumer and should never enter into the application requirements for obtaining insurance.

Genetic Discrimination Undermines the Social Goal of Insurance

Insurance is a publicly regulated activity designed to meet broad community goals. In the case of health insurance, the goal is to ensure access to health care by providing adequate financing mechanisms. In the case of life and disability insurance, the goal is to provide families some measure of economic security following a tragic death or disability. Underwriting practices for all three types of insurance are becoming increasingly stringent: they violate individual privacy and seem geared to identify and insure only the healthy and long-lived. This trend undermines the social goal of insurance, which is to spread the risk across communities. The number of individuals stigmatized as "substandard" risks or as "uninsurable," has increased. This stratification of our community into "haves" and "have nots" is not consistent with the public interest.

ACLI Position Paper
General Position of the American Council of Life Insurance
On Genetic Information and Genetic Tests
and Life and Disability Income Insurance

It is becoming increasingly difficult, if not impossible, to distinguish genetic conditions from other medical conditions and genetic tests from other medical tests. Increasing numbers of common diseases, such as various forms of cancer and heart disease, not previously considered genetic, are being found to have a genetic component. Also, DNA-based tests are widely expected to become the standard of practice in clinical medicine in connection with common conditions many of which have significant mortality and morbidity implications.

Genetic information and genetic tests include information and tests which have been used in and are essential to the underwriting process for a long time, such as height and weight and tests for high blood pressure and cholesterol. Also, if, as expected, DNA-based tests become as common as today's blood or urinalysis tests, it is likely that life and disability income insurers will wish and in some cases need to use some of these tests in underwriting. As a result, any inquiry into life and disability income insurers' use of genetic information and tests is more appropriately characterized as an inquiry into their continued use of all medical information. Fundamentally, it is an inquiry into the appropriateness of the risk classification process and the continued existence of the current private system of life and disability income insurance.

Risk classification is the cornerstone of the existing private life and disability income insurance market. It is the mechanism used to insure that premiums are fair in relation to each insured's risk and that premiums are adequate for the insurer to meet its future claims obligations. Elimination or significant restriction of risk classification would make it likely that prices for consumers would increase in order to compensate for losses arising from unknown risks. It would jeopardize insurers' ability to fulfill their existing contractual obligations to consumers because of insurers' resulting vulnerability to claims for which inappropriately low premiums were charged as a result of ignorance of the full extent of assumed risks. Ultimately, elimination or significant restriction of risk classification would result in some form of socialized risk or public insurance program to satisfy insurance needs now handled privately.

The private life and disability income insurance industry serves a vital role in our society through its provision of financial security to millions of Americans. This role will undoubtedly increase in importance as the federal and state governments become less willing and able to provide this security. The life and disability income insurance industry does not believe that insurance consumers desire a fundamental restructuring of the current life and disability income insurance marketplace or that the federal or state governments are able or willing to assume this role. Consequently, the life and disability income insurance industry would vigorously oppose any proposed limitation of their right to use relevant medical information and tests, including genetic information and tests, which would ultimately jeopardize the current life and disability income insurance marketplace.

These comments focus exclusively on underwriting for life and disability income insurance. Most life and much disability income insurance is individually underwritten. Individual life and disability income insurance policies cannot be canceled except for nonpayment of premiums. Once issued, neither the original terms of nor premiums for these policies can be changed except in the event of improvement in the insured's health in which cases premiums may be decreased. Consequently, careful risk assessment at the time of issue of life and disability income insurance policies is vital.

Proponents of limitations on insurer's use of genetic information or tests maintain that this legislation is necessary in order to prevent the creation of a "genetic underclass." They seem to believe that without such restrictions insurers will use genetic information or test results to refuse coverage to as many people as they can. This concern reflects a lack of awareness of certain important points.

First, life and disability income insurers have no desire to turn away business. They seek to offer coverage to as many people as possible while assuring themselves that their prices are both fair and adequate. After all, a fundamental purpose of life and disability income insurance companies is to provide financial security through the sale of insurance. The life and disability income insurance industry has every reason to seek to be inclusive, not exclusive.

Second, the life and disability income insurance industry is very competitive. Each company underwrites risks differently. If an applicant is turned down by one insurer, it is very possible that he or she may be able to receive coverage from another. Some insures specialize in substandard risks.

Third. because life and disability income insurers' prices are affordable, their products are widely available. The vast majority of life and disability income insurance applicants are issued standard insurance coverage at standard rates. This is

particularly true with respect to life insurance. Industry statistics indicate that 96% of those who apply for individual ordinary life insurance are provided coverage. Ninety-one percent of these individuals are covered at standard or better rates.

Fourth, historically, improved technology and scientific and medical advances have increased the availability and affordability of life and disability income insurance. They have made it possible for many people to obtain coverage who were unable to obtain any coverage before and have made it possible for many to purchase coverage at cheaper rates than they could have otherwise. For example, in 1952, 55% of the applications of persons with cardiovascular problems were declined. In 1992, only 25% of such individuals' applications were declined. In 1958, only 2% of the ordinary individual life insurance policies issued insured individuals 55 years old or older. In 1993, 11% of the ordinary individual life insurance policies issued insured individuals 55 years old or older. Moreover, life insurance is one of the few consumer products to enjoy a steady drop in cost. Today an average 25 year old working man can buy life insurance, equal to five times his income, for less than half the money his counterpart paid in 1960 (after adjusting for inflation).

Fifth, when people hear the term "genetic tests" they are prone to think of abnormal results and unfavorable consequences. Such a focus is unfortunate. The fact is that most tests, and DNA-based tests will be no exception, yield a vast preponderance of normal results and just a small minority of abnormal results. If it proves to be true, as many now are predicting, that genetic tests for common conditions become the standard of practice in clinical medicine, millions of Americans will receive reports from their doctors that they are not at increased risk for a number of diseases. Also, many individuals who learn that they are predisposed to certain conditions may be able to avoid or ameliorate those conditions through changes in lifestyle or diet. As a result, it is very possible that genetic tests, like past medical and technological advances, may make otherwise uninsurable individuals insurable or make it possible for many individuals to obtain insurance at cheaper rates than otherwise would have been possible.

The blurring of the distinctions between genetic conditions and other medical conditions and genetic tests and other medical tests has caused the question of life and disability income insurers' use of genetic information and genetic tests to become fundamental questions relating to the use of all medical information, the appropriateness of the process of risk classification and the continuation of the existing private system of life and disability income insurance, under which life and disability insurance are widely available at increasingly lower prices. There is no evidence that the federal or state governments are willing or able to assume responsibility for the financial security of the millions of Americans currently privately insured by life and disability income insurance policies. There is no evidence that American consumers desire a fundamental restructuring of the exiting life and disability income insurance marketplace. Consequently, the life and disability income insurance industry would vigorously oppose any proposed limitation of their ability to use relevant medical information and tests, including genetic information and tests, which limitation necessarily would ultimately jeopardize the current private marketplace.

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ATTACHMENT FOUR

Synthetic GIC Working Group of the
Life Insurance (A) Committee
New York, New York
June 3, 1996

The Synthetic GIC Working Group of the Life Insurance (A) Committee met in the New York A Ballroom of the Sheraton Hotel in New York, N.Y., at 4 p.m. on June 3, 1996. Reginald Berry (D.C.) chaired the meeting. The following working group members or their representatives were present: Rick Morse (N.Y.).

Reginald Berry (D.C.) challenged the working group to consider whether it was really serious about developing a model law. Rick Morse (N.Y.) said that in his viewpoint the issue of synthetic guaranteed interest contracts (GICs) has a large potential of risk to insurers and raises solvency concerns. He opined that states with a large concentration of pension writings should be concerned. He noted that New York had reversed its position, having previously not allowed synthetic GICs. Now they can be written in New York, and four products have recently been approved. He suggested that the working group go forward with development of a model law to address five main areas: (1) reserves; (2) contract provisions, including termination; (3) investment guidelines; (4) plan of operations; and (5) reporting requirements to the department. Mr. Berry agreed that there is a tremendous potential for exposure and urged other states to join the working group. He said the states of California and Texas had been asked to join and were currently considering becoming members of the working group. Mr. Morse suggested that it would also be advisable to get input from technical resource advisors. Mr. Berry asked those who were interested in becoming technical resource advisors to the group to provide that information to Carolyn Johnson (NAIC/SSO). He said a conference call would be held soon to plan the next step, and suggested starting drafting with the five areas Mr. Morse outlined.

Jack Gies (Conn.) asked if there were risk-based capital implications to this project. Paul Boucher (N.Y.) opined this would be outside of the charge to the working group and should be recommended to the Risk-Based Capital (EX4) Task Force. Robert Brown (CIGNA) said the American Academy of Actuaries has a task force that is working with the NAIC Risk-Based Capital Task Force on this project. Mr. Berry asked him to share the report that he had sent to that group with the Synthetic GIC Working Group (see page 539–541 of this volume of the *NAIC Proceedings*).

Having no further business, the Synthetic GIC Working Group adjourned at 4:30 p.m.

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ATTACHMENT FIVE

Life Disclosure Working Group
of the Life Insurance (A) Committee
New York, New York
June 4, 1996

The Life Disclosure Working Group of the Life Insurance (A) Committee met in the New York A Ballroom of the Sheraton Hotel in New York, N.Y., at 9:30 a.m. on June 4, 1996. Robert E. Wilcox (Utah) chaired the meeting. The following working group members or their representatives were present: Tom Foley, Vice Chair (N.D.); Sheldon Summers (Calif.); Roger Strauss (Iowa); Lester Dunlap (La.); Paul DeAngelo (N.J.); Rick Morse (N.Y.); Tony Higgins (N.C.); and Ted Becker (Texas).

1. Report of the Buyer's Guide Subgroup

Lester Dunlap (La.) reported that the Buyer's Guide Subgroup discussed the comments they received on the revised Buyer's Guide for Life Insurance in a conference call and at a meeting in New York City. The purpose of the revision is to update the information contained in the Guide and to present it in a more readable, consumer-friendly format. The only real issue remaining before the group is to determine the value of retaining information on cost indices in the document. He said most respondents said that the cost indices section was of little value and so the current draft does not contain cost indices information. James Hunt (Consumer Federation of America) suggested this be replaced with information on yield indices, and the group was considering that option. Mr. Dunlap said the group plans an additional conference call after comments have been received on the current draft and the group may participate in an interim meeting to be held in Kansas City in July. Tom Foley (N.D.) asked what the time frame was for completion of this project. Mr. Dunlap responded that, with an opportunity to meet before the Fall National Meeting, the group should be able to complete its project and have the Buyer's Guide ready for adoption at the Fall National Meeting.

Upon motion duly made and seconded, the report of the Buyer's Guide Subgroup was received (Attachment Five-A).

2. Report of the Variable Life Illustrations Subgroup

Rick Morse (N.Y.) reported that the subgroup held meetings with the Securities Exchange Commission (SEC) and the National Association of Securities Dealers to discuss NAIC's ideas regarding insurance illustrations. He said the SEC rules prohibit projecting historical experience into the future. The SEC is considering modification of its existing rule and expects to have a comment period beginning in the fall. Mr. Morse said this was fortunate timing so that the working group could coordinate with whatever new SEC rules were adopted. The working group will see how the SEC rules develop before preceding with the investment portion of an illustration regulation for variable life.

Upon motion duly made and seconded, the report of the Variable Life Subgroup was received (Attachment Five-B).

3. Report of the Replacement Issues Subgroup

Paul DeAngelo (N.J.) said he was pleased to report that 12 states had indicated an interest in participating in the subgroup. He anticipated completion of the project by March 1997. The subgroup will put together a survey to send to insurers. Topics will come from the experience of New Jersey with respect to a recent market conduct examination of one of the New Jersey domestics. Mr. DeAngelo said he expected to receive comments on survey topics by the end of June, the working group would have a conference call in July and would have the survey out to the insurers in September. Mr. Foley asked if the subgroup anticipated developing a new model regulation. Mr. DeAngelo responded that he did not want to preconceive the results of the study, but said that several existing models may be impacted. He also complimented the group that had developed the Buyer's Guide, and said he thought it did a good job of alerting consumers to replacement issues without coming down on one side or another. Commissioner Robert E. Wilcox (Utah) said he preferred a uniform approach to development of model laws related to illustrations so that pieces of the puzzle were not left out or conflicting models developed. Mr. DeAngelo said that as economic conditions change, issues are different and models need to be reviewed. For example, at one time it may have been a bad decision to replace any insurance policy but in a different economic situation it would be appropriate.

Upon motion duly made and seconded, the report of the Replacement Issues Subgroup was received (Attachment Five-C).

4. Report of the Annuity Illustrations Subgroup

Tony Higgins (N.C.) reported that the technical resource advisors met in April to respond to questions from the working group about annuity illustration issues. The advisors reported to the working group with their suggestions and the working group is considering the information provided. He suggested that it would be useful to hold an interim meeting to discuss the issues further.

Upon motion duly made and seconded, the report of the Annuity Illustrations Subgroup was received (Attachment Five-D).

5. Consideration of the Generally Recognized Expense Table (GRET)

Tim Harris (Society of Actuaries) reported that the group assigned the task of developing an expense table had created a document for the working group's consideration (Attachment Five-E). Mr. Harris said the group had created a separate category for home service, direct mail, branch office, and all other expenses. He said the table looked at the 200 largest companies and used data to create a table of average expenses.

Commissioner Wilcox reminded the audience of the role of the GRET. If the NAIC does not adopt the GRET, all companies must use fully allocated expenses in the calculation of illustrations. Only if a table is developed is a company given the opportunity to use marginal expenses. William Koenig (Northwestern Mutual) opined it would be very tempting to get lost in a level of detail beyond what the issue deserves. He reminded those in attendance that the GRET serves only as a floor. Companies will still need to identify all their direct expenses and once that is done will compare the direct expenses to the table. If the table is greater, but not greater than fully allocated expenses, the company may use the expenses generated by the formulas in the table. He said the company could not just ignore its own expenses and use the GRET.

Mr. Foley suggested that one of the underlying questions to grapple with was whether a large company with significantly higher expenses would be inclined to use the GRET. He said the purpose of designing the table was primarily for small companies, but if large companies used it, it might give them a competitive advantage over small companies. Scott Cipinko (National Alliance of Life Companies—NALC) said his members believe that small companies are better off with a flawed GRET than with no GRET at all. He suggested that the NAIC adopt the table and continue to refine it.

Ed Kiffel (Ernst & Young) expressed concern about the GRET, particularly about the speed with which it was prepared. He was not convinced that a bad GRET was better than no GRET at all. He said that the report raises questions and wondered whether it was prudent to push it through quickly without an understanding of how it had been developed and what abuses might result from its use. He suggested that large companies might not have expense systems in place to deal with the level of detail required and would just use the GRET rather than analyzing their own expenses. Commissioner Wilcox said it was important to recognize that the illustration actuary would be putting his career on the line if he did not do a full review of marginal expenses. Mr. Foley suggested that a question and answer document, currently being prepared by the working group, could answer some of the questions that might develop about the GRET. Mr. Harris responded that the work had not been done too quickly. He said the data used was contained in a Milliman & Robertson study that is updated on an annual basis. The best minds working in the Society of Actuaries did a peer review of the document. Mark Peavy (NAIC/SSO) said it would be necessary to review this document annually to determine if there is a need for an update. Mr. Harris said that would not be a difficult project.

Upon motion duly made and seconded, the Generally Recognized Expense Table was adopted by the working group.

6. Questions and Answers on the Life Insurance Illustrations Model Regulation

Commissioner Wilcox drew the attention of the attendees to the questions and answers document (Attachment Five-F) prepared to answer some of the issues raised about the model regulation and its implementation. He asked those in attendance to study the document and provide comments to the working group so that a further discussion could be held at an interim meeting to finalize this document. He asked those who wished to comment to provide those in writing to Carolyn Johnson (NAIC/SSO) by July 1. George Coleman (Prudential) said there may be hundreds of questions raised before companies have fully implemented the regulation. He suggested that in some cases the answer might be that the company procedure was optional. Commissioner Wilcox suggested that those with questions go through the minutes and reports of the working group to see what the members had said during development of the regulation. He suggested that would give many clues as to the intent of the working group.

7. Any Other Matters Brought Before the Working Group

Commissioner Wilcox announced that the working group expected to schedule an interim meeting in conjunction with an illustration seminar being held at the NAIC in July. He said the seminar was scheduled for July 22 and the morning of July 23 and suggested that the working group meeting be held in the afternoon of July 23 and July 24.

Having no further business, the Life Disclosure Working Group adjourned at 11:30 a.m.

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ATTACHMENT FIVE-A

Report of Buyer's Guide Subgroup
of the Life Disclosure (A) Working Group

The Buyer's Guide Subgroup of the Life Disclosure (A) Working Group met by conference call on May 23, 1996, and in New York, N.Y., on June 1, 1996. Lester Dunlap (La.) chaired the meeting. The following subgroup members or their representatives participated: Don Koch (Alaska); and Tony Higgins (N.C.).

During the conference call the Buyer's Guide Subgroup went through the draft of the Life Insurance Buyer's Guide section by section and reviewed the comments that have been received to date and made changes to each section as appropriate. When the group met in New York City, Lester Dunlap (La.) called on James Hunt (Consumer Federation of America) to comment on the earlier letter he had sent the working group. Mr. Hunt said that he had favored for many years the idea of rate of return disclosure, because he considered the indices in current use to be flawed and not useful. Mr. Dunlap said the consensus of those who had commented to the working group was that the indices were of little value to consumers. The working group decided to delete the section of the Buyer's Guide that explained the cost indices. Mr. Hunt suggested that this be replaced with a yield index description. He said consumers do not get much helpful information on how to decide what to buy or whether to replace a policy, and he thought the yield index information would be a helpful tool. Mr. Dunlap asked him to write a section for the Buyer's Guide that the working group could consider as a substitute. Mr. Hunt agreed to provide that information by early July.

