Brian Bayerle  
Senior Actuary  

October 2, 2019  

Mr. Mike Boerner  
Chair, NAIC Life Actuarial Task Force  

Re: Individual Life Insurance Mortality Improvement Scale Recommendation  

Dear Mike:  

The American Council of Life Insurers (ACLI)\(^1\) appreciates the opportunity to comment on the exposed Individual Life Insurance Mortality Improvement Scale Recommendation for Use with AG 38 and VM-20 on behalf of our member companies.  

ACLI appreciates the diligent work of the SOA in the development of the updated mortality improvement scale. ACLI recognizes there has been mortality deterioration in certain segments of the general population; however, it is not clear that such deterioration has occurred in the insured population. Member companies are not reporting the level of deterioration in their blocks of business that have been recognized in the general population. However, a 7-day exposure period for this scale does not allow enough time for companies to reconcile the differences between their results and the SOA study. Furthermore, we don’t believe that the automatic table updates allowed by the Valuation Manual extend to the mortality improvement scale, as the tables that are automatically updated follow a documented methodology in the Valuation Manual and are not subject to discretionary judgement. That is clearly not the case for the mortality improvement factors.  

In addition to the process concerns, ACLI is greatly concerned about the limited time for companies to implement and assess the impact to their reserve levels. While the impact is likely small for PBR, the impact on AG 38 could be quite significant. The current process of adopting changes to the mortality improvement scale during the Fall, with only three months to understand and implement the change, has been problematic for some time. This concern is magnified when the scale reflects a deterioration.  

Our other concerns regarding the scalars are as follows:  

**Additional analysis is necessary**  

More work needs to be done to understand differences between the insured and population mortality data. To date, the mortality improvement scale has been developed using purely population mortality due to limitations in available insured data. However, Kansas and New York data calls have existed for several years expressly for the purpose of updating mortality tables. In fact, this data was contemplated in a recent SOA report on individual life mortality experience:  

\(^1\) ACLI is a Washington, D.C.-based trade association with approximately 290 member companies operating in the United States and abroad. ACLI advocates in state, federal, and international forums for public policy that supports the industry marketplace and the 75 million American families that rely on life insurers’ products for financial and retirement security. ACLI members offer life insurance, annuities, retirement plans, long-term care and disability income insurance, and reinsurance, representing 95 percent of industry assets, 93 percent of life insurance premiums, and 98 percent of annuity considerations in the United States. Learn more at [www.acli.com](http://www.acli.com).
https://www.soa.org/globalassets/assets/Files/resources/research-report/2019/individual-life-
mortality-experience.pdf. The mortality improvement scale is an interim mortality change, and this available data should be considered in determining if the impact of the deterioration is consistent with the insured population. ACLI understands that availability of Causes of death (CODs) within the Kansas and New York data calls are limited as they are not a required field. ACLI would suggest that LATF investigate the possibility to increase the availability of CODs in future submissions.

The most recent SOA research on population mortality (https://www.soa.org/globalassets/assets/Files/resources/research-report/2019/us-population-
mortality-observations.pdf) provides some indication of the drivers of the deterioration. COD analysis indicates the primary drivers for the mortality deterioration are a slowdown in improvements in outcomes related to heart diseases and increases in death associated with opioids and suicide. Among these CODs, the magnitude of the impact associated with opioids and suicide on the insured population is not clear due to known demographic factors associated with those CODs. It would be extremely beneficial for analysis to be performed as more insured data emerges to broadly assess the impacts of the CODs to determine if these trends are as pronounced in the insured population.

Industry, the SOA, and regulators should take the time to further study and develop methods to reflect these differences, as appropriate.

**Methodology introduces volatility into the reserve framework**

We believe the methodology for updating the mortality improvement scale can introduce volatility into reserves, especially as a change to reflect insured mortality within the improvement factors is implemented. Even under the current methodology, we may see some volatility due to the need for judgment in the updating of the scale. The prior scale report recognized the trend of deterioration in the prior year, but it was not significant enough to justify changing the scale. Now that the trend has continued, the update results in a more significant impact, given the cumulative effect of the changes. While some volatility is inevitable, ACLI believes that there be a process to mitigate volatility with changing factors, such as a grade-in or smoothing of results. This would dampen some of the peaks and valleys of the volatility.

**Impact of the worsened scalars hurts smaller companies**

Both the AG 38 and VM-20 mortality methodologies recognize a company’s own experience in setting of the mortality assumption. Because the mortality improvement factors only impact the industry mortality tables, we are concerned that the update to the scalars penalizes companies with lower credibility. This creates some potential playing field concerns, particularly if the general population mortality continues to deteriorate, but the insured population does not.

**Potential harm to consumers**

ACLI is concerned about how the current methodology ultimately impacts consumers. If erroneous conclusions are drawn from population data, this may lead to harm to consumers vis a vis affordability of insurance.

ACLI would also like to comment on the work to develop product-neutral mortality improvement scales. It’s not clear this would be appropriate, given that life underwritten products have significant information on the insured populations, as opposed to annuity products. While there is inherently some overlap between these two populations, the disparity in availability data regarding underwriting suggests some valid reasons for separate scales.
In summary, ACLI believes it is appropriate to reflect deterioration if it is indicative of the mortality trends of the underwritten population. To avoid such late changes in the future, we encourage regulators to update the Valuation Manual to introduce a lag in implementation of the mortality improvement scale if it is exposed so late in the year, such as explicitly stating in the Valuation Manual that the mortality scale to be used is the named yearly report on the SOA website, as adopted by LATF.

We are optimistic we can work with LATF to develop a reasonable solution that appropriately reflects mortality trends while limiting potential hardship to companies.

We look forward to a discussion of these issues.

Sincerely,

[Signature]

cc Reggie Mazyck, NAIC