



Product Standards Committee Explanation of Meeting Materials

October 29, 2013

To accompany the October 29 draft of Group Term Life Insurance Uniform Standards for Accelerated Death Benefits (“Group Standards”), the Product Standards Committee (“PSC”) is also providing the following memorandum of supporting materials.

The supporting materials memo was created to detail and track the PSC’s deliberations on the Group Standards following its report to the Management Committee on August 23 that more time was needed to complete its recommendation on the public comments received by the Management Committee. During its deliberations, the PSC encountered additional questions from Compacting States. The PSC also considered suggestions raised during the IIPRC’s 5-Year Review of Uniform Standards that could affect the Group Standards.

The supporting materials memo was the PSC’s working document to track its deliberations. The memo also sets forth background information about related NAIC, state and federal laws and regulations. The memo indicates that the PSC carefully reviewed all issues raised by all parties during the comment periods for both the Group Standards and the 5-year review.

The October 29 draft of the Group Standards contains all substantive revisions recommended by the PSC marked with yellow highlighting. Further requests for comment are marked in the supporting materials memo with yellow highlighting. All other PSC outcomes are marked in bolded red text. Otherwise the supporting materials memo should be used as a transparent background record of the PSC’s deliberations.



TO: Product Standards Committee

FROM: IIPRC Office

DATE: October 28, 2013

SUBJECT: Supporting Materials for Discussion regarding the Group Term Life Insurance Uniform Standards for Accelerated Death Benefits and Individual Standards for Accelerated Death Benefits

Background

On April 12, 2012, after being recommended to the Management Committee by the Product Standards Committee (PSC), the Group Term Life Insurance Uniform Standards for Accelerated Death Benefits was published for notice and comment. Written comments were received from the Idaho Department of Insurance and the Industry Advisory Committee (IAC). A public hearing was conducted during the Management Committee's July 22nd conference call. During this conference call Commissioner Murphy asked the PSC to review the comments and report back to the Management Committee whether further changes were recommended.

The PSC held a public conference call on August 13th to receive comments on its proposed changes in response to Idaho's comments. The two key changes, which received no objections during the August 13th public conference call, are as follows:

- Changing the language (deleting an introductory sentence and adding a separate provision) to emphasize the existing requirements that a terminal illness qualifying event must always be included and a single qualifying event must be sufficient to trigger or provide accelerated benefits.
- Changing the language to specify a chronic illness that is defined as a permanent inability to perform activities of daily living include the limitation of "maximum of two activities of daily living".

A. Issues

On the August 20th member-only PSC call, the following issues were raised:

Issue 1. Would the use of the language "maximum of two" limit or prohibit companies that want to allow the inability to perform only one of the activities of daily living? How does

the “maximum of two” wording work with the IRC §7702B wording defining a chronically ill individual as being unable to perform “at least two” of the activities of daily living?

Issue 2. Does the provision under qualifying events that allows a consumer to trigger the accelerated benefits for a “specified medical condition that, in the absence of extensive or extraordinary medical treatment, would result in a drastically limited life span” allow companies to file critical illness products that more appropriately fall under long-term care insurance or stand-alone health insurance? (This issue was not the subject of written comments submitted during the rulemaking period.)

Issue 3. Whether the IAC comments submitted pursuant to the five-year review of the Individual Standards for Accelerated Death Benefits regarding removing the limitation that the Accelerated Death Benefit form not contain exclusions that are not also in the policy (see Substantive Change Item #6 under the IIPRC Office Report and Recommendation) also apply to the Exclusions provision [i.e., “The form shall not contain exclusions for an accelerated death benefit that are not also exclusions for the group term life insurance in the certificate.”] currently in the Group Term Life Insurance Uniform Standards for Accelerated Death Benefits?

Issue 4. Further, the IIPRC Office was contacted on Monday, August 19th by a member state that is not on the PSC and asked how the provisions of the chronic illness definition addressing federal requirements of IRC §7702B and IRC §101(g) interacted with other provisions of the uniform standard specifically:

- a. Must the insured wait 180 days under the interaction between §D(1)(e)(ii)(I) -- “chronic illness may also be defined . . . [f]or activities of daily living, requiring the inability to perform such activities to be for a period of at least 90 days” – and the provision under §2(H)(4) “Qualifying Events” elimination period – “[t]he term ‘elimination period’ means a specified period of time not to exceed 90 days during which the Covered Person meeting the terms of the qualifying event. The elimination period begins on the first day that the Covered Person meets the terms of the qualifying event and ends at the end of the specified period.”
- b. How does the federal requirement in §D(1)(e)(ii)(II) – “chronic illness may also be defined . . . [f]or periodic payments, requiring a re-certification at the end of each benefit period” – interact with the provision under §C(2)(a) “Benefit options” that “[p]eriodic payments based on the continued survival or institutional confinements of a Covered Person are prohibited.”?