Mr. Hunt opined that the most important warning to include in the Buyer's Guide was that an individual would lose if he did retain a cash value policy for 15-20 years. He suggested a warning that would jump out at people. He asked if the Buyer's Guide was intended to cover term insurance also, and suggested that replacing term insurance might be appropriate in many instances. Mr. Dunlap responded that the Buyer's Guide was intended to provide information about all types of insurance.

Mr. Hunt referred the members of the working group to the section on replacing the current policy entitled "What About the Policy You Have Now?" He suggested that the phrase "it is seldom in your interest to replace a policy" is not true of term insurance. Tom Foley (N.D.) suggested that perhaps the working group needed a broader discussion of whether to consider only cash value insurance in the Buyer's Guide or whether to consider all types. Mr. Hunt responded that the problem was that advice for cash value insurance was different than that for term insurance. Mr. Hunt said that it was important to make clear that term insurance might not be renewable at the end of the term, and he suggested adding information on insurability. Several more comments were received on the issue of replacement of life insurance and Mr. Dunlap clarified that the purpose of the paragraph was not to say "do not replace life insurance," but rather to suggest the purchaser find out more information before replacing a policy.

The group discussed the section entitled "How Much Do You Need?" Mr. Hunt said that the section was not very helpful and suggested replacing it with a statement that it was appropriate to purchase six to eight times gross income in life insurance. Mr. Dunlap asked whether this was a generally accepted parameter. Mr. Hunt responded that he did not know whether the guideline was always appropriate but he suggested the group stay away from fancy formulas in calculating a suggested amount of insurance.

The working group agreed to make several other amendments to the Buyer's Guide to improve readability and to clarify language that had been identified as ambiguous. Brenda Cude (University of Illinois) suggested a number of amendments to improve readability and to eliminate complex language from the draft. The draft is attached in both a clean version and one showing changes from the existing buyer's guide. (Attachment Five A-1) Mr. Dunlap suggested the working group hold a conference call sometime during the first two weeks of July to consider additional comments and he projected adoption of the model by the group at the NAIC Fall National Meeting.

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ATTACHMENT FIVE-1A

LIFE INSURANCE BUYER'S GUIDE
Draft: 6/3/96

Drafting Note: The language in the Buyer's Guide is limited to that contained in the following pages of this Appendix, or to language approved by the commissioner. Companies may purchase personalized brochures from the NAIC or may request permission to reproduce the Buyer's Guide in their own type style and format.

[The face page of the Buyer's Guide shall read as follows:]

Life Insurance Buyer's Guide

This guide can help you when you shop for life insurance. It discusses how to:

- Find a Policy That Meets Your Needs and Fits Your Budget
- Decide How Much Insurance You Need
- Make Informed Decisions When You Buy a Policy

Prepared by the National Association of Insurance Commissioners

The National Association of Insurance Commissioners is an association of state insurance regulatory officials. This association helps the various insurance departments to coordinate insurance laws for the benefit of all consumers.

This guide does not endorse any company or policy.

Reprinted by. . .

IMPORTANT THINGS TO CONSIDER

1. Review your own insurance needs and circumstances. Choose the kind of policy that has benefits that most closely fit your needs. Ask an agent or company to help you.

2. Be sure that you can handle premium payments. Can you afford the initial premium? If the premium increases later, can you still afford it?

3. Don't sign an insurance application until you review it carefully to be sure all the answers are complete and accurate.

4. Don't buy life insurance unless you intend to stick with your plan. It may be very costly if you quit during the early years of the policy.

5. Don't drop one policy and buy another without a thorough study of the new policy and the one you have now. Replacing your insurance can be very costly.

6. Read your policy carefully. Ask your agent or company about anything that is not clear to you.

7. Review your life insurance program with your agent or company every few years to keep up with changes in your income and your needs.

Buying Life Insurance

When you buy life insurance, you want coverage that fits your needs.

First, decide how much you need—and for how long—and what you can afford to pay. Keep in mind the major reason you buy life insurance is to cover the financial effects of unexpected or untimely death. Life insurance can also be one of many ways you plan for the future.

Next, learn what kinds of policies will meet your needs and pick the one that best suits you.

Then, choose the combination of policy premium and benefits that emphasizes protection in case of early death, or benefits in case of long life, or a combination of both.

It makes good sense to ask a life insurance agent or company to help you. An agent can help you review your insurance needs and give you information about the available policies. If one kind of policy doesn't seem to fit your needs, ask about others.

This guide provides only basic information. You can get more facts from a life insurance agent or company or from your public library.

What About the Policy You Have Now?

Think twice before dropping a life insurance policy you already have to buy a new one. It is seldom in your interest to replace a policy. Here are some things you should consider:

- If you decide to replace your policy, don't cancel your old policy until you have received the new one. You then have 10 days to review your new policy and decide if it is what you wanted.
- It can be costly to replace a policy. Much of what you paid in the early years of the policy you have now, paid for the company's cost of selling and issuing the policy. You will pay this type of cost again if you buy a new policy.
- If you are older or your health has changed, premiums for the new policy will often be higher. You will not be able to buy a new policy if you are not insurable.
- You may have valuable rights and benefits in the policy you now have that are not in the new one.
- If the policy you have now no longer meets your needs, you may not have to replace it. You might be able to change your policy or add to it to get the coverage or benefits you now want.
- At least in the beginning, a policy may pay no benefits for some causes of death covered in the policy you have now.

In all cases, if you are thinking of buying a new policy, check with the agent or company that issued you the one you have now. When you bought your old policy, you may have seen an illustration of the benefits of your policy. Before replacing your policy, ask your agent or company for an updated illustration. Check to see how the policy has performed and what you might expect in the future, based on the amounts the company is paying now.

How Much Do You Need?

Here are some questions to ask yourself:

- How much of the family income do I provide? If I were to die early, how would my survivors, especially my children, get by? Does anyone else depend on me financially, such as a parent, grandparent, brother or sister?
- Do I have children for whom I'd like to set aside money to finish their education in the event of my death?
- How will my family pay final expenses and repay debts after my death?
- Do I have family members or organizations to whom I would like to leave money?
- Will there be estate taxes to pay after my death?
- How will inflation affect future needs?

As you figure out what you have to meet these needs, count the life insurance you have now, including any group insurance where you work or veteran's insurance. Don't forget Social Security and pension plan survivor's benefits. Add other assets you have: savings, investments, real estate and personal property. Which assets would your family sell or cash in to pay expenses after your death?

What Is the Right Kind of Life Insurance?

All life insurance policies agree to pay an amount of money when you die. But all policies are not the same. Some give coverage for your lifetime and others cover you only for a specific number of years. Some build up cash values and others do not. Some policies combine different kinds of insurance, and others let you change from one kind of insurance to another. Some policies may offer other benefits while you are still living. Your choice should be based on your needs and what you can afford.

There are two basic types of life insurance: term insurance and cash value insurance. Term insurance generally has lower premiums in the early years, but it does not build up cash values that you can use in the future. You may combine cash value life insurance with term insurance for the period of your greatest need for life insurance to replace income.

Term Insurance covers you for a term of one or more years. It pays a death benefit only if you die in that term. Term insurance generally offers the largest short-term insurance protection for your premium dollar. It does not build up cash value. For example, you might buy a term policy to pay off a mortgage or other loan in the event of death.

You can renew most term insurance policies for one or more terms even if your health has changed. Each time you renew the policy for a new term, premiums will be higher. Ask what the premiums will be if you continue to renew the policy. Also ask if you will lose the right to renew the policy at some age. For a higher premium, some companies will give you the right to keep the policy in force for a guaranteed period at the same price each year. At the end of that time you may need to pass a physical examination to continue coverage, and premiums may increase dramatically.

You can trade many term insurance policies for a cash value policy during a conversion period—even if you are not in good health. Premiums for the new policy will be higher than you have been paying for the term insurance.

Cash Value Life Insurance is a type of insurance where the premiums charged are higher at the beginning than they would be for the same amount of term insurance. The part of the premium that is not used for the cost of insurance is invested by the company and builds up a cash value that may be used in a variety of ways. You may borrow against a policy's cash value by taking a policy loan. If you don't pay back the loan and the interest on it, the amount you owe will be subtracted from the benefits when you die, or from the cash value if you stop paying premiums and take out the remaining cash value. You can also use your cash value to keep insurance protection for a limited time or to buy a reduced amount without having to pay more premiums. You also can use the cash value to increase your income in retirement or to help pay for needs such as college costs without canceling the policy. However, to build up this cash value, you must pay relatively higher premiums in the earlier years of the policy. Cash value life insurance may be one of several types; whole life, universal life and variable life are all types of cash value insurance.

Whole Life Insurance covers you for as long as you live if your premiums are paid. You generally pay the same amount in premiums for as long as you live. When you first take out the policy, premiums can be several times higher than you would pay initially for the same amount of term insurance. But they are smaller than the premiums you would eventually pay if you were to keep renewing a term policy until your later years.

Some whole life policies let you pay premiums for a shorter period such as 20 years, or until age 65. Premiums for these policies are higher since the premium payments are made during a shorter period.

Universal Life Insurance is a kind of flexible policy that lets you vary your premium payments. You can also adjust the face amount of your coverage. The premiums you pay (less expense charges) go into a policy account that earns interest. Charges for the insurance are deducted from the account. If your yearly premium payment plus the interest your account earns is less than the cost of your insurance, your account value will drop. If it keeps dropping, eventually your coverage will end. To prevent that, you may need to start making premium payments, or increase your premium payments, or lower your death benefits. Even if there is enough in your account to pay the premiums, continuing to pay premiums yourself means that you build up more cash value.

Variable Life Insurance is a kind of insurance where the death benefits and cash values depend on the investment performance of one or more separate accounts, which may be invested in mutual funds or other investments. Be sure to get the prospectus from the company when buying this kind of policy and STUDY IT CAREFULLY. You will have higher death benefits and cash value if the underlying investments do well. Your benefits and cash value will be lower if the investments you chose didn't do as well as you expected.

Life Insurance Illustrations

You may be thinking of buying a policy where cash values, death benefits, dividends or premiums may vary based on events or situations the company does not guarantee (such as interest rates). If so, you may get an illustration from the agent or company that helps explain how the policy works. The illustration will show how the benefits that are not guaranteed will change as interest rates and other factors change. The illustration will show you what the company guarantees. It will also show you what *could* happen in the future. Remember that nobody knows what will happen in the future. You should be ready to adjust your financial plans if the cash value doesn't increase as quickly as shown in the illustration. You will be asked to sign a statement that says you understand that some of the numbers in the illustration are not guaranteed.

Finding a Good Value in Life Insurance

After you have decided which kind of life insurance is best for you, compare similar policies from different companies to find which one is likely to give you the best value for your money. A simple comparison of the premiums is not enough. There are other things to consider. For example:

- Do premiums or benefits vary from year to year?
- How much do the benefits build up in the policy?
- What part of the premiums or benefits is not guaranteed?
- What is the effect of interest on money paid and received at different times on the policy?

Remember that no one company offers the lowest cost at all ages for all kinds and amounts of insurance. You should also consider other factors:

- How quickly does the cash value grow? Some policies have low cash values in the early years that build quickly later on. Other policies have a more level cash value build-up. A year-by-year display of values and benefits can be very helpful. (The agent or company will give you a policy summary or an illustration that will show benefits and premiums for selected years.)
- Are there special policy features that particularly suit your needs?
- How are nonguaranteed values calculated? For example, interest rates are important in determining policy returns. In some companies increases reflect the average interest earnings on all of that company's policies regardless of when issued. In others, the return for policies issued in a recent year, or a group of years, reflects the interest earnings on that group of policies; in this case, amounts paid are likely to change more rapidly when interest rates change.

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LIFE INSURANCE BUYER'S GUIDE
Draft: 6/3/96

Drafting Note: The language in the Buyer's Guide is limited to that contained in the following pages of this Appendix, or to language approved by ~~[title of supervisory authority]~~ the commissioner. ~~However, companies can vary the type style and format and are encouraged to enhance the readability, design and attractiveness of the Buyer's Guide.~~ Companies may purchase personalized brochures from the NAIC or may request permission to reproduce the Buyer's Guide in their own type style and format.

[The face page of the Buyer's Guide shall read as follows:]

Life Insurance Buyer's Guide

This guide can help you ~~get the most for your money~~ when you shop for life insurance. It ~~can help you answer questions about~~ discusses how to:

- ~~Buying Life Insurance~~ Find a Policy That Meets Your Needs and Fits Your Budget
- ~~Deciding~~ Decide How Much Insurance You Need
- ~~Finding a Low Cost Policy~~
- ~~Things to Remember~~ Make Informed Decisions When You Buy a Policy

Prepared by the National Association of Insurance Commissioners

The National Association of Insurance Commissioners is an association of state insurance regulatory officials. This association helps the various insurance departments to coordinate insurance laws for the benefit of all consumers.

This guide does not endorse any company or policy.

Reprinted by. . .

IMPORTANT THINGS TO ~~REMEMBER~~ CONSIDER

1. Review your ~~particular~~ own insurance needs and circumstances. Choose the kind of policy ~~with~~ that has benefits that most closely fit your needs. Ask an agent or company to help you.

2. Be sure that you can handle ~~the~~ premiums payments ~~are within your ability to pay~~. ~~Don't look only at the initial premium, but take account of any later premium increase.~~ Can you afford the initial premium? If the premium increases later, can you still afford it?

Life Insurance Committee

~~3. Ask about cost comparison index numbers and check several companies which offer similar policies. Remember, smaller index number generally represent a better buy.~~

~~4~~ 3. Don't sign an insurance application until you review it carefully to be sure all the answers are complete and accurate.

~~5~~ 4. Don't buy life insurance unless you intend to stick with ~~it~~ your plan. It ~~can~~ may be very costly if you quit during the early years of the policy.

~~6~~ 5. Don't drop one policy and buy another without a thorough study of the new policy and the one you have now. Replacing your insurance can be **very costly.**

~~7~~ 6. Read your policy carefully. Ask your agent or company about anything that is not clear to you.

~~8~~ 7. Review your life insurance program with your agent or company every few years to keep up with changes in your income and your needs.

Buying Life Insurance

When you buy life insurance, you want coverage that fits your needs ~~and doesn't cost too much~~.

First, decide how much you need—and for how long—and what you can afford to pay. Keep in mind the major reason you buy life insurance is to cover the financial effects of unexpected or untimely death. Life insurance can also be one of many ways you plan for the future.

Next, ~~find out~~ learn what kinds of policies ~~are available to~~ will meet your needs and pick the one that best suits you.

Then, ~~find out how~~ choose the combination of policy premium and benefits that emphasizes protection in case of early death, or benefits in case of long life, or a combination of both.

It makes good sense to ask a life insurance agent or company to help you. An agent can ~~be particularly useful in~~ help you review~~ing~~ your insurance needs and ~~in giving~~ give you information about the ~~kinds of~~ available policies ~~that are available~~. If one kind of policy doesn't seem to fit your needs, ask about others.

This guide provides only basic information. You can get more facts from a life insurance agent or company or ~~at~~ from your public library.

What About ~~Your Present~~ the Policy You Have Now?

Think twice before dropping a life insurance policy you already have to buy a new one. It is seldom in your interest to replace a policy. Here are some things you should consider:

- If you decide to replace your policy, don't cancel your old policy until you have received the new one. You then have 10 days to review your new policy and decide if it is what you wanted.

- It can be costly to replace a policy. Much of what you paid in the early years of the policy you ~~now~~ have now, ~~was used~~ paid for the company's ~~expense~~ cost of selling and issuing the policy. ~~This expense will be incurred again for~~ You will pay this type of cost again if you buy a new policy.

- If you are older or your health has changed, premiums for the new policy will often be higher. You will not be able to buy a new policy if you are not insurable.

- You may have valuable rights and benefits in ~~your present~~ the policy you now have that are not in the new one.

- If the policy you have now no longer meets your needs, ~~Y~~you may not have to replace it. You might be able to change your ~~present~~ policy or ~~even~~ add to it to get the coverage or benefits you now want.

- At least in the beginning, a policy may pay no benefits for some causes of death covered in the policy you have now.

In all cases, if you are thinking of buying a new policy, ~~C~~check with the agent or company that issued you the one you have now. ~~present policy—get both sides of the story. In any case, don't give up your present policy until you are covered by a new one.~~ When you bought your old policy, you may have seen an illustration of the benefits of your policy. Before replacing your policy, ask your agent or company for an updated illustration. Check to see how the policy has performed and what you might expect in the future, based on the amounts the company is paying now.

How Much Do You Need?

~~To decide how much life insurance you need, figure out what your dependents would have if you were to die now, and what they would actually need. Your new policy should come as close to making up the difference as you can afford.~~ Here are some questions to ask yourself:

- How much of the family income do I provide? If I were to die early, how would my survivors, especially my children, get by? Does anyone else depend on me financially, such as a parent, grandparent, brother or sister?
- Do I have children for whom I'd like to set aside money to finish their education in the event of my death?
- How will my family pay final expenses and repay debts after my death?
- Do I have family members or organizations to whom I would like to leave money?
- Will there be estate taxes to pay after my death?
- How will inflation affect future needs?

~~In figuring~~ As you figure out what you have to meet these needs, count ~~your present~~ the life insurance you have now, including any group insurance where you work or veteran's insurance. Don't forget Social Security and pension plan survivor's benefits. Add other assets you have; savings, investments, real estate and personal property. Which assets would your family sell or cash in to pay expenses after your death?

