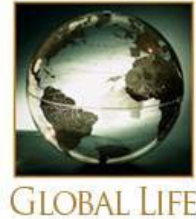


DEMYSTIFYING LIFE EXPECTANCY REPORTS

Howard Freedland recently gave a presentation on “*Demystifying LE Reports*” to the NY Society of Financial Service Professionals. This speech expanded on his series of webinars and recent article, “*Morbidity versus Mortality.*” As interest in and adoption of GLU’s LE methodology based on the 2008 VBT RR mortality tables and related UCS scoring process has progressed, a number of questions have been raised that are worth sharing.



Q&A with Howard Freedland, CEO of Global Life Underwriting

1. Isn't the calculation of mortality for life settlements different from life insurance?

- A. There is an argument to make that reverse adverse selection takes place in the LS market as individuals who develop terminal morbidities or unusually severe illness are more likely to maintain their policies or settle them directly with the carrier rather than do a life settlement; and individuals who are most healthy are likely to sell their (unneeded) policies. If LE providers were using published mortality tables (or publishing their proprietary tables), we might be able to develop A/E statistics that would support or defeat this question. As it is, by using 2008 VBT as a primary table, we assume that insureds that would currently qualify as insurable are included in a cohort of similarly healthy (for their age) individuals. While not perfect, this substantially mitigates the issue of reverse adverse selection.

2. Shouldn't 2008 VBT be adjusted by actual experience?

- A. Since existing LE providers have their own “black box” methods for placing insureds into separate risk groups (represented by different multipliers), we would first have to agree on a methodology for associating the various multipliers from different LE providers with “common” risk buckets. By using 2008 VBT and the RR tables appropriately and by allocating insureds into the correct UCS risk classes and non-UCS risk classes (SSA & Impaired), we can begin to develop sophisticated tools for measuring A/E vs. 2008 VBT RR. A great project for the industry would be to take the existing insured lives and perform a historical (retroactive) UCS analysis to back test the data and develop an accurate LS mortality table modification for 2008 VBT or other mortality tables. The advantage of published tables is that they reflect the largest available and most relevant data set. Having specific mortality tables published by a highly accredited source should give existing and new investors a much greater degree of confidence in LE projections and life settlement investments.

3. Should LE providers adjust 2008 VBT for future mortality improvements?

- A. From an investor's perspective, risk should be separated from normative data wherever possible so that it can be modeled separately. Mortality improvements ebb and flow and change by age, risk class, morbidity factors, and gender. An example of this occurs in comparing 2008 VBT vs. 2001 VBT. Measurement of overall mortality improvement would disguise significantly different changes in mortality between males and females. There are also important changes in various age ranges. Future change in mortality requires some degree of speculation. Most pricing software permits mortality improvement to be built-in (modeled) as a pricing assumption. I believe that modeling projected mortality changes separately is far preferable as it gives buyers and sellers greater control and accuracy versus LE providers who arbitrarily modify mortality tables. GLU does not arbitrarily modify published tables.

4. Don't 2008 VBT and the Relative Risk tables specifically exclude substandard risks which are a large percentage of the life settlement population?

- A. Technically yes, but **NO!** A recent article (available upon request) from David N. Wylde, Senior Pricing Actuary, Life Solutions, Transamerica Reinsurance, specifically discusses “expanded standard” programs among US life insurance companies which suggests that this data set is specifically applicable to a high percentage of life settlements. The point of the article is that a fairly high percentage of policies originally issued as “preferred” or “standard” would have been considered substandard. In fact, the life settlement

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industry's experience, which can be easily confirmed by looking at the morbidity data from recently issued policies that have been premium financed, is that seniors with a wide range of morbidity risk factors regularly obtain insurance rated "preferred" or "standard" (insurance agents commonly refer to this process as "table shaving"). According to Mr. Wylde, the objective of carrier's expanded standard programs is "to increase the placement of marginally substandard risks by avoiding the stigma associated with the term "substandard" or "rated." He goes on to say, "note that there may be increased field pressure to rate the borderline Table E or Table F risks as Table D so that they can be placed as **standard** (*emphasis added*)." Industry experts understand that this has been going on for quite a long time. A major goal of 2008 VBT RR was to separate these "standard" lives into separate risk categories (similar to the original substandard categories) to determine their relative mortality. The conclusion was that increased morbidity has some statistically measurable difference in mortality but much less than originally thought by reinsurers (and LE providers).