Issue 5. In the context of the five-year review process, a member of the PSC raised a concern about the disclaimer provision regarding eligibility for Medicaid or other government benefits or entitlements, and possible tax consequences of acceleration. The concern is that a company would construe a warning about creditor-coerced acceleration as a condition of eligibility, either directly by placing a condition in the form or indirectly by referring to the disclaimer in denying an application to accelerate. The member state requested that the standards address the issue of creditor coercion as a condition of eligibility.

B. Proposed Next Steps

During the August 20th member-only PSC conference call, the PSC wanted an opportunity to review the changes made in the Group Term Life Insurance Uniform Standard for Accelerated Death Benefits that were responsive to comments raised during the five-year review process and to review whether these changes should be clarified as well as extended to the Individual Standards for Accelerated Death Benefits.

The IIPRC Office proposes the following steps to accomplish this approach:

1. Review the key changes made by the PSC to the Group Term Life Insurance Uniform Standards for Accelerated Death Benefits originally transmitted to the PSC by the NAIC Life Subgroup in 2011 especially changes made to address comments that were raised/submitted under the five-year review process for the Individual Standards for Accelerated Death Benefits.
2. Identify the similarities and differences between the provisions in the NAIC Accelerated Benefits Model Regulation and the Group Term Life Insurance Uniform Standards for Accelerated Death Benefits and Individual Standards for Accelerated Death Benefits.
3. Review the federal requirements for tax qualification of accelerated death benefit products -- IRC § 101g (which uses the chronic illness definition of IRC §7702B)
4. Review the provisions in the uniform standards (including the individual long-term care uniform standards) that prevent long-term care or critical illness products from being filed under the Group Term Life Insurance Uniform Standards for Accelerated Death Benefits and the Individual Standards for Accelerated Death Benefits.
5. Address each issue from the August 20th PSC call to determine if there are further changes or recommendations to the Group Term Life Insurance Uniform Standards for Accelerated Death Benefits.
6. Review the IIPRC Office Report and Recommendation regarding the items for the Individual Standards for Accelerated Death Benefits to determine if there are further changes or recommendations to the Individual Standards for Accelerated Death Benefits.
7. If there are changes or recommendations to the Individual Standards for Accelerated Death Benefits, determine if these changes should be applied or are applicable to the Group Term Life Insurance Uniform Standards for Accelerated Death Benefits.

STEP ONE—KEY CHANGES MADE BY PSC TO ORIGINAL VERSION OF GROUP TERM LIFE UNIFORM STANDARD ACCELERATED DEATH BENEFITS TRANSMITTED BY NAIC

The Group Term Life Uniform Standard for Accelerated Death Benefits was transmitted to the PSC in October 2011 along with the full set of standards for this particular product line and the PSC started its thorough review of this particular uniform standard in January 2013. The following are key changes the PSC made to this uniform standard during its review and consideration process:

1. Revision to definition of Accelerated Death Benefit to add that the advance payment is “During the lifetime of the Covered Person” [Change made to make more consistent with Individual Standards for Accelerated Death Benefits].
2. Revision to definition of Qualifying Events to add the chronic illness definition/requirements in the Internal Revenue Code for recognition of favorable tax treatment of accelerated death payments. [Change made in response to comments submitted under the 5-year review process for the Individual Uniform Standards for Accelerated Death Benefits as well as feedback from the IIPRC Office regarding the language found in tax-qualified individual accelerated death benefit riders filed with the IIPRC].
3. Revisions to limit the expense charges associated with the accelerated death benefit as a one-time charge and requiring a detailed justification if it exceeds \$250. [Change made in response to comments submitted under the 5-year review process for the Individual Uniform Standards for Accelerated Death Benefits].
4. Revisions to consolidate disclosure requirement regarding the effect of benefit payment on other benefit provisions into one section as opposed to two – requiring the rider form to provide the same disclosure at “(a) prior to or concurrent with the election to accelerate the death benefit and (b) upon the payment of the accelerated death benefit. [Change made in response to request for public comments. *Note: this revision does not address the disclosure notice required by certain Compacting States at the time of sale of the product with an accelerated death benefit*].
5. Revisions to the provision regarding Qualifying Event to add a definition for “waiting period” to the subsection which provides the “form shall not include a waiting period requirement.” Add a new subsection indicating an elimination period for 2 of the 5 sections of the Qualifying Event definition (i.e., §3 – continuous confinement and §5 – chronic illness) is allowed and providing a definitions and conditions for an elimination period. [Change made in response to comments submitted under the 5-year review process for the Individual Uniform Standard for Accelerated Death Benefits].