~~In figuring what you **need**, think of income for your dependents—for family living expenses, educational costs and any other future needThink also of cash needs—for the expenses of a final illness and for paying taxes, mortgages or other debts.~~

What Is the Right Kind of Life Insurance?

All life insurance policies agree to pay an amount of money when you die. But all policies are not the same. Some ~~provide permanent coverage~~ give coverage for your lifetime and others cover you only for a specific number of years ~~temporary coverage~~. Some build up cash values and others do not. Some policies combine different kinds of insurance, and others let you change from one kind of insurance to another. Some policies may offer other benefits while you are still living. Your choice should be based on your needs and what you can afford.

~~A wide variety of plans is being offered today. You can get detailed information from a life insurance agent or company.~~

There are two basic types of life insurance: **term insurance** and **cash value insurance**. Term insurance generally has lower premiums in the early years, but it does not build up cash values that you can use in the future. You may combine cash value life insurance with term insurance for the period of your greatest need for life insurance to replace income.

Term Insurance covers you for a term of one or more years. It pays a death benefit only if you die in that term. Term insurance generally ~~provides~~ offers the largest ~~immediate death~~ short-term insurance protection for your premium dollar. It does not build up cash value. For example, you might buy a term policy to pay off a mortgage or other loan in the event of death.

You can renew m~~M~~ost term insurance policies ~~are renewable~~ for one or more ~~additional~~ terms even if your health has changed. Each time you renew the policy for a new term, premiums will be higher. ~~Check the premiums at older ages and how long the policy can be continued~~ Ask what the premiums will be if you continue to renew the policy. Also ask if you will lose the right to renew the policy at some age. For a higher premium, some companies will give you the right to keep the policy in force for a guaranteed period at the same price each year. At the end of that time you may need to pass a physical examination to continue coverage, and premiums may increase dramatically.

You can trade m~~M~~any term insurance policies ~~can be traded before the end of a conversion period~~ for a ~~whole life~~ cash value policy during a conversion period—even if you are not in good health. Premiums for the new policy will be higher than you have been paying for the term insurance.

~~Other policies may have special features which allow flexibility as to premiums and coverage. Some let you choose the death benefit you want and the premium amount you can pay. The kind of insurance and coverage period are determined by these choices.~~

Cash Value Life Insurance is a type of insurance where the premiums charged are higher at the beginning than they would be for the same amount of term insurance. The part of the premium that is not used for the cost of insurance is invested by the company and builds up a cash value that may be used in a variety of ways. You may borrow against ~~the~~ a policy's cash values by taking a policy loan. ~~Any~~ If you don't pay back the loan and the interest on ~~the loan it, that you do not pay back will be deducted~~ the amount you owe will be subtracted from the benefits when you die, or from the cash value if you stop paying premiums and take out the remaining cash value. You can also use your cash value to keep insurance protection for a limited time or to buy a reduced amount without having to pay more premiums. You also can use the cash value to increase your income in retirement or to help pay for needs such as college costs without canceling the policy. However, to build up this cash value, you must pay relatively higher premiums in the earlier years of the policy. Cash value life insurance may be one of several types; whole life, universal life and variable life are all types of cash value insurance.

Whole Life Insurance covers you for as long as you live if your premiums are paid. ~~The common type is called straight life or ordinary life insurance—y~~You generally pay the same amount in premiums for as long as you live. ~~These~~ When you first take out the policy, premiums can be several times higher than you would pay initially for the same amount of term insurance. But they are smaller than the premiums you would eventually pay if you were to keep renewing a term policy until your later years.

Some whole life policies let you pay premiums for a shorter period such as 20 years, or until age 65. Premiums for these policies are higher ~~than for ordinary life insurance~~ since the premium payments are ~~squeezed into~~ made during a shorter period.

~~Whole life policies develop cash values. If you stop paying premiums, you can take the cash or you canused the cash value to buy continuing insurance protection for a limited time or a reduced amount. (Some term policies that provide coverage for a long period also have cash values.)~~

~~One~~ *Universal Life Insurance* is a kind of flexible ~~premium~~ policy ~~often called universal life,~~ that lets you vary your premium payments, ~~every year, and even skip a payment if you wish.~~ You can also adjust the face amount of your coverage. The premiums you pay (less expense charges) go into a policy account that earns interest~~, and.~~ eCharges for the insurance are deducted from the account. ~~Here, insurance continues as long as there is enough money in the account to pay the insurance charges.~~ If your yearly premium payment plus the interest your account earns is less than the cost of your insurance, your account value will drop. If it keeps dropping, eventually your coverage will end. To prevent that, you may need to start making premium payments, or increase your premium payments, or lower your death benefits. Even if there is enough in your account to pay the premiums, continuing to pay premiums yourself means that you build up more cash value.

~~Endowment insurance policies pay a sum or income to you if you live to a certain age. If you die before then, the death benefit is paid to the person you named as beneficiary.~~

Variable Life Insurance is a ~~special~~ kind of insurance where the death benefits and cash values depend ~~up~~on the investment performance of one or more separate accounts, which may be invested in mutual funds or other investments. Be sure to get the prospectus ~~provided by~~ from the company when buying this kind of policy and STUDY IT CAREFULLY. ~~The method of cost comparison outlined in this Guide does not apply to policies of this kind~~. You will have higher death benefits and cash value if the underlying investments do well. Your benefits and cash value will be lower if the investments you chose didn't do as well as you expected.

~~Combinations and Variations. You can combine different kinds of insurance. For example, you can buy whole life insurance for lifetime coverage and add term insurance for the period of your greatest insurance need. Usually the term insurance is on your life—but it can also be bought for your spouse or children.~~

Life Insurance Illustrations

You may be thinking of buying a policy where cash values, death benefits, dividends or premiums may vary based on events or situations the company does not guarantee (such as interest rates). If so, you may get an illustration from the agent or company that helps explain how the policy works. The illustration will show how the benefits that are not guaranteed will change as interest rates and other factors change. The illustration will show you what the company guarantees. It will also show you what *could* happen in the future. Remember that nobody knows what will happen in the future. You should be ready to adjust your financial plans if the cash value doesn't increase as quickly as shown in the illustration. You will be asked to sign a statement that says you understand that some of the numbers in the illustration are not guaranteed.

Finding a ~~Low Cost Policy~~ Good Value in Life Insurance

After you have decided which kind of life insurance is best for you, compare similar policies from different companies to find which one is likely to give you the best value for your money. A simple comparison of the premiums is not enough. There are other things to consider. For example:

- Do premiums or benefits vary from year to year?
- How much ~~cash value~~ do the benefits builds up ~~under~~ in the policy?
- What part of the premiums or benefits is not guaranteed?
- What is the effect of interest on money paid and received at different times on the policy?

~~Cost comparison index numbers, which you get from life insurance agents or companies, take these sorts of items into account and can point the way to better buys.~~

~~**Cost Comparison Indexes.** There are two types of cost comparison index numbers. Both assume you will live and pay premiums for the next 10 or 20 years.~~

~~1. The Surrender Cost Comparison Index helps you compare costs over a 10 or 20 year period assuming you give up (surrender) the policy and take its cash value at the end of the period. It is useful if you consider the level of cash values to be of special importance to you.~~

~~2. The Net Payment Cost Comparison Index helps you compare costs over a 10 or 20 year period assuming you will continue to pay premiums on your policy and do not take its cash value. It is useful if your main concern is the benefits that are to be paid at your death.~~

~~The two index numbers are the same for a policy without cash values.~~

~~Guaranteed and Illustrated Figures. Many policies provide benefits on a more favorable basis than the minimum guaranteed basis in the policy. They may do this by paying dividends, or by charging less than the maximum premium specified. Or they may do this in other ways, such as by providing higher cash values or death benefits that the minimums guaranteed in the policy. In these cases the index numbers are shown on both a guaranteed and currently illustrated basis. The currently illustrated basis reflects the company's current scale of dividends, premiums or benefits. These scales can be changed after the policy is issued, so that the actual dividends, premiums or benefits over the years can be higher or lower than those assumed in the indexes on the currently illustrated basis.~~

~~Some policies are sold only on a guaranteed or fixed cost basis. These polices do not pay dividends; the premiums and benefits are fixed at the time you buy the policy and will not change.~~

~~Using Cost Comparison Indexes. The most important thing to remember is that a policy with smaller index numbers is generally a better buy than a similar policy with larger index numbers.~~

~~Compare index numbers only for **similar** policies—those which provide essentially the same benefits, with premiums payable for the same length of time. Make sure they are for your age, and for the kind of policy and amount you intend to buy.~~ Remember that no one company offers the lowest cost at **all** ages for **all** kinds and amounts of insurance.

~~Small differences in index number should be disregarded, particularly where there are dividends or nonguaranteed premiums or benefits. Also, small differences could easily be offset by other policy features, or difference in the quality of service from the agent or company. When you find small differences in the indexes, your choice should be based on something other than cost.~~

~~Finally, keep in mind that index numbers cannot tell you the whole story~~. You should also consider other factors:

- ~~The pattern of policy benefits~~How quickly does the cash value grow?~~:~~ Some policies have low cash values in the early years that build ~~rapidly~~ quickly later on. Other policies have a more level cash value build-up. A year-by-year display of values and benefits can be very helpful. (The agent or company will give you a ~~P~~policy ~~S~~summary or an illustration that will show benefits and premiums for selected years.)

- ~~Any~~ Are there special policy features that ~~may be~~ particularly suit~~ed to~~ your needs~~:~~?

- ~~The methods by which~~ How are nonguaranteed values ~~are~~ calculated~~:~~? For example, interest rates are ~~an~~ important ~~factor~~ in determining policy ~~dividends~~ returns. In some companies ~~dividends~~ increases reflect the average interest earnings on all of that company's policies regardless of when~~ever~~ issued. In others, the ~~dividends~~ return for policies issued in a recent year, or a group of years, reflect~~s~~ the interest earnings on ~~those~~ that group of policies; in this case, ~~dividends~~ amounts paid are likely to change more rapidly when interest rates change.

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ATTACHMENT FIVE-B

Variable Life Illustrations Subgroup
of the Life Disclosure (A) Working Group
New York, New York
June 2, 1996

The Variable Life Illustrations Subgroup of the Life Disclosure (A) Working Group met in New York A Ballroom of the Sheraton Hotel in New York, N.Y., at 1 p.m. on June 2, 1996. Rick Morse (N.Y.) chaired the meeting. The following subgroup members or their representatives were present: Tom Foley (N.D.); and Robert E. Wilcox (Utah).

Rick Morse (N.Y.) described the reason for the subgroup and the events that had transpired so far. He reported that the members of the subgroup met March 12, 1996, with the Securities and Exchange Commission (SEC), and on April 4, 1996, with the SEC and the National Association of Securities Dealers (NASD). The SEC and the NASD were given a hriefing about the NAIC's Life Insurance Illustrations Model Regulation and information about the desire to use the same framework for variable life illustrations. Mr. Morse reported that under the current rules, a personalized illustration may be prepared using 0% and 12%. The 12% includes the current morality and expenses and the 0% illustration uses the maximum mortality and expenses allowed in the contract. Mr. Morse opined that this approach does not do consumers the best service. He saw two problems with this approach: (1) it does not do a good job of showing a consumer what the risks and results might be. The risks in a variable life product include investment risks, a risk that the cost of insurance charges may go up, and a risk that the mortality costs may go up as time passes; (2) not all purchasers invest in an aggressive stock investment option. If 50% of the investment goes into treasury bills and 50% in stocks, the return shown should be 8% or 9% rather than 12%.

Mr. Morse suggested that he would like to provide illustrations based on the allocation of premium among the available investment subaccounts the potential insured plans to make. The insurer would illustrate based upon recent historical experience of each subaccount selected by the potential insured based on a bench period of five years with an overall cap of 12%. If a particular subaccount did not have five years experience, the insurer could illustrate the subaccount based upon a nationally recognized index that reasonably reflexes the investment strategy cap at 90% of the index or cap at a lower percentage the current permitted 12%. Consistent with the current Life Insurance Illustrations Model Regulation, an insurer would be required to use 0% with guaranteed morality and expenses and the third column would reflect the average between the illustrated scale and the 0% and guaranteed morality and expense scale. He said this would give an average yield much closer to what might actually apply to the individual. If the SEC rules changed so that the illustration could project recent historical experience, this would make the illustration even more informative. The issue is also important for in-force illustrations because, under the current rules, the insurer is required to use the 0% and 12% for in force illustrations too. This would not help policyholders obtain information as to where they are in relation to their goals.

Mr. Morse reported that the SEC is currently reviewing its position in these areas and hopes by the end of the year to release a regulation that will either change or reaffirm the position that only hypothetical returns may be illustrated. He suggested it would make sense to wait to draft the NAIC's Variable Life Insurance Illustrations Model Regulation until the direction of the SEC is clear.

Roger Strauss (Iowa) asked if the illustration arrangement to show weighted averages was now prohibited. Mr. Morse responded that it would be necessary to use recent historical experience to make that type of illustration and that is now prohibited under the SEC rules. It is only possible to project a hypothetical return into the future, using nothing that shows actual company experience.

Mr. Morse said the pending proposals for illustrations in New York has a maximum for a variable illustration of 8%. He said showing 12% up to 50 years in the future had no basis in reality. George Coleman (Prudential) expressed concern that requiring a hypothetical of 8% because it had more of a basis in reality would give the impression to the consumer that this is what he could expect. Saying 8% is a more reasonable figure implies the purchaser could expect to attain what is illustrated in the hypothetical. Mr. Morse opined that people tend to ignore the 0% illustration, because if they thought that they would get a 0% return, they would not invest in variable life insurance.

Mr. Morse also noted that the narrative of the current model will need modification to reflect the nature of available products including disclosure that fund performance and policy performance may not match because of the timing of premium payment, fund viability and the impact of contract charges as the net amount of risk increases during periods with negative investment results.

James Hunt (Consumer Federation of America) said that the illustrations of variable life that he had seen had been relatively cleaner than those illustrations of nonvariable life. He was unaware of the reason why the SEC chose 12%, because the highest average return he had seen for historical returns on stock funds was approximately 10%.

Craig Raymond (American Academy of Actuaries—AAA) chairs a working group on disclosure issues charged with interfacing with the NAIC committee. He said his group is prepared to start work as soon as it is able to determine the direction to go. He suggested that his group begin looking now at how to apply the nonvariable rules to issues other than the investment return.

Commissioner Robert E. Wilcox (Utah) agreed that it was important to keep the decisions on the variable life illustrations regulation as close as possible to the existing model for nonvariable life. He also emphasized the importance of continuing discussion with federal regulators.

Having no further business, the Variable Life Illustrations Subgroup adjourned at 1:55 p.m.

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ATTACHMENT FIVE-C

Replacement Issues Subgroup
of the Life Disclosure (A) Working Group
New York, New York
June 3, 1996

The Replacement Issues Subgroup of the Life Disclosure (A) Working Group met in the Riverside Ballroom of the Sheraton Hotel in New York, N.Y., at 8 a.m. on June 3, 1996. Paul DeAngelo (N.J.) chaired the meeting. The following subgroup members or their representatives were present: Paul Hogan (Ariz.); Charlotte Williams (Ark.); Richard Rogers (Ill.); Jo Oldson (Iowa); Lester Dunlap (La.); Cindy Martin (Mass.); Hollis Allen (Minn.); Tony Higgins (N.C.); Paul Boucher (N.Y.); Kerry Barnett (Ore.); and Ted Becker (Texas).

Paul DeAngelo (N.J.) explained the purpose of the subgroup. He said New Jersey had recently organized a multistate market conduct examination of a company domiciled in New Jersey that focused on charges of "churning." Now it was appropriate to bring to the NAIC the larger issues of insurance practices that were highlighted in the company examination. He said the Life Disclosure (A) Working Group had been charged to study replacement issues, and this subgroup was created to take on that charge. Mr. DeAngelo said that the group would make recommendations to the Life Disclosure (A) Working Group, perhaps in

the form of changes to existing models or creation of a new model to address problems. Mr. DeAngelo presented a work plan of how the tasks for the subgroup might proceed (Attachment Five-C1). Mr. DeAngelo proposed beginning the subgroup's work with a survey of major insurers that would ask questions related to replacement issues (Attachment Five-C2). A white paper or a report would be produced that summarized the results without identifying the insurers in the paper. Mr. DeAngelo asked for comments from the audience and the regulators on possible survey topics and asked that those comments be submitted to Carolyn Johnson (NAIC/SSO) by the end of June.

Tony Higgins (N.C.) said the National Association of Life Underwriters (NALU) had a replacement project and suggested that the working group review their work to date. He said the chair of that project was a North Carolina agent and he agreed to make initial contact to gather information from NALU.

Al Dawson (American Council of Life Insurance—ACLI) said the issue of replacements was generally reviewed about every 20 years and the ACLI had recently charged a group to specifically study market conduct issues. He said the ACLI would, as a result of their study, make recommendations for possible changes to the Life Insurance Replacement Model Regulation. Mr. DeAngelo said that more models may have an impact on replacement, such as the advertising regulation and the Life Insurance Illustrations Model Regulation recently adopted. Mr. DeAngelo also clarified that he did not want to give the impression that replacements are inherently bad. Richard Rogers (Ill.) asked why the ACLI started this project. Mr. Dawson responded that the subject has vexed the industry for many years. The scathing headlines in the newspapers made it clear that it was time to examine the problem. During the 1980s, the dynamics of replacements changed, with replacement destigmitized. But times have changed, and he suggested it was time for a fresh look at the replacement regulation.