Since a meaningful percentage of life settlements represent policies issued in the past 25 years or less (the underwriting "Select" period), I believe that seeking to place policies in their appropriate RR category using UCS is the best and closest data fit for measuring LE. Non-RR rated lives can be separately analyzed using various medical underwriting techniques or other tables (such as SSA).

5. Isn't UCS (Underwriting Criteria Scoring) designed for a younger population?

- A. UCS is far from perfect, but it seems to have worked for the Society of Actuaries (SOA) and the insurance industry (and reinsurers). The SOA established separate criteria for individuals 65+ years old in an attempt to recognize changing morbidity among seniors. Over time, this methodology and the resulting data set will be enhanced with better techniques designed to measure key morbidity factors of the senior population. Future changes are more likely to loosen most existing risk criteria while adding some criteria exclusively for the aged (cognitive skills and stability factors).

6. Isn't UCS designed for life insurance as opposed to life settlements?

- A. Yes. The idea of UCS was to replicate (and standardize) the underwriting risk scoring of carriers by subdividing their "preferred" and "standard" risks into homogenous risk categories. Since the general goal of carriers (and reinsurers) is successful adverse selection, UCS tends to penalize insureds for currently presenting symptoms or risk factors, independent of the degree, severity, cure, or longevity of the risk. In fact, UCS severely penalizes insureds for the absence of key data.

Since GLU is using UCS to determine mortality for an already insured population, we have modified the scoring to err on the side of inclusive selection as opposed to adverse selection. Investors are economically disadvantaged if newly presenting transient, minor, or curable risk factors are severely scored placing an insured in a higher RR class causing a possibly temporary decline in LE. Morbidity risk factors should be confirmed, documented, persistent, and material before a change in RR category is warranted. This is especially true of insureds that have experienced a change to their health since the issuance of their policy (which can also be measured in time since the issuance of the policy). Health changes do occur, and should be properly accounted for when confirmed.

7. Aren't the SSA mortality tables too general to be used for substandard risks?

- A. Generally, it is always better to utilize a published mortality table than to create artificial multipliers to modify mortality tables. SSA represents the largest (and broadest) data set for measuring mortality. If an individual does not fit into the insured sub-population, they must by definition fit into the general population. This is conservative in that it covers a wide range of morbidity and other risk factors. Where an individual has specific and serious abnormal morbidity associated with reduced mortality, traditional impaired risk underwriting can be used to provide a more accurate LE.

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8. How should investors measure the A/E of LE providers?

- A. There has been a lot of conversation about actual/expected (A/E) measurement given the negative historical experience of investors using the LEs of various LE providers. Some LE providers “publish” their A/E statistics and several LE providers have proposed various methods for calculating and comparing their A/E. First, one must know that it is **impossible** to accurately calculate A/E without having the actual mortality table(s) the LE provider used to calculate their LEs (GLU always provides this information). Second, most LE providers do not have a sufficient number of LEs by duration period to have a statistically relevant data set compared to 2008 VBT.
- B. An alternative A/E calculation can and should be done. LE providers can measure the accuracy of their medical underwriting by using their multipliers as surrogates for assigned risk classes and then comparing (1) how they have rated comparable insureds; and (2) whether their risk classes have measurably distinct mortality (similar to the 2008 VBT RR classes and SSA). This would separate underwriting accuracy from the accuracy of the mortality table that was used.
- C. GLU has proposed a research study to several large investment groups and independent research organizations that would back test the accuracy of using 2008 VBT (and/or the RR tables) against their database of existing LE reports.

Global Life Underwriting is committed to promoting standards-based LE Reports that provide consistent, accurate, reliable, accountable, and transparent results. Additionally, we believe that an open, frank, and constructive dialog about life expectancy will result in better investment decisions and an influx of capital to support the growth of the life settlement industry. We welcome any questions and discussions regarding the methodology of our life expectancy reports. Inquiries should be addressed to Laura Sellers at Laura.Sellers@GLULLC.com.



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