The following changes to the Group Term Life Insurance Uniform Standard for Accelerated Death Benefits are currently under consideration by the PSC in response to the request by the

Management Committee to consider the public comments submitted during the formal rulemaking period to determine whether the PSC would recommend further changes:

1. Revisions to the definition of Qualifying Event to emphasize that a terminal illness qualifying event must always be included and that meeting the conditions of one of the specified qualifying events (when more than one is available in the benefit form) shall be sufficient to entitle the Covered Person to accelerate the death benefit. [Change made in response to comments from the Idaho Department of Insurance].
2. Revisions to the chronic illness definition in the definition of Qualifying Event to replace the term “specified number of activities of daily living” with “a maximum of two activities of daily living”. [Change made in response to comments from the Idaho Department of Insurance].

STEP TWO—COMPARE CERTAIN PROVISIONS OF THE NAIC ACCELERATED DEATH BENEFITS MODEL REGULATION WITH THE GROUP AND INDIVIDUAL UNIFORM STANDARD PROVISIONS

The definitions for Accelerated Death Benefit and Qualifying Event in the uniform standards closely follow the provisions of the NAIC Accelerated Death Benefits Model Regulation and the New Jersey Accelerated Death Benefits Model Regulation, which we understand was also used as a reference during the drafting of the Individual Uniform Standards for Accelerated Death Benefits).

1. DEFINITION FOR ACCELERATED DEATH BENEFIT:

NAIC MODEL

“Accelerated benefits” covered under this regulation are benefits payable under a life insurance contract:

1. To a policyowner or certificateholder, during the lifetime of the insured, in anticipation of death or upon the occurrence of specified life-threatening or catastrophic conditions as defined by the policy or rider; and
2. That reduce the death benefit otherwise payable under the life insurance contract; and
3. That are payable upon the occurrence of a single qualifying event that results in the payment of a benefit amount fixed at the time of acceleration.

NEW JERSEY REGULATION

"Accelerated death benefits" means the advance payment of some or all of the death proceeds payable under a life insurance policy or group certificate:

1. To the owner or certificate holder, during the lifetime of the insured, at the time of a qualifying event;
2. That reduces the death benefit otherwise payable under the policy or certificate; and
3. That is payable upon the occurrence of a single qualifying event resulting in the payment of a benefit amount fixed at the time of acceleration

INDIVIDUAL UNIFORM STANDARD FOR ACCELERATED DEATH BENEFITS

“Accelerated death benefit” means the advance payment of some or all of the death proceeds payable under a life insurance policy:

1. To the owner, during the lifetime of the insured at the time of a qualifying event;
2. That reduces the death benefit otherwise payable under the policy through a present value payment or imposition of a lien upon the death benefits; and

3. That are payable upon the occurrence of any single qualifying event with respect to the insured resulting in the payment of a benefit amount fixed at the time of acceleration.

GROUP TERM LIFE UNIFORM STANDARD FOR ACCELERATED DEATH BENEFITS

“Accelerated death benefit” means the advance payment of some or all of the death proceeds payable under a certificate:

1. During the lifetime of the *Covered Person*;
2. That reduces the death benefit otherwise payable under the certificate; and
3. That is payable upon the occurrence of a single qualifying event with respect to a *Covered Person* resulting in the payment of a benefit amount fixed at the time of acceleration.