Mr. DeAngelo asked the working group members if they thought a survey would be an appropriate way to attack the problem. Mr. Rogers responded that it was imperative to understand what the problem was before beginning to derive solutions, and he agreed that a survey was an appropriate way to go.

Mr. DeAngelo identified two types of replacements: internal replacements, where policies of a company were replaced with other policies sold by that same company, and external replacements where a policy was sold from a different company. He opined that more activity may have occurred with respect to internal replacements in the last 10 years. In external replacements, the fact that a policy is being replaced is not frequently concealed because commissions are not reduced by the company as they often are when an internal replacement is occurring.

James Hunt (Consumer Federation of America—CFA) said he had concerns about replacements. He said there are tools to use to determine if a replacement is good or bad. From the 1950s to the 1980s, replacements of life insurance tripled, and by the mid-1980s, one-half of sales were replacements. Mr. Hunt said some policyholders knew if they were making a good replacement, but the typical consumer spent very little time on life insurance decisions. Mr. Hunt said he makes a rate of return calculation to determine whether replacement is a good value, but he did not think very many consumers could understand that. He suggested companies should have a suitability requirement for replacements. He explained that, in Australia a needs analysis is prepared for all sales, and if the sale is a replacement, the form must include reasons why it is good to replace the policy.

Scott Cipinko (National Alliance of Life Companies—NALC) cautioned the working group to understand that there are people who do want to replace their policies even if they have been told that it is not the best idea. Mr. DeAngelo responded that the working group understood the need to recognize that some replacements were good. Charlotte Williams (Ark.) suggested it was also important to know how states treat annuities. She said in some states annuities are covered under the life insurance rules, and it would be helpful to know whether the state's replacement law covered replacement of life insurance with an annuity.

Mr. DeAngelo referred to his work plan that suggested mailing out a survey in September and offered to begin drafting survey questions. He said the working group would have a conference call in July to refine the survey questions and determine if an interim meeting is necessary.

Having no further business, the Replacement Issues Subgroup adjourned at 8:50 a.m.

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ATTACHMENT FIVE-C1

Multistate Task Force
Study of Life Insurance Marketing Practices

Completion Date	Function
6/96 - 7/30/96	Collect info of other states experiences with and market conduct exams of other companies Meet with ACLI?
7/30 - 9/96	Construct survey of major life insurers
9/96	Mail survey (return date 6/1/96) Return Date 10/30/96
10/96	Review NAIC Model Regulation on Life Insurance Illustrations, Life Advertising, Solicitation and Replacement
10/96	Review Actuarial Task Force Recommendations

11/96	Receive report summarizing survey responses
12/96	Meet with subgroup to review results of survey
2/97	Produce draft report on study
3/97	Issue final report with recommendations

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ATTACHMENT FIVE-C2

POSSIBLE SURVEY TOPICS

1. Agent hiring practices
2. Compensation practices
3. Agent training
4. Agent terminations and disciplines
   a. Volume
   b. Reasons
5. Agent Turnover
6. Reassignment of terminated agent's books
7. Internal compliance controls
   a. Where, when
   b. Report to whom
   c. Systems to monitor
8. Product suitability guidelines
9. Dividend or excess interest practices
10. Compliant statistics
11. Sales productions (Premium income)
12. Volume of:
    a. Financed sales
    b. Replacements
    c. Abbreviated payment plans

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ATTACHMENT FIVE-D

Annuity Illustrations Subgroup
of the Life Disclosure (A) Working Group
New York, New York
June 2, 1996

The Annuity Illustrations Subgroup of the Life Disclosure (A) Working Group met in the Princess Ballroom of the Sheraton Hotel in New York, N.Y., at 10 a.m. on June 2, 1996. Tony Higgins (N.C.) chaired the meeting. The following subgroup members or their representatives were present: Roger Strauss (Iowa); Lester Dunlap (La.); Jerry Fickes (N.M.); Ted Becker (Texas); and Robert E. Wilcox (Utah).

Linda Lanam (Life of Virginia), coordinator of the technical resource advisors, discussed the information submitted by the advisors (Attachment Five-D1). She said the resource advisors had met in person and also by conference call and decided to provide material addressing four aspects of annuity illustrations: (1) scope of the regulation, (2) content of an illustration, (3) when to use an illustration, and (4) information on competing financial instruments. Ms. Lanam said it was the consensus of the technical resource advisors to suggest a slightly different direction than was included in the Life Insurance Illustrations Model Regulation. The reason for this change is that life insurance already is sold with a significant use of illustrations, but that is not true in the annuity market. The advisors recognize there are disclosure issues and agree that, if an illustration is used, it should comply with standards similar to those in the Life Illustrations Regulation. Rather than require a full numeric illustration in all instances, the group suggests focusing on specific disclosure information to provide with solicitation for all contracts. Ms. Lanam suggested that an illustration not be required in all sales, as had been included in the first draft of the Annuity Illustrations Model Regulation and suggested that in force illustrations not be required. She said many companies do not have the technical capacity to do an in force illustration because they do not currently prepare sales illustrations. Ms. Lanam asked the regulators to be aware that annuity products were in competition with other financial instruments, and asked the regulators to consider the impact on the market place as they developed a model regulation.

Mr. Higgins asked if the advisors had considered disallowing the use of all illustrations. Ms. Lanam said that had not been discussed and she did not know what the impact of such a direction would be because her company did not use illustrations very much. Mr. Higgins pointed out that competing products such as certificates of deposit do not use an illustration or make any projections into the future.

Barbara Lautzenheiser (Lautzenheiser & Associates) said it was important that the materials provided in a sales situation encourage people to keep their annuity and not cash it in. She was afraid that would be a result of a prohibition to illustrate. She pointed out that insurance products are different from other financial vehicles because they provide an insurance benefit.

Craig Raymond (American Academy of Actuaries) said the academy had a working group ready to lend support to the Annuity Illustrations Subgroup and said the Academy group had three comments to make: (1) any annuity regulation should build on the life illustrations model, (2) market place differences must be recognized, and (3) provide consumers sufficient information. Mr. Raymond said his group had discussed lapse support, self-supporting illustrations and disciplined current scale, and decided to wait and see what issues might come up in this regard. He asked the regulators not to prohibit the use of illustrations because there were times when an illustration was needed to show the mechanics of the annuity contract. He suggested that it was important to disclose loads and charges that would effect the annuity value. Ted Becker (Texas) asked what should be disclosed, and Mr. Raymond suggested that anything that depletes the value should be shown. Mr. Becker asked if that included disclosure of commissions. Mr. Raymond responded that the commission did not directly effect the policyholder, but rather the loads insurers impose to recover the commissions they paid.

Scott Cipinko (National Alliance of Life Companies—NALC) reminded the working group that the annuity market was growing faster than the life insurance market and that its decisions would have a wide impact. He pleaded with the regulators not to make it difficult for small companies to do business by over regulation. Mr. Higgins predicted that banks would become the largest marketers of annuities. Jerry Fickes (N.M.) said that many of the problems regulators were now facing with the Office of the Comptroller of the Currency had to do with the fact that insurance regulators had not been as diligent at regulating annuities as they should have been. He suggested that, if banks were selling annuities, they should be licensed sellers of licensed company products.

James Hunt (Consumer Federation of America) suggested it was important to disclose the annual effect of yields and suggested this should be at the heart of any disclosure required by the regulators. He used the example of the certificate of deposit offered at a bank where the annual yield must be disclosed. He suggested that for an annuity the current rate being paid should be disclosed and how long that rate was guaranteed. Mr. Higgins said this provision had been included in the original draft of the Annuity Illustrations Model Regulation. Tom Foley (N.D.) suggested that if an interest rate was used, a full illustration should be required. Ms. Lanam suggested that a list of events that would trigger an illustration should be a part of the regulation. Mr. Foley asked if the technical resource advisors could begin creating a disclosure document for regulators to consider.

Commissioner Robert E. Wilcox (Utah) voiced a concern that there should be as much consistency as possible between life insurance and annuity illustrations. He emphasized the importance of a seamless transition where types of products were structured differently and said it was important that the illustration requirements should not drive product design. Mr. Higgins agreed that various factors have encouraged development of life products that look more like annuities, and suggested this might be because many states granted a premium tax exemption for annuities.

Having no further business, the Annuity Illustrations Subgroup adjourned at 11:45 a.m.

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ATTACHMENT FIVE-D1

Report of Technical Resource Advisors
to the NAIC Annuity Illustrations Working Group

Annuity Products, Markets and Distribution System
Compiled by: Riva F. Kinstlick, Prudential Insurance Company of America
Elizabeth A. Sutherland, Teachers Insurance and Annuity Association

INTRODUCTION

The purposes of this paper are twofold: to describe the variety and uses of annuity products in the marketplace and to discuss why we believe certain products should be exempted from the NAIC Annuity Illustration Model Regulation under development. Parts I and II describe annuity products, and Part III discusses their uses. Part IV explains various distribution systems, followed by, in Parts V and VI, our proposed Sections 3 and 4 of the Annuity Illustration Model Regulation. Finally, Part VII sets forth our bases for exclusion.

This should not be viewed as definitive, especially with respect to our listing of specific products. There may well be annuity products that we have not described, such as charitable gift annuities, which are produced by sources outside the insurance industry.

1. Generic Descriptions

Immediate and Deferred Annuities

An immediate annuity is a contract for a series of periodic payments designed to systematically liquidate a principal sum. Under such a contract, regular benefit payments begin within a short time of the issue date and continue for the life of the annuitant or annuitants or for some time certain.

Benefit payments under an immediate annuity may be fixed, with no provision for change (non-participating), modified by non-guaranteed elements determined from time to time (participating, or receiving excess interest credits), or may vary according to the investment experience of a variable account (variable). Benefits payments may also increase (often relative to

a stated index) and may be structured to meet the minimum distribution requirements of federal tax law. Interest-only payments from a deferred annuity, even if periodic, are not immediate annuity payments because they do not liquidate the principal sum. Periodic withdrawals of a specified amount from a deferred annuity are not an immediate annuity if the payments may be stopped, or if the accumulation is returned on request.

Benefits payments may continue for life of one annuitant, may continue for the life of one annuitant and at the same or a reduced level for the life of a second annuitant, or may continue for a fixed period without regard to the life of an individual. Guaranteed periods generally not to exceed life expectancy or joint life expectancy, in order to comply with Internal Revenue Code (the "Code") definitions of an annuity, are often used to provide benefits to other individuals in the event of the early death of the annuitants. For a joint life annuity with reduced payments after the death of one annuitant, the guaranteed payments continuing during a guaranteed period are the reduced payments.

A deferred annuity is used to accumulate funds with the intention of making benefit payments at some future time. These annuities may be purchased with a single premium, or more commonly, with flexible premiums, subject to the policyholder's choice. Contracts requiring stated premiums are, to our knowledge, no longer sold.

A deferred annuity is designed to automatically annuitize to provide retirement income. The contractholder may, however, elect to further defer the annuity payout or leave the contract in its accumulation phase as part of an estate. The contractholder may also elect to partially or fully surrender the contract, taking systematic withdrawals or receiving a lump sum payment.

Individual and Group Annuities

An individual annuity is a contract which usually covers one named annuitant and is owned by an individual who maintains control of the contract at all times. A contract may provide benefits based on the survival of more than one individual. While the named annuitant is most often the owner of an individual annuity, there are exceptions. An annuitant under a structured settlement annuity, for example, does not have control of the contract. In addition, employers or trusts may purchase individual annuities on behalf of their employees or beneficiaries, retaining control of the contracts until and unless they are otherwise assigned.

A group annuity is a contract which covers more than one annuitant and is which owned by an employer, pension plan, association, union, or trust, which exercises control over the contract. It should be pointed out that the amount of control varies widely. A group annuity using a separate account may have a distinct separate account for each large policyholder and/or may pool assets of several contractholders in one separate account. In addition to contracts sold to employers as funding vehicles for pension and profit sharing plans, group annuities are sold to other entities, such as association, unions, and trusts.

Fixed and Variable Contracts

A fixed annuity is a contract providing principal guarantees in which the underlying assets are usually held in an insurer's general account. Some fixed annuities credit interest at a guaranteed interest rate while others credit interest at a crediting rate periodically declared by the insurer, but in no event lower than the guaranteed rate. Contracts may be participating or non-participating.

A variable annuity is a contract which permits the contract owner to allocate premiums to investment options, at least some of which are variable. Each variable investment option invests either directly in a portfolio of securities or in a mutual fund. Consequently, the investment experience passes directly to the contract owner. In contrast to investments under fixed annuities, variable investment options generally carry no principal guarantees. Nevertheless, many variable contracts also include guaranteed interest options which are part of the insurer's general account and which do not subject the contract owner to market risk.

Variable contracts are widely used in the annuity marketplace, often serving as funding vehicles for employer-sponsored pension and profit sharing plans as well as for individual qualified and non-qualified plans. A variable annuity may be immediate or deferred, and in individual or group form. Many individual variable annuities provide a minimum death benefit guarantee, proving principal (or principal plus interest) protection in the event of death before benefit payments begin. It is our understanding that variable annuities will be considered in a separate illustration regulation.

II. Specific Products

Fully Guaranteed Annuity is a contract which provides a stated return (benefit) on the premiums, with no provision for non-guaranteed amounts. Benefits may be guaranteed to increase with a stated external index, such as the Consumer Price Index.

Interest-indexed Annuity is a contract in which the crediting interest rate is linked to an external reference. The contract contains a minimum guaranteed value based upon a guaranteed interest rate. The insurer assumes the risk associated with the investment decisions. The assets underlying the contract are usually in a general account, especially a non-registered contract. Usually the product is marketed as a fixed annuity product. If marketed as a security under federal law, the product may be subject to greater degree of regulation, including registration with the Securities and Exchange Commission.

Equity Indexed Annuity is an interest-indexed contract in which the external reference to which the crediting interest rate is linked is an equity-indexed reference. All or a specified portion of the principal (such as 80%) is guaranteed. The contract may be funded in the insurer's general account, with the insurer purchasing a call on the equities index to get the performance

return for market rises. Alternatively, the contract may be funded in an equities account with the insurer purchasing a put on the index to get the principal protection for market drops.

Market Value Annuity is a contract, the underlying assets of which are held in a fixed account and the values of which are guaranteed if held for a specified period. The contract contains non-forfeiture values which are usually based upon a market-value adjusted formula if held for a shorter period. Contracts may provide minimum guaranteed values in accordance with standard nonforfeiture regulations. The assets underlying the contract must be in a fixed account during the period or periods when the contract holder may surrender the contract.

Modified Guaranteed Annuity is a contract, the underlying assets of which are held in a separate account, and the values of which are guaranteed if held for specified periods. The contract contains nonforefeiture values that are usually based upon a market-value adjustment formula if held for shorter periods. This formula may or may not reflect the value of assets held in the separate account. The assets underlying the contract must be in a separate account during the period or periods when the contract holder may surrender the contract.

Two-tier Annuity is a fixed contract which has a tier difference between the accumulation value and the cash surrender value. The tier difference is often created by a difference in the interest rates credited to the accumulation value (a long-term rate) and the cash surrender value (a short-term rate). A tier difference may also be created by greater expense charges assessed against the cash surrender value or by a substantial permanent surrender charge.

Guaranteed General Account Contract is a contract under which all contract assets are allocated to the insurer's general account, where they are commingled with the assets of all of the insurer's other general account contracts. General account contracts may be either non-participating (e.g., guaranteed investment contracts) or participating (e.g., immediate participation guaranteed contract or deposit administration contract). Generally, there is a guaranteed return of principal as long as the contract is in effect. Furthermore, these contracts receive book value accounting treatment although they are subject to adjustment under certain circumstances.

Guaranteed Separate Account Contract is a group contract under which all contract assets are allocated to either a pooled or individual separate account. Such contracts may be either participating or non-participating. Generally, there is a guaranteed return of principal as long as the contract is in effect. Furthermore, these contracts usually receive book value accounting treatment although they are subject to adjustment under certain circumstances.

Market Value Separate Account Contract is a contract under which all contract assets are allocated to either a pooled or individual separate account. The actual investment experience of the separate account is reflected directly in the investment results of the contract, which does not provide a guaranteed return of principal. These contracts receive market value accounting treatment.

Alternate Guaranteed Investment Contract (Synthetic GIC) is a group contract under which all contract assets are held by a third party custodian and are owned by the contract owner. The insurer guarantees principal and a pre-established rate of return for certain benefit payments. These contracts receive book value accounting treatment.

CD Annuity, an annuity designed to compete with bank products, is a fixed contract providing a guaranteed rate of interest for a specified number of years.

III. Uses for Annuity Products

Personal Savings and Income

Individuals purchase annuities as the personal savings component of the "three-legged stool" of retirement funding (the other two "legs" being Social Security and the employer sponsored plans). Annuities may also be used for other savings purposes, such as purchase of a home or funding of a child's education. Personal savings and income annuities may be immediate or deferred, and fixed or variable.

A deferred annuity is designed to automatically annuitize to provide retirement income. However, the contractholder may elect to further defer the annuity payout or leave the contract in its accumulation phase as part of an estate. The contractholder may also elect to partially or fully surrender the contract, taking systematic withdrawals or receiving a lump sum payment.

Funding of Retirement Plans

Annuity contracts are widely used to fund all types of retirement plans, including but not limited to: qualified retirement plans under the Code, Sections 401(a) and 403(a); cash and deferred arrangements under Section 401(k); tax sheltered annuity plans under Section 403(b); Individual Retirement Annuities (IRAs) under Section 408, including Simplified Employer Plans; non-qualified plans under Section 457; and other non-qualified plans, such as excess benefit plans and top-hat plans.

Retirement plans may be funded solely by contributions from the plan sponsor, by employee salary reduction or deduction, or by a combination of both plan sponsor and participant contributions.