2. DEFINITION FOR QUALIFYING EVENT:

NAIC MODEL

“Qualifying event” means one or more of the following:

- (1) A medical condition that would result in a drastically limited life span as specified in the contract, for example, twenty-four (24) months or less;
- (2) A medical condition that has required or requires extraordinary medical intervention, such as, but not limited to, major organ transplant or continuous artificial life support, without which the insured would die;
- (3) A condition that usually requires continuous confinement in an eligible institution as defined in the contract if the insured is expected to remain there for the rest of his or her life;
- (4) A medical condition that would, in the absence of extensive or extraordinary medical treatment, result in a drastically limited life span. Such conditions may include, BUT ARE NOT LIMITED TO, one or more of the following:
 - (a) Coronary artery disease resulting in an acute infarction or requiring surgery;
 - (b) Permanent neurological deficit resulting from cerebral vascular accident;
 - (c) End stage renal failure;
 - (d) Acquired Immune Deficiency Syndrome; or
 - (e) Other medical conditions that the commissioner shall approve for any particular filing; or

- (5) Other qualifying events that the commissioner shall approve for a particular filing.

NEW JERSEY REGULATION

"Qualifying event" means the following:

1. A medical condition that is reasonably expected to result in a drastically limited life span for the insured. The definition of a drastically limited life span shall have a minimum of "six months or less" and a maximum of "24 months or less" and shall be specified in the policy or certificate; and
2. At the option of the insurer, the policy or certificate may also include one or more of the following:
 - i. A medical condition that requires extraordinary medical intervention, such as a major organ transplant or continuous artificial life support, without which the insured would die;
 - ii. A condition that is reasonably expected to require continuous confinement in an institution, as defined in the policy or certificate, and the insured is expected to remain there for the rest of his or her life;
 - iii. A specified medical condition that, in the absence of extensive or extraordinary medical treatment, would result in a drastically limited life span;
 - iv. A chronic illness as defined in 26 U.S.C. § 7702B(c)(2)(A), that is, a permanent inability to perform, without substantial assistance from another individual, a specified number of activities of daily living (bathing, continence, dressing, eating, toileting and transferring) and/or permanent severe cognitive impairment and similar forms of dementia; and
 - v. Any other qualifying events which the Commissioner may approve.

INDIVIDUAL STANDARDS FOR ACCELERATED DEATH BENEFITS

"Qualifying event" means the following:

1. A medical condition that is reasonably expected to result in a drastically limited life span for the insured. The company's definition of a drastically limited life span shall have a minimum of "6 months or less" and a maximum of "24 months or less", and shall be specified in the form;

and, at the option of the company, may include one or more of the following:

2. A medical condition that requires extraordinary medical intervention, such as major organ transplant or continuous artificial life support, without which the insured would die;

3. A condition that usually requires continuous confinement in an institution, as defined in the form, and the insured is expected to remain there for the rest of his or her life;
4. A specified medical condition that, in the absence of extensive or extraordinary medical treatment, would result in a drastically limited life span; or
5. A chronic illness defined as permanent inability to perform, without substantial assistance from another individual, a specified number of activities of daily living (bathing, continence, dressing, eating, toileting and transferring), and/or permanent severe cognitive impairment and similar forms of dementia.

GROUP TERM LIFE INSURANCE UNIFORM STANDARDS FOR ACCELERATED DEATH BENEFITS [Redlined with changes currently being considered by PSC]

(1) “Qualifying event” means the following:

- (a) Terminal Illness. A medical condition that is reasonably expected to result in a drastically limited life span for a *Covered Person*. The insurance company’s definition of a drastically limited life span shall have a minimum of “6 months or less” and a maximum of “24 months or less”, and shall be specified in the form;

~~In addition to a terminal illness qualifying event, the insurance company may include one or more of the following qualifying events:~~

- (b) A medical condition that requires extraordinary medical intervention, such as major organ transplant or continuous artificial life support, without which a *Covered Person* would die;
- (c) A condition that is reasonably expected to require continuous confinement in an institution and the *Covered Person* is expected to remain there for the rest of the *Covered Person’s* life. The term “institution” shall be defined in the form;
- (d) A specified medical condition that, in the absence of extensive or extraordinary medical treatment, would result in a drastically limited life span; or
- (e) (i) A chronic illness defined as permanent inability to perform, without substantial assistance from another individual, a ~~specified number of~~ maximum of two activities of daily living (bathing, continence, dressing, eating, toileting and transferring), ~~and~~/or permanent severe cognitive impairment and similar forms of dementia.
- (ii) For purposes of complying with the requirements of IRC §7702B and IRC §101(g) (“federal requirements”), chronic illness may also be defined as prescribed in these federal requirements, such as:
 - (I) For activities of daily living, requiring the inability to perform such activities to be for a period of at least 90 days;

- (II) For periodic payments, requiring a re-certification at the end of the end of each benefit period; and
- (III) For cognitive impairment, requiring substantial supervision.

(2) A Terminal Illness qualifying event must always be included. The insurance company may also provide accelerated benefits upon the occurrence of other qualifying events. If the accelerated death benefit provides multiple qualifying events, meeting the conditions of any one specified qualifying event shall be sufficient to entitle the Covered Person to accelerate the death benefit.

3. NAIC MODEL PROVISIONS NOT ADDRESSED IN THE UNIFORM STANDARDS

When the Group Term Life Insurance Uniform Standards for Accelerated Death Benefits was transmitted from the NAIC Life Subgroup to the PSC, it included the following note at the beginning:

NOTE: Industry has asked the IIPRC to advise regarding the intent of the individual ACCB standards: no reference is made to Model #620. Sixteen states have adopted the Model which became one in 1990. A regulator drafted the standards without the Model since not many states had adopted it, it was much out of date and not very clear on intent (for example, in the DISCLOSURE section some of the items are not disclosures and there is no indication of when certain information needed to be disclosed). Some of the Model requirements did not make their way into the standards because the regulators probably did not believe them to be relevant at the time. In any case, it is not clear that if a company complies with the IIPRC standards, would any of the 16 states have an issue?

Most of the provisions in the NAIC Accelerated Death Benefits Model Regulation appear to map to provisions in the Group Term Life Insurance Uniform Standards for Accelerated Death Benefits and the Individual Standards for Accelerated Death Benefits with the following exceptions:

Section 3. Type of Product

Accelerated benefit riders and life insurance policies with accelerated benefit provisions are primarily mortality risks rather than morbidity risks. They are life insurance benefits subject to [State inserts sections referencing life insurance provisions].

Section 6. Disclosures

C. Solicitations.

- (1) A written disclosure including, but not necessarily limited to, a brief description of the accelerated benefit and definitions of the conditions or occurrences triggering payment of the benefits shall be given to the applicant. The description shall include an explanation of any effect of the payment of a benefit on the policy's cash value, accumulation account, death benefit, premium, policy loans and policy liens.

- (a) In the case of agent solicited insurance, the agent shall provide the disclosure form to the applicant prior to or concurrently with the application. Acknowledgment of the disclosure shall be signed by the applicant and writing agent.
- (b) In the case of a solicitation by direct response methods, the insurer shall provide the disclosure form to the applicant at the time the policy is delivered, with a notice that a full premium refund shall be received if the policy is returned to the company within the free look period.
- (c) In the case of group insurance policies, the disclosure form shall be contained as part of the certificate of coverage or any related document furnished by the insurer for the certificateholder.

STEP THREE—REVIEW THE FEDERAL REQUIREMENTS FOR TAX QUALIFICATIONS OF ACCELERATED DEATH BENEFIT PRODUCTS – IRC §101(g) (WHICH USES CHRONIC ILLNESS DEFINITION OF IRC §7702B)

The following is an excerpt from the Executive Summary of an April 2012 Milliman Research Report entitled *Chronic Illness Accelerated Death Benefit Riders* which has a useful explanation of the interplay of the chronic illness definition under Internal Revenue Code §101(g), the NAIC Accelerated Death Benefits Model Regulation (#620), and the Individual Standards for Accelerated Death Benefits.

Many companies offering chronic illness riders in the marketplace design their riders to comply with §101(g) requirements for an accelerated benefit design, because it means that the accelerated benefit payments received by the policyholder (subject to limitations for per-diem plans) are intended to qualify for favorable tax treatment under §101(g), or in other words, are intended to be tax-free to the policyholder. It should be noted that whether an individual's accelerated benefit payment in fact actually qualifies for this favorable tax treatment will depend on a number of specific circumstances. Therefore, the owner of such a plan is typically advised by the insurer to consult with a personal tax advisory regarding tax treatment of these proceeds.

One challenge in structuring these plans is the §101(g) definition of chronic illness points back to the §7702(B) definition, which is the same section used to define triggers for LTCI products. However, Model Regulation 620 expressly precludes companies from marketing chronic illness riders as LTCI. In fact §3 of Model Regulation 620 states that the plans subject to that regulation reflect primarily life insurance risks and are treated as life insurance benefits. In reality, most chronic illness riders that are based on one of the first four qualifying events defined in Model Regulation 620 have more restrictive terms than the standards LTCI trigger definitions, so the prohibition of marketing those plans as LTCI is appropriate.