Multiple funding vehicles, including both insurance and non-insurance products (such as mutual funds), may be used to fund a retirement plan or a single investment option under a plan. In defined benefit plans, participants receive a benefit

determined by a formula adopted by the plan. Under these plans, the plan fiduciary has complete control over the funding vehicles used and may choose and switch funding vehicles, subject to the fiduciary duties imposed by ERISA. Generally, in defined contribution plans, participants may choose from a range of different investment options, such as equity, bond, or stable value, which are available under the plan. The funding vehicle or vehicles are selected by the plan fiduciary, who has complete control over the selection of the funding vehicle and the specific investment options available under the funding vehicle. In some defined contribution plans, the participant may choose from among the actual funding vehicles (rather than just the investment options available under the funding vehicle) approved by the plan sponsor. Thus, the investment performance of the particular funding vehicle chose may have a direct impact, an indirect impact, or no impact on a participant's benefit from the retirement plan.

Annuity products used to fund retirement plans include group and individual, fixed and variable, and hybrid products. In many cases the plan sponsor owns the contract and exercises all rights under it. In some cases, however, the individual participant owns the contract and exercised all rights under it, within the limits of the plan provisions. In other cases, the plan sponsor shares ownership rights with the individual participant.

Structured Settlements

A structured settlement annuity is purchased to fund future periodic payments, based on an agreed upon schedule, for a plaintiff or other claimant to compensate or otherwise pay for a personal or physical injury or sickness suffered by the individual. The plaintiff does not own or otherwise have control over such an annuity.

Under the Code, monies received by a plaintiff in settlement of a personal injury suit are not taxable to that claimant. In order to preserve this tax status, the plaintiff may not own an annuity purchased to fund the agreed upon payments. Consequently, the defendant or his liability carrier either purchases an annuity, retaining ownership of the contract, or assigns his liability and provides funds to a third party, described under the Code as a qualified assignee, which purchases the annuity and retains ownership of it. In either case, as an accommodation, and without jeopardizing the tax status for the plaintiff, the party owning the annuity may make payments directly to the plaintiff.

Preneed and Final Expenses

Annuities are sold on both an individual and discretionary group basis to individuals who are specifically seeking to fund a prearranged funeral agreement or anticipated funeral expenses. These products, which are typically for small amounts, may contain both guaranteed and nonguaranteed elements. They are sold through funeral homes, which may receive an assignment of the policy benefit at the time of purchase. This assignment effectively shifts the risk of increased funeral expenses from the annuitant to the funeral home.

Unlike annuity products purchased by most consumers, preneed or final expense annuities may annuitize as late as age 99, consistent with the purpose for which they are sold (paying for a funeral). For this reason, ledger type illustrations which highlight the investment feature of the product are not used. A majority of the annuities sold by the preneed and final expense industry are single premium deferred annuity contracts, with the remainder falling into the flexible premium category.

IV. DISTRIBUTION SYSTEMS

Annuities are sold under a variety of distribution systems. We would propose that an illustration regulation be flexible enough to accommodate all of these systems without unduly advantaging or hindering any particular system over another.

Agent Sales

Annuity products are often marketed by direct, one–on–one sales by licensed agents or brokers. These agents may be captive agents or independent agents, depending upon distribution systems utilized by the company. In addition to use of their own field representatives, some companies market annuity products through financial institutions such as banks or brokerage houses.

Direct Response Marketing

Many types of annuities, ranging from individual qualified and non–qualified annuities to employer–sponsored group annuities for pension and profit sharing plans, may be sold on a direct response basis. Direct response marketing generally incorporates media and mail campaigns and may include inbound and outbound telemarketing. Most significantly, direct response is based on a high degree of standardization of advertising materials to make possible economies of scale; there is no face–to–face contract between the sales representative, if any, and the buyer.

Mass media advertisements used in direct response marketing are not generally invitations to contract but rather invitations to inquire; the literature provided to an individual after his response to a mass media advertisement is expected to meet the same requirements as those for any initial direct mail piece. Direct response is a favored method of associations that choose to make annuity products available to their members.

One of the benefits of direct response marketing is the degree of control it affords the issuer over the marketing and disclosure materials used. Marketing campaigns are tightly planned and each enclosure carefully considered. With mass campaigns, there is virtually no opportunity for materials not specifically authorized by the company to be used since most of the information used by the issuing company is standardize, generic information, and all materials are expected to be reviewed by

a company's compliance department. Further, with the possible exception of sales made on the Internet, the sale is usually dependent on the buyer returning a completed set of application forms by mail to the issuing company. Customer service representatives may or may not be licensed agents or registered representatives.

Association, Union, and Trust Groups

Association groups are fairly common in the annuity marketplace. An association will typically endorse a particular insurer's contract, lending its name in the marketing of the product, generally on an exclusive basis. If the association receives compensation from the insurance company for the endorsement, it must, under some state regulatory requirements, disclose such compensation in its advertising. The association may perform a significant oversight function, with the insurer reporting to the association at regular intervals. Further, the association often reviews marketing material and provides a clear avenue for participant complaints. Participating association members benefit from the economies of scale derived from inclusion in a group product.

Union groups are also present in the annuity marketplace, with the union endorsing an insurer's product and cooperating with the insurer in the marketing effort. An endorsement by a union often influences the insurer's marketing of the product since the insurer usually is given the opportunity to solicit at union meetings and may also be permitted to include information in newsletters. Such information usually includes basic information on why annuities are useful, descriptions of the various products and their features, and the financial results of the products over time. Solicitation encounters may be one–on–one or occur in a group setting where the ability to use generic illustration information is crucial to being able to complete enrollment within the meeting's time limits. Finally, the union may also help in effectuating payroll deduction for the payment of annuity premiums.

Trusts sometimes hold group annuity contracts whereby individuals who purchase annuities under the contract receive group certificates. The trust often performs only minimal and, in some cases, no oversight function. The group approach may, however, provide economies of scale which are passed on to the buyers.

Electronic (Internet) sales of annuities are beginning to be discussed in the marketplace. While little is known of this distribution system, we are noting it because we believe it may emerge to become common in the future marketplace. We would hope that the technological innovations which are bringing about this distribution system would be encouraged.

V. Proposed Applicability and Scope of Annuity Illustration Regulation

We suggest the following text for Section 3 of the Regulation. Our bases for excluding these products is contained in Part VII of this paper.

> Section 3. Applicability and Scope
>
> This regulation applies to all group and individual annuity policies issued after the effective date of the regulation except:
>
> A. Variable annuities, including contracts registered with the Securities and Exchange Commission and contracts which have variable annuity features available at the option of the contract owner;
>
> B. Fully Guaranteed Annuities;
>
> C. Annuity contracts purchased under an employee pension benefit plan covered by the fiduciary standards of ERISA, or a governmental, church, excess benefit, to "top–hat" plan (as described in ERISA) or a plau described in Section 401(a), 401(k), or 457 of the Code; or
>
> D. Annuity contracts purchased to fund a Structured Settlement.

VI. Proposed Definitions Section of Annuities Illustration Regulation

Together with the amendment of Section 3 of the Regulation in accordance with our suggestions, the following definitions should be added to Section 4:

> "Fully Guaranteed Annuity" means an annuity, including a guaranteed investment or funding contract, which provides a stated return (benefit) on the premiums, with no provision for non–guaranteed amounts. Benefits may be guaranteed to increase with a stated external index, such as the Consumer Price Index.
>
> "Structured Settlement Annuity" means an annuity which is purchased to fund periodic payments (future payment or payments to be made according to an agreed upon schedule rather than a single lump sum payment) for a plaintiff or other claimant in compensation or other payment for or with respect to personal or physical injury or sickness suffered by such plaintiff or other claimant.

VII. Bases for Exclusions

A. Variable Annuities

We would exclude these contracts based on our understanding that they will be covered in another illustration regulation.

B. Fully Guaranteed Annuities

We urge exclusion of these contracts, which include most immediate annuities and many preneed funeral contracts, because the benefit levels will not change and, consequently, there are no variations in future income to be illustrated. Since benefit levels are shown in the contract, there is no purpose to be served by requiring illustrations for fully guaranteed annuities.

C. Annuity Contracts Purchased under Certain Retirement Plans

It is our position that annuity contracts used to fund employee pension benefit plans covered by the fiduciary standards of ERISA, as well as governmental, church, excess benefit, and "top–hat" plans (as described in ERISA) should be excluded from the annuity illustration regulation requirements. Give the current high level of regulation of the pension market, imposition of additional requirements is unnecessary. In many cases, the plan fiduciary, rather than the participant, makes the investment decisions. Also, requiring insurers to provide illustrations would put them at a competitive disadvantage. Finally, illustration are irrelevant in the case of defined benefit plans, and for excess benefit, top–hat, and Section 457 plans. Our reasons are more fully set forth as follows:

1. The pension market is already highly regulated. Participants presently receive a great deal of informational materials required under ERISA, including an annual benefit statement, investment information furnished pursuant to ERISA Section 404(c), a summary plan description (which must identify the issuer of an annuity contract which is used to fund plan benefits), and a summary annual report (which must describe the annuity contract and provide specified financial information). Additionally, many insurers voluntarily make participants' current account balances and historical investment performance available.

A plan fiduciary, when selecting an annuity contract, must act for the exclusive benefit of the plan participants and with the expertise of a sophisticated investor in compliance with his fiduciary duties. The plan sponsor, if it does not have sufficient experience or expertise to choose an appropriate annuity contract, must delegate this responsibility to someone who can satisfy this fiduciary standard. Accordingly, the fiduciary responsible for selecting an annuity contract and insuring that it continues to be a prudent choice must be a sophisticated investor rather than the "typical person within the segment of the public" to whom individual life insurance policies are sold. The fiduciary remains liable under ERISA for the investment of a participant's accounts if he controls the investment of those accounts. In the case of a participant–directed defined contribution plan which does not meet the safe harbor afforded by ERISA, Section 404(c), the plan fiduciary remains liable. (In order for such a plan meet the 404(c) safe harbor, it must, among other things, provide adequate information to the participants to allow them to make informed decisions.) Furthermore, even if a plan falls within the safe harbor of 404(c), the plan fiduciary remains liable if he fails to act prudently in the selection of the annuity contract and in his ongoing monitoring of the annuity contract's performance. Finally, ERISA mandates that an administrative claims procedure be available to plan participants and provides for legal and equitable relief for participants, beneficiaries, and the Department of Labor with respect to alleged violations of fiduciary duties.

2. Requiriug the use of illustrations in this marketplace will result in a great competitive disadvantage to the iusurance industry. Compliance with an illustration regulation will increase the cost of selling and administering these contracts and add to the complexity of purchasing them as compared to other funding vehicles, such as mutual funds.

3. Illustrations have the potential for fragmenting communications and confusing participants because they are inconsistent with the retirement plan context (for example, rather than referring to plan contributions, the illustration regulation requires disclosure of premium payments) and, in certain circumstances, will be inaccurate (for example, under a plan which uses multiple group annuity contracts to fund its stable value investment option, an illustration for a siugle group annuity contract would inaccurately reflect the rate of return under such investment option, since the return to the participant is actually the blended rate of return under all the group annuity contracts). Furthermore, third party administrators often provide plan level reporting to participants; requiring insurers to send illustrations to individuals would be redundant and confusing.

4. In many retirement plans, the plan fiduciary, rather than the plan participant, decides on the purchase or replacement of an annuity contract to fund the plan. Often, the only decision a participant makes is whether or not to participate in the plan. In the case of a group annuity, the plan fiduciary always has responsibility for the purchase or replacement of the contract.

5. Illustrations are irrelevant for defined benefit plan participants, who are entitled to a benefit based on a formula, adopted by the plan sponsor, which typically considers a participant's years of service aud compeusation level. An annuity contract's investment performance in no way affects the amount of the participant's retirement benefit, thus rendering an illustration of the contract's anticipated investment returu immaterial.

6. Illustration are likewise irrelevant for use with non–qualified Section 457, excess benefit, and top–hat plans since the annuity contracts funding such plans are not owned by the participants but are the property of the plan sponsor, and subject to claims of the sponsoring employer's creditors.

D. Structured Settlement Annuities

Structured settlement annuities should be excluded from the annuity illustration regulation requirements. They are a specialized form of annuity product in which sales are individually negotiated between sophisticated parties, most often with the advice of counsel. In addition, structured settlement annuity agreements must be approved by the court having jurisdiction over the underlying action. Finally, while the annuitant under a structured settlement annuity knows at the outset what the future payment stream will be, he has no control over the purchase (or ownership) of the contract. Therefore, illustrations are not used and would be neither useful nor desirable in the structured settlement arena.

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Annuity Illustrations—Technical Resource Advisors
Report of the Components of an Illustration Subgroup
June 1, 1996

Subgroup Charge

Review, revise and offer comments on Section 5A on what a basic illustration shall contain, Section 5C requiring the interest rate used to determine the illustrated non-guaranteed elements to be no greater than the rate of return underlying the disciplined current scale, Section 6 on standards for basic illustrations and Section 7 on standards for supplemental illustrations. Define basic illustration. Define supplemental illustration.

Comments on the Charge

Generally speaking, the subgroup's thoughts have focused on identifying the principles and key issues involved rather than providing specific language for the regulation. The feeling is that effort should focus on building a strong foundation so that language can actually be drafted as the next step.

Principles

It would be helpful to receive guidance on the following:

1. What are the factors and issues that are driving the NAIC to be discussing annuity illustrations? What problems are to be solved?

Is the objective to have annuities generally consistent with life illustration requirements? Are there other objectives?

We agree with comments that it would be helpful for the regulators to identify their guiding principles and/or produce a white paper (like was done with the life reg).

2. Our understanding is the NAIC Annuity Illustrations Subgroup has identified that they do not want to change how the marketplace functions. We interpret this to mean the following three items need to be balanced:

i) Appropriate information should be provided to the consumer
ii) Regulation should not create an expense or time consuming burden on the insurance industry, and
iii) That the model regulation should be sensitive to regulatory requirements of non-insurance alternatives available to consumers.

3. We assume and accept an objective of consumer education and product understanding. Since consumers can be bombarded with information they do not take the time to study or understand, this objective may best be met with the regulation keeping requirements simple, clear and focused.

Key Issues

1. The annuity marketplace is rich with diversity. Annuities are often very simple products that focus on the accumulation (investment) phase. Other annuities focus on the annuitization (retirement) phase.

Following the NAIC Illustration Subgroup's goal to keep it simple and not change how the marketplace functions, we are suggesting a three-level approach:

1. Annuity Product Overview—This is a new concept explained more completely below. It would provide simple disclosure for a product design. it could even be pre-printed. It is envisioned the information would always be required to be provided at the time of sale, would not have a signature requirement, and could be part of the normal marketing material. The company and/or agent would identify if additional illustration information is needed.

There is a parallel to this in the Life Insurance Illustration Regulation. The group business can provide generic information. This is the same concept of providing generic information.

2. Basic Illustration—if a company wants to provide additional information (such as an annuity illustration focusing on both the accumulation and annuitization phases), then (in addition to the disclosure in #1 above) ledger and possibly annuitization information would be provided.

3. Supplemental Illustration—if a company wants to do even more comparisons or provide different information, then both #1 and #2 above must be provided and a supplemental illustration can be provided assuming the additional requirements are met. Freedom for the company to tailor information is provided as long as the other parts (#1 and #2) are provided and consistency requirements are satisfied.

This approach is based on providing a simple disclosure option because frequently annuities are simple products, and then to leave in place the basic and supplemental illustration concepts from the Life Insurance Illustration Model Regulation (with appropriate modifications for annuities).

2. Signature requirements

The Subgroup did not identify a critical need for a signature requirement, especially given the "Annuity Product Overview" document would be provided to all consumers.

- Besides being similar to the Life Insurance Illustration Regulation, it is not clear what value is added if a sign–off is required.
- Our recommendation is the "Annuity Product Overview" document does not need a signature requirement.

3. Self–support/lapse–support tests

This is being addressed by the American Academy of Actuaries working group. They are coordinating with the technical resource advisors (TRA).

If tests are developed, it is unclear how it would work with frequently changing rates (daily or weekly).

4. Illustrated Phases: accumulation/annuitization

A consensus has not yet been reached by the TRA.

The majority believe the minimum requirements for a basic illustration should specify the accumulation phase requirements, with companies being allowed to present annuitizaton information according to their product design and marketing methodology. The idea is to keep the information to the consumer focused and simple, thus allowing for a more complete understanding of the product. This approach also considers a requirement in the "Annuity Product Overview" document, which specifies information must be provided on the annuitization options in the product design.

The minority believe the minimum requirements for the basic illustration should address both the accumulation and annuitization features. They believe the complexities can be overcome and such requirements are consistent with the retirement focus of annuities.

5. Non–guaranteed elements

A. We were unable to locate a concept in annuities similar to the terminal dividends in life contracts. We believe this wording can be eliminated from the Annuity Regulation.

B. Illustration of dividends in the annuitization phase should be permitted if identified in the contract.

6. Components

A. Basic Illustration

I. Account value should be shown to fulfill the goal of promoting consumer understanding of how the contract works.

- Consumers also need to see the long-term value of keeping the contract. This will help eliminate the unnecessary replacement of contracts.
- For contracts such as the "no cash value annuity" how would charges or assessments be shown if only monthly income can be illustrated?
- Can the objective of consumer education be fulfilled if components (like the account value) that are key to the mechanics of the contract cannot be shown?

II. Time Periods to be shown

- Annuities are different than life insurance contracts.
- The life requirement of age 100 does not seem to be appropriate.
- A more appropriate minimum requirement would be to illustrate, say, the first 10 years plus years 15 and 20. An alternative would be to show a number of years plus a retirement age (possibly age 65 or 10 years after issue, if later).