The Interstate Insurance Product Regulation Compact (IIPRC) . . . contains a rule (item number 5 under the qualifying event definition) that is modeled after Model Regulation 620 and the §7702B definition of chronic illness but with the proviso that the trigger condition must be permanent. It is interesting to note that the IIPRC chronic illness definition is not as complete as that provided in the tax code. However, it should be noted that in order to meet the chronic illness rules of § 101(g), it is further necessary that the benefit trigger require that the insured be chronically ill within the meaning of the tax law.

§101(g) of the Internal Revenue Code recognizes favorable tax treatment of certain accelerated death benefits as follows:

For purposes of this section, the following amounts shall be treated as an amount paid by reason of the death of an insured:

- (A) Any amount received under a life insurance contract on the life of an insured who is a terminally ill individual.
- (B) Any amount received under a life insurance contract on the life of an insured who is a chronically ill individual.

§101(g)(4)(A) defines terminally ill individual as “an individual who has been certified by a physician as having an illness or physical condition which can reasonably be expected to result in death in 24 months or less after the date of the certification.”

§101(g)(4)(B) defines chronically ill individual as “the meaning given such term by section 7702B(c)(2); except that such term shall not include a terminally ill individual.”

§7702B(c)(2)(A) provides:

- (A) In general. The term “chronically ill individual” means any individual who has been certified by a licensed health care practitioner as—
 - (i) being unable to perform (without substantial assistance from another individual) at least 2 activities of daily living for a period of at least 90 days due to a loss of functional capacity,
 - (ii) having a level of disability similar (as determined under regulations prescribed by the Secretary in consultation with the Secretary of Health and Human Services) to the level of disability described in clause (i), or
 - (iii) requiring substantial supervision to protect such individual from threats to health and safety due to severe cognitive impairment.

Such term shall not include any individual otherwise meeting the requirements of the preceding sentence unless within the preceding 12-month period a licensed health care practitioner has certified that such individual meets such requirements.

§101(g) also refers to the per diem limit in §7702B with respect to periodic payments to a chronically ill individual under an accelerated death benefit providing that when a periodic payment that exceeds a per diem limit, such excess shall be included in gross income. In its written comments under the 5-year review process, the IAC requested the §7702B definition of chronic illness be added along with the following language addressing per diem limitation:

For the purposes of complying with the requirements of IRC Section 7702B and IRC Section 101(g) (“federal requirements”), the periodic benefit may be subject to the per diem specifications of the federal requirements to avoid tax consequences. If the application of the federal cap requirement results in a reduced accelerated death benefit from that requested, the remaining death benefit which can be accelerated will be available for acceleration in future months.

STEP FOUR—PROVISIONS THAT PREVENT LONG-TERM CARE OR CRITICAL ILLNESS PRODUCTS FROM BEING FILED UNDER THE ACCELERATED DEATH BENEFIT UNIFORM STANDARDS

There are several references within both the Individual Standards for Accelerated Death Benefits along with the Core Standards for Individual Long-Term Care Insurance Policies that prevent a long-term care insurance product from being filed as a life accelerated death benefit feature. Further, for other than an accelerated death benefit that triggers upon a terminal illness, the Individual Standards for Accelerated Death Benefit and the Group Term Life Insurance Uniform Standards for Accelerated Death Benefits require a certification that the value and premium of the accelerated death benefit is incidental to the life coverage.

The accelerated death benefit uniform standard for both individual and group life prohibit a premium charge or cost of insurance charge for a qualifying event described under item 1 of the Qualifying Events definition (i.e., terminal illness). When filing an individual accelerated death benefit rider that includes qualifying events described under items 2, 3, 4, and 5 (i.e., other than terminal illness), Compact filers are required to submit an Accelerated Death Benefit Incidental Value and Premium/Cost of Insurance Rate Relationship Certification based on Appendix A signed by a member of the American Academy of Actuaries.

The Appendix A certification must demonstrate that the value of the accelerated death benefits provided on an aggregate basis, pursuant to a prescribed formula, does not exceed 10%. The formula requires showing the relationship between the net single premium for the base policy benefits assuming the non-death accelerated death benefit trigger and the net single premium for the base policy benefits assuming there is no accelerated death benefit.

In addition, the Individual Standards for Accelerated Death Benefits and the Group Term Life Insurance Uniform Standards for Accelerated Death Benefits explicitly provide that “[p]roducts subject to these standards shall not be described as long-term care insurance or as providing long-term care benefits.” Further, the Scope section for the individual uniform standard provides “[t]hese standards shall not apply to long-term care insurance or products providing long-term care benefits as provided in the Interstate Insurance Product Regulation Commission standards for long-term care insurance”. In the Group Term Life Insurance Uniform Standards for Accelerated Death Benefits, the Scope section provides: “[i]f the payment of accelerated death benefit is contingent upon receipt of long-term care services or support, these standards shall not apply and such benefit will be subject to the Interstate Insurance Product Regulation Commission standards for group long-term care insurance.”

The Core Standards for Individual Long-Term Care Insurance Policies has a detailed definition of “long-term care insurance” as follows:

any insurance policy, rider, endorsement or amendment advertised, marketed, offered or designed to provide coverage for not less than twelve (12) consecutive months for each covered person on an expense incurred, indemnity, prepaid or other basis; for one or more necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services, provided in a setting other than an acute care unit of a hospital,

unless the area of the hospital or unit where the services are provided is licensed or certified as a nursing care facility and the insured is receiving long-term care services and not acute care.

The term includes:

- *individual annuities, disability income and life insurance policies, riders, endorsements or amendments that provide directly or supplement long-term care insurance (emphasis added);*
- policies, riders, endorsements or amendments that provide for payment of benefits based upon cognitive impairment or the loss of functional capacity; and
- qualified long-term care insurance policies.

The term shall not include any insurance policy that is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income or related asset-protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage.

Following this definition of long-term care insurance in the Core Standards for Individual Long-Term Care Insurance Policies, certain exceptions are enumerated with respect to disability income, life insurance and annuities. With regards to life insurance, it provides:

“this term [long-term care insurance] shall not include life insurance policies that accelerate the death benefit specifically for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention or permanent institutional confinement, and that provide the option of a lump-sum payment for those benefits and where neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care.”

STEP FIVE—ADDRESS EACH ISSUE FROM THE AUGUST 20th PSC CALL

Issue 1. Would the use of the language “maximum of two” limit or prohibit companies that want to allow the inability to perform only one of the activities of daily living? How does the “maximum of two” wording work with the IRC §7702B wording defining a chronically ill individual as being unable to perform “at least two” of the activities of daily living.

In response to Idaho’s concern that the language in the chronic illness definition of the Group Term Life Insurance Uniform Standards for Accelerated Death Benefits regarding “specified number of activities of daily living” could require the inability to perform all ADLs before triggering the benefit, the PSC recommended changing the wording to “a maximum of two activities of daily living”. On August 20th, the question was raised whether the new wording could prohibit product designs that trigger the benefit upon the inability to perform only **one** of the activities of daily living.

It may be useful to see how this issue was handled in the uniform standards for individual long-term care and disability income where a trigger based on activities of daily living is included:

Core Standards for Individual Long-Term Care Insurance Policies: *Eligibility for the payment of benefits shall not be more restrictive than requiring either a deficiency in the ability to perform not more than two of the activities of daily living or the presence of cognitive impairment.*

Standards for Individual Disability Income Insurance Policies: *The definition/concept of Catastrophic Disability shall be triggered by an inability of the insured to perform, due to Injury or Sickness, a maximum (the company may reduce the number to one, but cannot raise it above two) of two activities of daily living (ADLs) out of the following six ADLs . . .”*

If the PSC wishes to keep the “maximum of two” wording, it may wish to include the parenthetical that was included in the Standards for Individual Disability Income Insurance Policies.

However, the PSC may wish to consider changing the language from a “maximum of two” to “not more than two” to match the wording of the Core Standards for Individual Long-Term Care Insurance Policies as qualified long-term care policies and riders under IRC §7702B and accelerated benefit riders to a life insurance policy under IRC §101g utilize the same definition of “chronically ill individual” which includes “*being unable to perform (without substantial assistance from another individual) at least 2 activities of daily living . . .*” In other words, the uniform standards would have consistency with regards to the chronic illness trigger based on activities of daily living.