B. Supplemental Illustration

No additional points identified—see above.

C. In-force Illustration

The technical resource advisors recommend in-force illustration requirements be deleted from the Annuity Illustration Model Regulation. It is felt that Annual Report requirements can be used to provide consumers with ongoing information about their contracts and benefits.

This is a key area where annuity and life insurance are different. We were unable to identify a need that would be met by requirements beyond the Annual Report. A concern is that in-force illustrations would add complexity not found for other financial choices consumers may elect, and would change how the marketplace functions.

In addition, because the systems in companies are different, we believe the development costs associated with in-force illustrations for annuities far outweigh the benefits to consumers. Again, Annual Reports can be used to achieve similar benefits and it is felt most companies could support modifications to annual report systems easier than building new in-force illustration systems.

D. We suggest the new "Annuity Product Overview" document be incorporated in the next draft of the regulation.

Annuity Product Overview—Additional Information

Because annuities are different than life contracts, suggestions were received from TRA members that something more simple was needed than the a basic illustration modeled after the life regulation.

Input from the subgroup suggested a third type of document. It is more of a disclosure document or contract summary, which could allow the Life Insurance Illustration Regulation definitions of basic and supplemental illustrations to be used with few (if any) modifications.

This new "Annuity Product Overview" document would be very generic and cold even be pre-printed. The types of information it would contain are identified below. We see this as being required at the time of sale, with the company/agent deciding if more detailed information (i.e., a ledger statement) is to be illustrated. If so, the requirements for a basic illustration must be followed. If the company wanted to go even further, then a supplemental illustration could be done.

Annuity Product Overview Document Components

This would inform the consumer what an annuity is and how it works. It could include the following:

A. Identification of what is an annuity and its purpose
   - Provide long-term tax-deferred accumulation for retirement income or other future needs.

B. Consumer choices of benefit options can result in different benefit levels.
   - Tax penalties may apply for early distributions
   - Different benefits may be provided depending upon the form of benefit annuitization and the number of years in force. For example:
     - Surrender charges may apply if the cash value is elected in the early years, or
     - The cash value is used for lump sum payments, where the higher accumulation value is used for annuitizations.
   - Any other charges or differences in benefits should be disclosed.

c. Contract Features—Explanation of how the contract works:
   - Disclosure of guaranteed interest rates and durations.
   - If provided in the contract, identification of early additional interest rates or other yield or benefit enhancements and the conditions and periods for which they apply.
   - Surrender charges or front-end loads.
   - Generic conceptual examples in graphical form.

How is this information provided?

While this would be required information, how it is done would be up to the company. It is envisioned the information would be provided at the time of sale.

Signature Requirement

Because this is simple, basic information, there would not be a signature requirement,

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TO: Technical Resource Advisors, Annuity Illustration Regulation
FROM: Ross Hansen/Lisa Reitano
DATE: May 9, 1996
RE: Purchase of Competitive Financial Products

Following are short descriptions of the process a typical customer goes through to purchase an annuity and other financial products that compete with annuities. Sample disclosure documents are attached as exhibits to this memo.

A. Bank Certificate of Deposit
   1. Customer completes a signature card.
   2. Certificate is provided at time of purchase. Certificate describes terms and conditions including penalties.
   3. Sales brochures may be used.

B. Mutual Fund
   1. Complete new account application for securities broker–dealer
   2. Prospectus mailed at time of purchase. Prospectus descries risks and expenses.
   3. Sales brochures and hypotheticals may be used.

C. Municipal Bond
   1. Complete new account application for securities broker–dealer.
   2. No sales material or disclosure document typically provided unless purchasing bonds in new issue. Offering circular, like prospectus, provided in new bond issues.

D. U.S. Savings Bond
   1. Complete application.
   2. Bond describes terms and conditions.

E. IRA Account at Securities Broker Dealer
   1. Complete special new account application.
   2. Custodial agreement and IRA disclosure statement sent to customer.
      IRA disclosure statement describes restrictions and tax provisions applicable to IRA accounts
   3. Sales brochure may be used.

F. Fixed Annuity
   1. Complete application for annuity.
   2. Contract mailed to customer or delivered at time of purchase. Contract describes terms and conditions including surrender penalty. Contract provides right to return contract.
   3. Sales brochures may be used.

G. Variable Annuity
   1. Complete application for annuity.
   2. Contract provided to customer. Contract describes terms and conditions, including surrender penalty. Contract contains right to return contract.
   3. Prospectus provided to customer. Prospectus describes contract and underlying mutual funds including expenses, risks and penalties.
   4. Sales brochures and hypotheticals may be used.

* It should be noted that once a new account application has been submitted to a broker–dealer mutual funds, municipal bonds, U.S. savings bonds, brokered certificates of deposit and numerous other types of securities and other financial products could be purchased without additional disclosure documents or applications. However, broker–dealers selling annuities and other life insurance products must obtain a new application for each product sold.

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ATTACHMENT FIVE-E

To: Commissioner Robert E. Wilcox, Utah Department of Insurance
From: John J. Palmer, Chair, Life Practice Advancement Committee, Society of Actuaries
RE: Generally Recognized Expense Table for the NAIC Life Insurance Sales Illustration Model Regulation

In your capacity as chair of the NAIC Life Disclosure Working Group you requested the Society of Actuaries to develop an expense table for use in connection with the Life Insurance Sales Illustration Model Regulation recently adopted by the NAIC. In response to that request, the Society established a research project to develop such a table.

To carry out this project, a Project Oversight Group was established by the Society's Committee on Life Insurance Research, one of the committees in the Society's life practice area under the general oversight of the Life Practice Advancement Committee.

The resulting report of the Project Oversight Group is attached. It has been approved by the Committee on Life Insurance Research and by the Life Practice Advancement Committee. In addition, the Society Board has authorized the Life Practice Advancement Committee to opine as to the appropriate application of the expense table.

The Life Practice Advancement Committee believes that the expense table in the attached report is appropriate for use in connection with the Life Insurance Sales Illustration Model Regulation. It wishes to emphasize that the table is not intended for any other use, and that no other application was envisioned by the Project Oversight Group. The report goes into some detail in describing the characteristics and limitations of the underlying data and the construction of the table that would limit any other use of the table.

The Committee on Life Insurance Research felt strongly that, in spite of obvious concerns, the table factors should be differentiated by distribution system. This feeling reflects the fact that the expenses produced by the generally recognized expense table are subsequently combined with directly paid field costs in carrying out calculations under the model regulation. Since distribution systems vary significantly by type in the incidence of expenses between directly paid field costs and other expenses, a serious systematic distortion would occur in the application of the table if distribution system type were ignored.

The report attempts to define as clearly as possible the distribution system categories uses. While interpretive variations might still occur, we believe that the purposes of the model regulation are better served by making these distinctions, albeit imperfectly, than by ignoring them and assuring more serious distortions.

Since the purposes of the model regulation will require a periodic updating of the table, we look forward to the opportunity to improve its quality in future years.

Please contact me or Tim Harris, chairperson of the Project Oversight Group, if you have any questions or comments.

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Society of Actuaries Life Research Committee Report
to the NAIC Life Disclosure Working Group

Life Insurance Illustrations – Generally Recognized Expense Table

The Society of Actuaries Committee on Life Insurance Research (Committee) established a Project Oversight Group to develop or identify a table of expenses that would qualify as a "Generally Recognized Expense Table" (GRET) for the life insurance industry.

This GRET is to be relied upon by actuaries and insurance companies in their compliance with the NAIC Life Insurance Illustration Model Regulation (Model Reg) and the Actuarial Standard of Practice "Compliance with the NAIC Model Regulation on Life Insurance Sales Illustrations" (ASOP).

This table will represent the industry's expenses on a fully allocated basis. The use of this table, however, does not relieve actuaries and companies from the allocation of direct expenses in complying with the Model Reg and ASOP.

During the process of developing a Model Reg which both met the concerns of the regulators and still allowed the insurance industry to efficiently function, the issue of expenses became a sticking point.

A compromise position on the expense issue was proposed at the Snowbird, Utah, meeting among representatives from the NAIC, consumer organizations, the insurance industry and the Actuarial Standards Board (ASB). The proposed compromise was that the actuaries and the insurance industry would be allowed to use marginal expenses in complying with the self-supporting provision of the Model Reg to the extent that these marginal expenses (ME) were not less than those of the GRET. GRET expenses may be used if they are greater than the company's marginal expenses (Note: this is not clear from the Model Reg but is spelled out in the ASOP). The company's fully allocated expenses (FAE) may always be used regardless of their relationship to the GRET. Note that company direct sales costs are in addition to the GRET.

The following relationships result from this compromise using the acronyms previously defined and assuming that ME < FAE.

1) If	GRET < ME < FAE	Then use	ME or FAE
2) If	ME < GRET < FAE	Then use	GRET or FAE
3) If	ME < FAE < GRET	Then use	GRET or FAE

The mission of the Project Oversight Group was to:

- Identify existing industry expense tables and studies. Review these studies for accuracy, completeness, lines of business covered, categories of expenses included and period(s) of time covered.

- Address the split between direct and indirect expenses. Direct would obviously include commissions and indirect would include overhead. Determine where all else falls and, in particular, how companies with different sales compensation approaches should be dealt with equitably.

- Determine the appropriate form that a GRET should take, giving due consideration to:

i) Variations, if any, by company size or market, e.g., Career Agency vs. General Agency.
ii) Presentation of expense factors in the table to facilitate ease of application.
iii) Rates of inflation to be used for periods beyond the central point of time of the GRET.

- Recommend methods of combining table factors for comparison to company factors in order to comply with required relationships.

- Interface with the NAIC and the Life Committee of the Actuarial Standards Board and insurance industry representatives throughout this process.

- Present a proposed GRET to the NAIC for their approval well before the July 1996 date that had been set by the NAIC.

- Propose a method for updating the proposed GRET on at least an annual basis with consideration given to interim adjustments based on estimated inflation.

- Establish the set of expense factors that are appropriate for use as the GRET.

After reviewing the expense studies available to the industry, the Project Oversight Group focused on the One Source Database which was used in several of the studies. This is a database service which provides statutory data obtained from the NAIC. The database is updated on a monthly basis; however, there is a time lag of several months on the information included.

The following NAIC annual statement fields were accessed in One Source database.

NAIC Annual Statement References [1]			
Item	Acquisition	Maintenance	Aggregate
Policies	Exh of Life Ins.; 12, col 3	Exh of Life Ins.; . 5*(11, col 3 + 120, col 3)	N/A
Units	Exh of Life Ins.; 12, col 4	N/A	N/A
Premiums	Exh 1 Pt 1; col 3, 19a + 110a[2]	Exh 1 Pt 1; 120a, col 3	N/A
Expenses	N/A	N/A	Pg; col 3, 122 + 123[3]

[1] Group products to which the regulation is applicable were thought to be very similar in their expense elements to ordinary life. Therefore, no attempt was made to isolate the annual statement expenses attributable to group products marketed directly to individual members of a group.

[2] Single premiums were weighted using 6% after reduction for any dividends applied.

[3] Only the estimated life insurance component of FICA and unemployment tax was included. Premium taxes and other state and municipal taxes must be considered separately.

The group decided to use LOMA's functional cost expense factors as seed expense factors used in one of the published expense studies based on One Source data.

The Project Oversight Group was of the opinion that expense factors should not be shown separately by type of company ownership (stock vs mutual) and should not be stratified by company size. The group examined variations in expenses attributable to company distribution methods and decided that this refinement was appropriate. However, they were concerned about the difficulty of adequately defining distribution systems and the fact that many companies in today's environment actually market through multiple distribution systems.

After reviewing LOMA functional cost data and initial results using the One Source data, the Project Oversight Group decided to use four categories of distribution systems: Branch Office, Direct Marketing, Home Service and All Other. Companies were placed in the appropriate category based on research performed by Conning and Co. and public information (e.g., Bests' reports) for our analysis.

The expense factors were developed based on a review of the application of the LOMA seed expense factors to the 1995 statutory results of the 200 largest life insurance companies as measured by life insurance expenses. The sample represented approximately 90% of industry life insurance expenses. The final expense factors were derived by scaling the LOMA seed factors to cover the 50th percentile of the companies in each distribution system. This produced a set of expense factors which was slightly higher than the average.

The tables of expense factors by distribution system are shown below.

BRANCH OFFICE		
	Acquisition	Maintenance
Per Policy	$63.46	$31.75
Per Unit	$1.13	
Percent of Premium	70.26%	

DIRECT MARKETING		
	Acquisition	Maintenance
Per Policy	$79.95	$40.01
Per Unit	$1.42	
Percent of Premium	44.07%	

HOME SERVICE		
	Acquisition	Maintenance
Per Policy	$47.28	$23.66
Per Unit	$0.84	
Percent of Premium	26.06%	

ALL OTHER		
	Acquisition	Maintenance
Per Policy	$68.56	$34.31
Per Unit	$1.22	
Percent of Premium	37.80%	

Note the following in applying these expense factors:

- All of the expense factors are to be used and the results summed.
- Premiums for single premium products should be multiplied by 6% prior to the application of the percent of premium factor.
- These factors do not cover premium taxes, state and federal income taxes or commissions. All of these items must be considered in addition to the expenses generated by the GRET.

The factors by distribution system may be used by a company or division that meets the description of that distribution system. A company may use one set of GRET factors for a specific distribution system and another set of GRET factors for a separate distribution system but cannot mix GRET factors and the company's own, e.g., if a company chooses to use the GRET factors for their Home Service Division they can not use fully allocated factors for their Direct Marketing Division.

General descriptions of the different distribution systems are shown below. It is expected that actuaries will apply professional judgment in determining distribution system categories.

Branch Office – A company or division which operates an agency building system featuring field management that are employees although their compensation may be largely based on production. The company provides significant employee benefits to field employees in addition to direct compensation.

Direct Marketing – A company or division that markets directly to the public through printed or other media. No direct field compensation is involved.

Home Service – A company or division that markets smaller insurance policies through an organization that resembles the Branch Office system in organizational and compensation structure but focuses on smaller policies and agent collections of premiums. Note that we have focused only on the ordinary life business of companies and have not considered industrial business.

Other – Companies or divisions other than those described above including those that market through brokers and general agents.

No inflation adjustment is proposed for the table at this time. Recent LOMA data indicates a slight reduction in life insurance expenses factors in recent years.

This Project Oversight Group included the following individuals:

Doug Doll – Tillinghast–Towers Perrin
Tim Harris – Milliman & Robertson (Chair)
John Palmer – Life of Virginia and Society of Actuaries Vice President

Mark Peavy – NAIC
Irwin Vanderhoof – Chair of Society of Actuaries Research Committee

The following individuals and their organizations assisted the Project Oversight Group in this project.

Greg Story and Scott Cass – LOMA
Brad Smith and Susan Hunt – Milliman & Robertson, Inc. – Dallas Office
John Kleiman – Conning and Company

Please contact any of the Project Oversight Group members at their yearbook address with any comments or concerns that you may have.

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ATTACHMENT FIVE-F

QUESTIONS ON LIFE ILLUSTRATIONS MODEL REGULATION
DRAFT 5/23/96

Section 1. Purpose

1.1. How does the Life Illustrations Model Regulation affect the inclusion of the table of values in the individual's policy?

The model regulation applies to any information that could affect the decision of a consumer to purchase or renew a policy. Therefore it does apply to any information included in the policy that relates to nonguaranteed elements.

Section 3. Applicability and Scope

3.1. We sell a policy that is a combination of life insurance with a flexible premium annuity rider. The life policy is modified whole life with all guaranteed values. The annuity rider has a guaranteed interest rate, but also an interest sensitive element. It would appear that neither of these elements would presently come under the illustrations regulation, but since this policy is always sold with both elements present, the complete policy could be construed as an interest sensitive policy. Should we illustrate such a product to comply with the NAIC model? Should the life policy and annuity rider be illustrated separately or as one combined product?

Answer: In order to be an illustration, a presentation or depiction must include "nonguaranteed elements of a policy of life insurance." In the example cited above, the basic life insurance policy and the annuity rider each function as stand-alone products, so it is not logical to argue that there are any "non-guaranteed elements of a policy of life insurance." Therefore, while it would be appropriate to subject this policy to the requirements of a future annuity illustration regulation, there currently exist no standards by which to review this type of product.

3.2. If a traditional (nonparticipating) product has an annuity rider (fixed premium) attached and the annuity rider has excess (nonguaranteed) interest credited, is it subject to the regulation?

See above.

3.3. Will benefits provided by membership in a fraternal have to be included in the illustration?

The model regulation applies to life insurance policies without specifying types of organizations. Neither the purpose section of the regulation (Section 1) or the excepted policies (Section 3) given any indication that fraternals are excluded.

Section 4. Definitions

4.1. Are premiums on products such as paid-up additions riders contract premiums?

Section 4B of the model regulation says that if the rider requires payment of a premium, and benefits from the rider are shown in the illustration, the rider premiums are "contract premiums."

4.2. Are there exceptions to the requirement that the disciplined current scale be "reasonably based" on actual recent historical experience?

Yes. To gain an adequate understanding of what the disciplined current scale is, a thorough reading of both the regulation and standard of practice is necessary. One example of where the disciplined current scale may not be based on actual recent historical experience is where a change in practice has occurred. Section 5.4 of the standard of practice describes the way in which the disciplined current scale may be modified to reflect changes in practice which have not yet had time to result in actual changes in experience.

4.3. Suppose your current credited interest rate is 6.5%. If an agent submits an illustration using 6% (or any lower rate), is a "revised illustration" necessary?

Section 4G defines "illustrated scale" as a scale of non-guaranteed elements that is "not more favorable to the policy owner" than the lesser of the disciplined current scale or the currently payable scale. Assuming all of the requirements of the model regulation are met, use of an interest rate lower than 6.5% is permissible.

4.4. Are cost disclosures "illustrations"? "basic illustrations"? Do state cost disclosure regulations still apply?

The possibility for overlap with existing NAIC models and state regulations was discussed by the working group and the recommendations of the group are contained in a report attached to the March 1996 minutes. A letter was sent to each commissioner from the working group chair recommending that an illustration could take the place of a required policy summary. If a state chooses not to change such a rule, a policy summary and an illustration meeting the requirements of the illustrations regulation could both be required.

4.5. According to the regulation's definition, which of the following are "illustrations":

a. A rate book page for an indeterminate-premium term plan, with both guaranteed and current premiums.

b. A universal life brochure that talks about non-guaranteed elements (interest and mortality), but doesn't show any numbers.

c. Company-developed agent training material on a par. whole life plan that discusses dividend options, guaranteed cash values, etc., and shows some hypothetical projections.

d. An advertisement for a universal plan that shows the current interest rate.

e. A short print-out of numbers for a universal case that is generated through company-provided software, and is clearly labeled for agent use only, not for use with a client, and is used by an agent in his office to compare and contrast his own company's plans, so he can arrive at the best strategy before seeing the client.

f. A company announcement on a new dividend scale that discusses the changes to be implemented in the various elements.

The working group's minutes reflect an intent to interpret the term broadly. The following answers assume the material might be shown to the prospect.

a. A rate book would be considered an illustration if it showed nonguaranteed elements over a period of years.

b. A brochure describing nonguaranteed elements without any actual examples would not be a "ledger or proposal showing nonguaranteed elements."

c. Agent training materials would be illustrations if the agent used them in the sales process. If they were restricted to the training process, they would not.

d. An advertisement showing current interest rates would not be an illustration because it does not constitute a display over a period of years. However, the regulation requires the agent to certify that he has made no statements inconsistent with the illustration, so use in the sales process of an advertisement showing numbers in excess of what can be shown in an illustration would not be permitted. The agent would also need to be careful to clearly represent that this was the current rate and not to imply that the current interest rate would apply into the future.

e. The use of such a print-out requires the company to rigorously enforce the prohibition against disclosing this material to the potential insured. If the company merely stamps "for agent use only" on the material but makes no serious follow-up effort to assure that the material is not being misused, then "for agent use only" would not be a credible defense as to why the material did not meet the definition of an illustration. The company would prescribe that standard procedure will be for the agent to use the information to prepare a basic illustration meeting the requirements of the model, and then dispose of the print-out.

f. A company announcement to existing policyholders might rise to the level of an in force illustration if it depicted future dividends that are not guaranteed. It would not be an illustration if it dealt only with declared dividends that are guaranteed.

4.6. Section 3 indicates that the model is applicable to group life policies and certificates, however Section 4H indicates that an illustration by definition contains "non-guaranteed elements" over "a period of years." Now if a regular old garden variety group term life plan is sold and an "illustration" (using the term loosely here) is provided to the employer in the course of that sale indicating covered lives, volume and monthly premium, is that an "illustration" in the terms of the regulation? It covers one year (not years), and the rate is the rate—no non-guaranteed elements.

This is not an "illustration" and is not covered by the regulation.

4.7. Is a handwritten worksheet considered an illustration?

Since it is a "depiction" (Section 4H of the model), it is not excluded from the definition of "illustration" merely by being a handwritten worksheet.

4.8. Is marketing on the Internet considered an illustration? We need a clear definition of what an illustration is.

Since marketing on the Internet involves a "presentation or depiction" (Section 4H of the model), information so communicated is not excluded from the definition of "illustration" merely because it is sent via Internet.

Section 5. Policies to be Illustrated

5.1. Does a policy which the company discloses is to be marketed without an illustration need to pass the actuarial test?

The model regulation requires no actuarial tests for such policies.

5.2. How do you show a re-proposal on a policy that is six months old? Does it need to comply as a new issue or in force?

Section 5B of the model regulation implies that use of an illustration prior to the first policy anniversary constitutes "marketing" with the illustration. Accordingly, use of an illustration with a six-month-old policy constitutes use "in the sale" of the policy. Section 4H(3) says an in force illustration must be furnished at any time after the policy has been in force for one year or more.

5.3. If a policy form has been designated as marketed without illustrations, can an in-force illustration be required after the first policy year?

Section 5B of the model regulation says that if an insurer identifies a policy form as one to be marketed without an illustration, any use of an illustration for any policy using that form prior to the first policy anniversary is prohibited. Section 4H(3) defines an in-force illustration as one furnished at any time after the policy has been in force for one year or more. Section 10C says an in-force illustration shall be furnished upon the request of the policy owner.

5.4. Is group term life included in the provisions of Section 5C and D?

When discussing the applicability of the model to term life, the drafters went through the entire model and identified provisions that would not apply to term life. No such designation is included in Section 5C and D.

5.5. It seems that a typical group term life plan would be defined as "non-term group life" under Section 4L of the regulation. In a typical plan, the employer selects the benefits and levels, pays the premium, and the group is issued on approval of the underwriters (group underwriting?). It seems odd to call this "non-term group life." If in fact that is the case, then Section 5D would indicate that "quotations" should be provided and "illustrations" on request. The wording seems to obviously be directed at more typical examples of "non-term group life," such as group universal—obviously a whole different ball game.

The definition is aimed at non-term types of group plans and was not intended to imply that group term life was included. The minutes of the Nov. 8, 1995, conference call make clear that the drafters changed the language from "universal life" to "non-term group life" so it would include group traditional whole life. However, even if the definition in Section 4L includes what most would regard as group term products, this does not create a problem. As pointed out in #11, an insurer may choose never to use an illustration; nothing in Section 5D compels them to do so. Instead, if a policy form uses an illustration, then Section 5D functions as a liberalization of the regulation which permits the deferral of the delivery of the basic illustration until the time the certificate is delivered.

5.6. If a traditional (nonparticipating) product has a guaranteed renewable disability income rider attached, is it subject to the regulation because of the nonguaranteed premiums of the rider?

Section 5C of the model regulation indicates that, if a policy form is to be marketed with an illustration, a basic illustration (defined to include both guaranteed and nonguaranteed elements) prepared and delivered in accord with the regulation is required.

5.7. Are payroll deduction sales of small (but over $10,000) universal life policies, sold via employer sponsored meetings, considered sales to individual group members (because they sign an individual application) or are they considered group sales and therefore exempt from this regulation?

Section 5C of the model regulation indicates that a basic illustration need not be provided to individual members of a group or to individuals insured under multiple lives coverage issued to a single applicant unless the coverage is marketed to these individuals. If individual applications are signed, as postulated in the question, it would appear that coverage was marketed to such individuals and therefore an illustration is required. Further, Section 5D indicates that a basic illustration shall be provided at delivery of the certificate to enrollees for non-term group life, i.e., payroll deduction, who enroll for more than the minimum premium necessary to provide pure death benefit protection.

Section 6. General Rules and Prohibitions

6.1. Some have argued that the disciplined current scale is subject to the self-support and lapse-support tests. Others have argued that it is actually the illustrated scale that is subject to the self-support and lapse-support tests. Which position is correct? Does the answer have any practical implications?

It is actually the illustrated scale which is subject to the self-support and lapse support test. The disciplined current scale is merely used in determining the accumulated cash flows within those tests. It is the values of the illustrated scale that are compared against the accumulated cash flows when testing for compliance. There may be little in the way of practical implications of this, other than giving the illustration actuary somewhat more flexibility than he or she would otherwise have in setting the disciplined current scale.

6.2. Under the generic name requirement, the regulation refers to "flex premium benefit life." Is "universal life" acceptable as a generic name?

Presumably, states that have permitted use of "universal life" as a short title will continue to permit its use.

6.3. Are new policies that come into existence as a result of term conversions or the exercise of a guaranteed purchase option subject to the regulation? Note that these policies are not marketed in the same way that most policies are.

There is no specific exclusion for term conversions, etc. in the model regulation. Assuming that the new policy is one that has been identified as marketed with illustrations, it would seem evident that an illustration would be expected by a regulator.

6.4. If a policy form is designated to be marketed with an illustration, can you not show an illustration if there are riders added to the policy you do not wish to illustrate?

One is not allowed to provide an incomplete illustration (Section 6B(6)). Moreover, one should not be able to avoid an illustration simply by adding one or more riders. If a policy form is designated to be marketed with an illustration, then a basic illustration of that policy form must be provided. The benefits provided by the riders should be included in the basic illustration.

6.5. How are requested changes to an active policy to be illustrated (e.g., an increase or decrease in death benefit, addition of an optional rider, or change in dividend option)? Are such changes considered a new policy with an entirely new basic illustration or does this require an in-force illustration?

The model regulation makes reference to "marketing policies" (Section 5) and "sale of a life insurance policy" (Section 9) but does not specifically refer to policy changes. It would appear that the "spirit" of the model regulation would require the use of an illustration when such a change is being proposed by the insurer or its agent.

6.6. Assume that a company has decided to illustrate a term product. This product is then quoted by a term quote service. Is an illustration required with the quote or only on the select product you deliver?

The obligation to provide an appropriate illustration is an obligation of an insurer, its producers or other authorized representatives. If the quote service does not fall into one of those categories, presumably it would not be required to provide an illustration meeting the requirements of the model regulation. An agent or company selling the product would be required to produce an illustration.

6.7. How will agent/broker produced illustrations comparing several companies' premiums side-by-side be impacted by this new model?

Any effort to sell a particular policy would require the agent/broker to provide the illustration required by the model regulation.

Section 7. Standards for Basic Illustrations

7.1. Does the law really define the format (i.e., sequence of text, etc.)? It appears that the numeric summary must follow the narrative summary and that the signature blocks must appear with the summary. But nowhere does it say that the summary must immediately follow the narrative. My feeling is that a summary or a summation is a cursory review of the detail. Therefore can the signature block appear last?

The model says the signatures must appear on the same page as the numeric summary.

7.2. Will other numbering systems suffice for § 7A(2) or is that a standard rather than an example.

The numbering "four of seven" in the model is an example rather than a standard. The intent of the working group was clearly to alert the applicant that he had not received all the pages. Any similar system that achieves that goal is suitable.

7.3. Since "premium outlay" is "net out of pocket," should loan and withdrawal payments be netted from this column?

"Out-of-pocket" presumably refers to the total amount remitted to the insurer by the premium payer. Loan repayments are part of the total amount remitted, and therefore should be included in "premium outlay." Withdrawals are not part of the remitted amount, and should not be included.

7.4. If a company is illustrating the effect of loans on policy values, what do they illustrate in the "guaranteed" column if the contract does not specify a maximum interest rate?

If the contract does not explicitly specify a maximum interest rate, then the maximum rate of interest which could be charged under state and federal law would have to be utilized in illustrating guaranteed values.

7.5. Companies have some flexibility as to what constitutes a basic illustration. I assume it was meant to range anywhere from only a full pay illustration to much more complex patterns. However, I believe that the regulation states that the premiums shown in the basic illustration must be those anticipated by the policyholder. How does this reconcile with the concept of having basic illustrations be full pay only? Furthermore, how useful would it be to have signed full pay illustrations in the file if the policy was sold anticipating some other payment pattern?

Section 7E(1)(a) of the model regulation requires that the illustration be based on the premium and mode of payment that the applicant plans to pay.

Section 7A(5) requires that the assumed payments on which the illustrated benefits and values are based shall be identified as premium outlay or contract premium, as applicable. For fixed premium policies, the contract premium must be shown and full disclosure is required under 7A(13) if nonguaranteed credits are used to reduce the premium outlay below the contract premium or to zero so that it does not appear the policy is paid up. For flexible premium policies there is no specified contract premium and the basic illustration must be based on the premium outlay anticipated to be paid by the policyholder.

7.6. Do graphs, charts, concepts have to be included in the pagination?

Section 7A(2) of the model regulation says that each page, including any explanatory notes or pages, shall be numbered and show its relationship to the total number of pages in the illustration.

7.7. What is the term of the contract referenced in Section 7B(2) for a contract without a maturity date?

The working group has not addressed this issue. It would seem reasonable to use the limiting age underlying the valuation table or to use age 100, consistent with the tabular detail specified in Section 7E(1).

7.8. Minimum premium payable to keep policy in force: level annual? n-pay premium? single? any desired pattern?

Section 7B(2) of the model regulation requires that the illustration "show the premium outlay that must be paid to guarantee coverage for the term of the contract... ." The illustration may show any pattern of premium payments that are exactly sufficient to guarantee the coverage.

7.9. Sec. 7B(2) requires that the illustrations show the premium outlay that must be paid to guarantee coverage for the term of the contract, subject to the maximum premiums allowable to qualify as life insurance under the Internal Revenue Code. Suppose the guideline level premium under the IRC is $1,000 per year; the illustration assumes a monthly mode; the premium required to guarantee coverage is $1,100 paid annually or $100 paid monthly. Which of these three numbers do we show?

Section 7B(2) does not preclude the illustrating of premiums which exceed the guideline premiums in Section 7702 of the IRC. Rather, it merely compels the insurer to at least show the lesser of a) the premium outlay required to guarantee coverage and b) the maximum premium allowable to qualify as a life insurance policy under the applicable provisions of the IRC. Thus, in the cited example, if the insurer does not want to illustrate premium payments over $1,000 per year, this is permissible. However, if the insurer wants to illustrate the payment of $1,200 during each policy year, paid by $100 monthly premiums, this is permissible also. Assuming that the $1,200 premium is illustrated in the numeric summary, the insurer would be required to disclose in the narrative summary that $1,000 is the maximum premium qualifying premium under the IRC. In this circumstance, the insurer would need to clearly disclose that the $1,200 premium violated the guideline premium test.

7.10. Section 3 of the illustration regulation lists the exceptions to the regulation. Riders are not listed as an exception. Section 7B(3) states that a basic illustration shall include a brief description of any policy features, riders or options, guaranteed or non-guaranteed, shown in the basic illustration and the impact they may have on the benefits and values of the policy. Does this mean that riders that pay dividends, such as a 10-year level term rider, are exempt from the disciplined scale requirements and from the self-support and lapse-support tests? What about a product like flexible whole life which has a rider made up of a combination of one-year term and paid-up whole life?

No non-guaranteed element, whether provided through the base policy or rider, is exempt from the self-support and lapse-support tests.

7.11. Can the description of supplementary benefits and riders be in footnotes or must they all be included in the text of the narrative summary?

Section 7B(3) says the narrative summary shall include a brief description of any policy features, riders or options, guaranteed or nonguaranteed, shown in the basic illustration. Section 1 articulates the goal of eliminating footnotes as much as possible.

7.12. Where do you see the information being disclosed that ties the various insureds with their risk classes, face amounts, riders associated with the specific insureds? It does not appear that this information can easily fit into a "brief" narrative or policy description.

Section 7B of the model regulation uses the phrase "brief description" without definition. Each company must provide its own interpretation.

7.13. If an agent illustrates at issue a change in benefit, such as a face amount decrease after five years, does the company have to automatically honor this change when this change date occurs, or can the company wait for the policyholder to request the change at that future date?

The inclusion of a future benefit reduction in an illustration does not, by itself, obligate or authorize the insurer to implement the benefit reduction. The language contained in the policy itself will control the insurer's practice. Section 7B(3) of the model regulation requires that the insurer include a description of any future benefit reduction (and the policyholder's options with respect to the changes) if it affects any information (e.g., Numeric Summary, Tabular Detail) contained in the illustration.

7.14. If the basic illustration includes a depiction of paid-up additions on paid-up additions, settlement options, etc., do they all have to be factored into the illustrated scale at "50%"?

The numeric summary required by Section 7C says that all values shown in the illustration must be calculated on three different bases, one of which is dividends at 50% of those contained in the illustrated scale.

7.15. Are illustrated reductions going to be defined/explained—can a straight average of current and guaranteed be used, or must components (like mortality, interest, rider charges, expenses) be averaged?

In the case of participating policies, the dividends in the reduced scale are to be one half of the corresponding dividends in the illustrated scale. In the case of policies with nonguaranteed elements of other types, each experience factor (interest rate, mortality rate, etc.) is to be the average of the corresponding factor underlying the illustrated scale and the guaranteed factor.

7.16. Section 7C(1)(c) refers to numeric summary guaranteed values, illustrated values and 50% basis. The last one's "average" values are not exactly arithmetic mean value, are they? If not, would you please elaborate how these values can be determined? The calculated values may not be exactly average of guaranteed and illustrated values.

Section 7C(1)(c)(ii) and (iii) uses the word "average" but do not give an example of how the calculation is to be performed. The result expected by the working group lies one-half the way between guaranteed and illustrated charges.

7.17. Can the numeric summary be restricted to annual premium mode only or must it use the same mode as in the tabular detail?

Section 7C(1) says the numeric summary shall include the premium outlay. Section 7E(1)(a) says the tabular detail shall show the premium outlay and mode the applicant plans to pay. The numeric summary and the tabular detail should be consistent with each other.

7.18. Can illustrated nonguaranteed interest credits increase with duration?

Yes, but with certain constraints. The regulation states that "if an interest rate used to determine the illustrated non-guaranteed elements is shown, it shall not be greater than the earned interest rate underlying the disciplined current scale." Thus, even if the cash values which are illustrated are increasing at a rate greater than the interest rate underlying the disciplined current scale, no interest rate greater than that underlying the disciplined current scale can be explicitly displayed.

7.19. Do the same disciplined current scale, illustrated scale, and experience factors underlying the disciplined current scale apply equally to new business illustrations and in force illustrations of the same policy form?

It depends on whether the same conditions pertain to new business and in force policies. For example, a company that credits interest on the basis of new money rates would have different "recent experience" applicable to new issues and in force business. However, expense assumptions might apply equally to all business. If different disciplined current scales, illustrated scales, and experience factors did exist, this should be prominently disclosed in the annual certification. The illustration actuary should carefully read Section 5.3.6 of Actuarial Standard of Practice No. 24 for guidance on in force illustrations.

7.20. Is it acceptable to illustrate interest credits for policies with large face amounts that are higher than the interest rate underlying the disciplined current scale, so long as policies with low face amounts have their interest credits reduced so that the overall policy form is self-supporting?

Yes, this would appear to be acceptable, although the illustration actuary would be responsible for monitoring experience to make sure the assumed sales of low face amounts are enough to sustain the higher amounts credited to the larger policies.

7.21. For a new policy form relative to which a company argues it sells no similar forms, how does the regulator determine what a realistic currently payable scale is?

There is no precise answer possible for this question. However, if the company's other policies utilize disciplined current scales that are generally greater than the corresponding currently payable scales, the regulator should question the company as to why it is realistic to expect that this policy form will be different.

7.22. With the requirement that all nonguaranteed elements be described in the contract, will policies illustrated with "persistency bonuses" need to be refiled to include a description of these bonuses?

Section 7E(3) says that nonguaranteed elements may be shown (in the illustration) if they have been described in the contract. Therefore, a company wishing to include a persistency bonus in its illustration it would need to include a description in the policy.

7.23. Doesn't Section 7E(2) need some more words to clearly express its intent?

The meaning of Section 7E(2) is clear, even if the wording is somewhat awkward. The guaranteed policy values should be those that will be provided if the contract premium is paid.

7.24. Must the tabular detail be shown at the premium mode that is expected to be paid, or can annualized premium be used? This would obviate having to calculate interpolated net single premiums for some riders.

Section 7E(1)(a) says the illustration shall include the premium outlay and mode the applicant plans to pay.

7.25. If a nonguaranteed element is not shown in the contract, it cannot be illustrated. If it is the company's practice to pay a persistency bonus, may it be illustrated as long as a zero is shown in the guaranteed column?

The phrasing of the question leaves the impression that the company does not plan to include a description of its persistency bonus in the contract. If that is the situation, Section 7E(3) says the persistency bonus cannot be shown in the illustration. Showing a zero in the guaranteed column is not proper compliance with 7E(3).

7.26. If the expected premium outlay but not the contract premium on a traditional policy is to change at some point after the 10th policy year, need that be shown in the tabular display, or will it suffice to just show every fifth year ending at 100, etc.?

Section 7E(1) of the model regulation indicates that the tabular detail will need to be shown (except for term insurance beyond the 20th year) for any year in which the premium outlay is to change.

7.27. Are there any special provisions regarding terminal dividends?

Section 7E(3) of the model regulation contains the following statement: "In the case of an illustration for a policy on which the insurer intends to credit terminal dividends, they may be shown if the insurer's current practice is to pay terminal dividends."

7.28. Section 7E(3) states "nonguaranteed elements may be shown if described in the contract." What does "if described" mean?

The model regulation provides no specific guidance. Failure to make any reference in the policy to any particular nonguaranteed element means that it cannot be illustrated.

Section 9. Delivery of Illustrations and Record Retention

9.1. If a person applies for a flexible premium policy and states a planned premium of $600/month, but at application changes to $500 per month, is the illustration not "as applied for"?

The policy would not have been issued "as applied for" and a new illustration would be required at the time of policy delivery.

9.2. "Other than applied for" may mean that the beneficiary or address changes. It may mean in a § 1035 exchange that the exact amount of the proceeds to be applied from another policy are not known until weeks or even months after the policy is issued. Do these situations require a revised illustration?

There is no requirement that the illustration show the intended beneficiary. This type of change would not necessitate a revised illustration. A change of address could be a significant change, for example if the applicant moved across a state line, and, regardless, could indicate a lack of due diligence if future communications were mailed to the wrong address. If the amount of the § 1035 exchange was not known, a revised illustration would be required when that amount became known.

9.3. Is an agent's signature required on revised illustrations sent from the home office?

Section 7D(2) of the model regulation says that the statement must be signed and dated "by the insurance producer or other authorized representative of the insurer."

Section 9A(2) says the revised illustration shall conform to the requirements of the model regulation, shall be labeled "Revised Illustration," and shall be signed and dated by the applicant and producer or other authorized representative of the insurer.

9.4. For Section 9B(1), is it permissible to show an illustration conforming to the model requirements on a computer screen, and obtain the signature at policy delivery?

Section 9A(1) requires a signature at application if a basic illustration is used by the producer. It does not limit that requirement to printed format. If the agent is unable to print out the illustration, he or she should return with a print-out and obtain the necessary signature before submitting the application. Section 9B(1) only applies if no illustration has been used.

9.5. Now looking at Sections 5A and 9B, if in fact the situation described above is not an "illustration," the regulation seems to indicate that notification to that effect needs to be given to the commissioner, and furthermore that signatures need to be obtained from the agent and potential insured that no illustration was provided. Am I reading this right?

The insurer may choose never to use illustrations for this policy form, and then the certification to the commissioner provided for in Section 5A is required. If the policy form is typically sold with an illustration, but isn't in this instance, Section 9B applies, and signatures are required that no illustration was provided at time of application, and an illustration will be required at time of policy delivery.

9.6. (a) Must the copies in the company's policy owner file be paper copies or is it satisfactory to have the capability to regenerate an exact duplicate of the illustration used in the sale? Can only the signature page be retained, or the signature be imaged into the computer illustration?

(b) If the insurer can show § 9C due diligence, must it still retain the signed illustration page?

(a) The purpose of the signature page in the file is to assure a market conduct examiner that the standards in the regulation have been followed. In order for the examiner to be assured by a computer-generated duplicate of the illustration used in the sale and/or a computer imaged signature, the company's system must be reliable enough to convince the examiner that the technology used by the company will freeze the illustration at the time of solicitation so that it would not be possible to change it before or after placing it in the applicant's electronic file. The technology used might be hardware that scans in the actual illustration used and the applicant's signature and preserves it, or a program that stores the parameters to allow the recreation of the illustration used.

(b) The Section 9C due diligence requirement applies only when the illustration is mailed out from the insurer's office rather than provided by the agent. If no signed page is returned, the due diligence standards are sufficient.

9.7. Does § 9D require an insurer to keep a signed certification from the original sale and a subsequently delivered basic illustration and a revised basic illustration if issued other than as applied for?

Yes, the plain language of the subsection does make that requirement. When discussing this requirement, there was mention made by the working group that this would be useful to point out a pattern of agents illustrating policies not as issued.

Section 10. Annual Report; Notice to Policy Owners

10.1. If a person buys a policy in a state that has not adopted the regulation, then moves to a state that has, which state's regulations govern in force illustrations?

General contract law would require you to use the law of the state where the contract was made. However, the laws of the particular states in question should be researched in order to determine whether this general rule applies.

Section 11. Annual Certifications

11.1. Can consultants be hired to perform the "illustration actuary" function?

The model regulation does not require the illustration actuary to be an employee of the insurer.

11.2. Is it acceptable for a holding company to allocate expenses disproportionately among its subsidiaries so as to make the illustrations of certain subsidiaries more favorable?

No. In addition, it would be a violation of Section 5A(1)(c) of the NAIC's Holding Company Act to allocate expenses in this manner.

11.3. Can an insurance company that is the part of the same holding group as a bank negotiate an artificially high interest rate on a deposit with the bank in order to make the illustrations more attractive?

Section 5A(1)(a) of the Model Holding Company Act prohibits transactions within a holding company system which are not "fair and reasonable."

11.4. When one policy form is sold through two different distribution channels, does the illustration actuary need to prepare two illustrations and certifications to reflect the differing distribution channels, or can one illustration and certification be prepared that reflects an average of the two?

Unless there is a compelling reason to do otherwise, the clear intent of the regulation and standard of practice is to test for compliance on a policy form basis, assuming a mix of policies consistent with actual experience. However, an unyielding adherence to this approach could lead to undesirable results. In fact, an insurer is prohibited from using or describing "non-guaranteed elements in a manner that is misleading or has the capacity to mislead" (Section 7B(2)). Combining policies which are anticipated to credit significantly different non-guaranteed elements would clearly have "the capacity to mislead." Therefore, in the new or annual certification, the actuary should clearly disclose that, in order to comply with the prohibition against misleading illustrations, he/she has separated policies within the forms into homogeneous blocks.

11.5. If one group universal life policy form is utilized to write business where some of the nonguaranteed elements reflect group-specific experience, does the illustration actuary have to tailor-make the illustration and certification for each group, or can the illustration reflect some sort of averaging of all the groups insured under the policy form?

See answer above.

11.6. Must (a) each illustrated value for the specific demographic/premium paying/benefit combination for each insured who receives an illustration meet the definition of self-supporting and non lapse-supported, or (b) can the insurance company certify that the self-supporting and lapse supported tests are met looking at accumulated cash flows in the aggregate across the assumed distribution of ages, premium-paying patterns, etc.?

Provision (b) is the correct answer. The regulation speaks to certifying of the policy form, and, unless you have a situation like those described in questions 11.4 and 11.5, certification must be done at the policy form level.

11.7. Under fully-allocated expenses, does each policy form have to receive some allocation of general overhead expenses, such as rent, furniture and equipment expense, and the president's compensation?

Yes, each policy form must receive a proportion of the general overhead expenses which is reasonably related to the actual incidence of costs for that form. The standard of practice states that "indirect costs should be fully allocated using a sound basis of expense allocation." Some have argued that the company could create a policy form for which it does not intend to use illustrations, and allocate all indirect expenses to that form. This would effectively allow the company to use marginal expenses while stating in its certifications that it is using fully allocated expenses, or a company could argue that it is allocating all of its indirect expenses to non-life lines, and accomplish the same thing. In short, if the regulation and standard of practice are interpreted so as not to require that indirect expenses be spread over all policy forms which are reasonably related to the incurral of these expenses, then situations will inevitably arise which make the phrase "full expense allocation" nothing more than a subterfuge.

11.8. Does the allocation of assets among policies for purposes of illustration certification have to be the same as the allocation of assets for statutory cash flow testing? Does the allocation of expenses for purposes of illustration certification have to be the same as the allocation of expenses done for statutory financial reporting?

There may be valid reasons for differences between allocations on a statutory and illustration basis. However, as much consistency as possible should be maintained between the two, and the illustration actuary should be prepared to explain any differences.

11.9. If a policy form is 100% reinsured, are the "experience factors" defined in the standard of practice the actual experience of the direct insurer, the actual experience of the reinsurer, or the interest, mortality, and expense elements specified in the reinsurance contract?

Generally, the experience factors should reflect the interest, mortality and expense elements specified in the reinsurance contract. However, the actuary should be prepared to demonstrate that the values incorporated into the reinsurance contract accurately reflect the underlying interest, mortality, and expenses that can be reasonably anticipated for the reinsured block. Otherwise, the use of reinsurance might become a gaming device for the creation of aggressive illustrations.

11.10. If the valuation actuary changes his or her opinion as to what constitutes recent historical experience prior to the deadline for the next annual certification, does the actuary have to change the disciplined current scale?

If recent historical experience has deteriorated (e.g., expenses have increased, investment yields have diminished), then the illustration actuary should conduct studies to determine if the disciplined current scale is still consisteut with recent historical experience. Otherwise, an insurer may be in violation of Section 7B(2) (prohibition of using or describing nonguaranteed elements in a manner that is misleading or has the capacity to mislead).

11.11. What is the basis for the generally recognized expense table?

As indicated in Section 4K(1)(c) of the model, the generally recognized expense table will be based on the experience of a number of companies, using fully allocated expenses. The Society of Actuaries is currently developing tables appropriate for this purpose for consideration and adoption by the NAIC.

11.12. Is there relief for any unusual expense items when it comes to determining expense assumptions? What if there is a one-time expense in 1996, such as purchases of new administration software? Does that have to be reflected in 1997 illustrations?

Section 5.3.3.e.1. of the Actuarial Standard of Practice states, "Nonrecurring costs, such as systems development costs, may be spread over a reasonable number of years (e.g., system lifetime) in determining the allocable expenses for a particular year."

11.13. Can the unit expense, fully allocated or marginal, vary by product?

Yes. Two sources of variation, as indicated in Section 5.3.3.e of the Actuarial Standard of Practice may be the average policy size and volume of sales for a particular policy block. The allocated costs may also vary.

11.14. Will the different costs of various levels of underwriting (guaranteed issue, simplified issue, nonmed, paramed, etc.) be recognized within the expense structure?

Presumably, differing costs of various levels of underwriting can be reflected in a company's own fully allocated or marginally allocated expense assumptions.

11.15. In the individual life product line, may you choose only one of the expense methods for that line regardless of the product (term vs. universal life vs. par universal life, etc.)?

Section 4K(1) of the model regulation says "the insurer may choose to designate each year the method of determining assumed expenses for all policy forms . . ." In addition, Section 5.3.3.e. of the Actuarial Standard of Practice indicates that the same expense method—fully allocated, marginally allocated, or generally recognized study—must be used for all policy forms during the certification year.

11.16. Is it appropriate to exclude the cost of complying with the illustration regulation in setting the (allocated) expense levels?

The cost of complying with the illustration regulation should be allocated in a manner consistent with the method of allocating other expenses.

11.17. What is a "similar" in-force policy under Section 11C(5)?

The question of what policies, if any, are "similar" would seem to be a matter of professional judgment.

11.18. If the illustration is based on zero-profit (minimum), why must income tax be included?

Section 5.3.3.C. of the Actuarial Standard of Practice says the cash flows used in carrying out the self-supporting test should include cash flows arising from all applicable taxes. All income taxes, except the additional tax associated with the differential earnings rate, should be recognized in accordance with their impact by duration in the self-supporting test. However, to the extent that the underlying assumptions would result in no income tax liability being incurred, then clearly the disciplined current scale would not reflect any expense for income taxes.

11.19. What if no company or industry experience exists for a certain experience factor, i.e., level of antiselection, effectiveness on select and ultimate term products—what does the actuary do?

Section 5.3.3 of the ASOP says that when no experience of the given company or under similar classes of business in that company or other companies is available, "other sources" may be used.

11.20. How narrowly is disciplined current scale to be defined, i.e., can it say interest rate margin is between 1.25% and 1.75%, if 1.25% margin passes tests?

The interest assumption underlying the disciplined current scale is an interest rate (e.g., 7.00%), not a "margin."

11.21. For interest and mortality assumptions for the disciplined current scale, is there any guidance on what is considered credible and what is the definition of recent?

Section 5.3.3.a. and b. of the Actuarial Standard of Practice contains guidance on "recent." For guidance on "credible," Actuarial Standard of Practice No. 23, "Data Quality," might be consulted.

11.22. How does an illustration actuary demonstrate that the required tests have been met?

Section 6.3. of the Actuarial Standard of Practice gives sufficient guidance.

11.23. Suppose a block of business is sold from one company to another. Would the company purchasing the business immediately have to apply its own standards to the illustrations, or would there be a transition period during which they could continue to rely on the prior company's certification, disciplined current scale, and illustrated scale?

Before the company purchasing the business can issue illustrations, it will have to file a certification with the commissioner. This is necessary because there is no assurance that the recent historical experience for the prior company will be applicable to the new company.

11.24. Can a disciplined current scale be changed more often than annually? Must a changed scale be refiled?

The disciplined current scale is to be reasonably based on recent historical experience. If the illustration actuary's judgment regarding recent historical experience changes more frequently than annually, then good actuarial practice would suggest changing the disciplined current scale more frequently than annually. Specifically, Section 5.3.4 of the ASOP says "changes in experience should be reflected promptly once they have been determined to be significant and continuing."

The question of whether to refile the scale was answered by the working group in its report at the June 1995 meeting. An earlier draft had contained a requirement for a new filing each time the scale changed. The working group agreed it was not necessary to certify each time a change was made. Instead the actuary was allowed to wait until the annual certification date.

11.25. When an actuary certifies that an illustrated scale is in compliance with the regulation, is that actuary certifying as to all illustrated scales since the last certification, illustrated scales currently being used, or something else?

The actuary is certifying to all illustrated scales in use at the time of the certification as well as all illustrated scales used since the previous certification.

11.26. Must an insurer file § 11 certifications both before the effective date of the regulation and later on the date the insurer elects under Subsection G?

Perhaps the language of Section 11D is not as clear as it should be. The intent of the Life Disclosure Working group was clear. All policy forms, whether existing on the effective date of the regulation or developed later, should not be illustrated until after a certification has been filed with the Commissioner. The answer to the question being asked is "yes" and a technical amendment will be proposed to the model to delete the word "new" in Section 11D(1)(b). Then there will be no question that an insurer will file a certification when the regulation becomes effective, and again on the date it chooses, which might be a week or a month or a year later.

11.27. Will the actuarial certification be subject to review as part of the regular state examination process?

Yes, probably as part of the market conduct examination.

11.28. The Actuarial Standard of Practice is directed at compliance with the NAIC Model. What kind of standard would be applied if some state adopts a regulation significantly different from the model?

ASOP Section 1.2, "Scope," says: "Actuaries involved in the preparation of illustrations subject to a regulation that differs materially from the model may consider the guidance in this standard to the extent that it is applicable and appropriate." There is no actuarial guidance for any provisions contained in a particular state's law or regulation which are not also part of the model.