For the PSC's consideration:

The current provision in the Individual Standards for Accelerated Death Benefits and in the Group Term Life Insurance Uniform Standards for Accelerated Death Benefits as recommended to the Management Committee on April 12th:

A chronic illness defined as permanent inability to perform, without substantial assistance from another individual, *a specified number of* activities of daily living (bathing, continence, dressing, eating, toileting and transferring), and/or permanent severe cognitive impairment and similar forms of dementia.

The PSC's current recommended change to the provision in the Group Term Life Insurance Uniform Standards for Accelerated Death Benefits to address Idaho's comments:

A chronic illness defined as permanent inability to perform, without substantial assistance from another individual, a ~~specified number of~~ *maximum of two* activities of daily living (bathing, continence, dressing, eating, toileting and transferring), ~~and~~/or permanent severe cognitive impairment and similar forms of dementia.

Proposed for PSC consideration to make consistent with wording in the Core Standards for Individual Long-Term Care Insurance Policies and make this change for both the Group Term Life Insurance Uniform Standards for Accelerated Death Benefits and the Individual Standards for Accelerated Death Benefits:

A chronic illness defined as permanent inability to perform, without substantial assistance from another individual, ~~a specified number of~~ *no more than two* activities of daily living (bathing, continence, dressing, eating, toileting and transferring), ~~and~~/or permanent severe cognitive impairment and similar forms of dementia.

PSC OUTCOME: On 9/24, the PSC discussed and favored changing to “no more than two.”

***Issue 2.* Does the provision under qualifying events that allows a consumer to trigger the accelerated benefits for a “specified medical condition that, in the absence of extensive or extraordinary medical treatment, would result in a drastically limited life span” allow companies to file critical illness products that more appropriately fall under long-term care insurance or stand-alone health insurance? (This issue was not the subject of written comments submitted during the rulemaking period.)**

A concern was raised by a member state during the August 20th conference call that item 3 under the Qualifying Event definition under the accelerated death benefit standards would allow filers to submit critical illness or long-term care products that more appropriately fall under long-term care insurance or stand-alone health insurance.

As explained above, the drafters of both the Individual Standards for Accelerated Death Benefits and the Group Term Life Insurance Uniform Standards for Accelerated Death Benefits included a requirement that the company's actuary demonstrate that the value and premium of the accelerated death benefit is incidental to the life coverage. This required demonstration and certification is an added protection that goes beyond the NAIC Accelerated Benefits Model Regulation.

This particular qualifying event is found in both the NAIC Accelerated Benefits Model Regulation as well as New Jersey's accelerated death benefit regulation. Further, the scope of both the individual and group accelerated death benefit uniform standards provides products subject to such standards cannot be described as long-term care insurance or as providing long-term care benefits.

The Individual Standards for Accelerated Death Benefits was implemented on May 31, 2007 and to date, the IIPRC Office has not received a concern from regulators in Compacting States that product filings reviewed and approved for compliance with the uniform standard exceeded the scope or should be considered a long-term care insurance or critical illness product.

If the PSC wishes to provide more detail to the scope of these uniform standards, it may wish to consider the language in the NAIC Accelerated Benefits Model which provides "Accelerated benefit riders and life insurance policies with accelerated benefit provisions are primarily mortality risks rather than morbidity risks." As stated above, the drafters of the uniform standards codified this provision by requiring the actuarial certification demonstrating the accelerated benefit provisions are incidental to the life coverage.

Proposed for PSC consideration is to add the following language in bold to the Scope sections. These standards apply to accelerated death benefits that are built into individual life insurance policy forms or added to such policy forms by rider, endorsement, or amendment **where the accelerated benefit provisions are primarily mortality risks rather than morbidity risks.**

PSC OUTCOME: On 9/24, the PSC concluded two weeks of discussion on this issue and determined no revisions to the proposed standards are necessary due to the mandatory terminal illness qualifying event and the actuarial certification, which applies when any qualifying event other than terminal illness is present and requires both the value of the benefit and any associated premium to be incidental to the life insurance coverage. It was confirmed that most filings the IIPRC has received under the individual standards do not include a separate premium for the accelerated death benefit, but a separate premium has occasionally been seen. This is consistent with the reported experience of PSC member states. There was also extended discussion about the safeguards in the subject uniform standards and the individual long-term care standards, which specifically carve out from the definition of long-term care insurance accelerated death benefits "that provide the option of a lump-sum payment for those benefits and where neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care."

Issue 3. Whether the Industry Advisory Committee comments submitted pursuant to the five-year review of the Individual Standards for Accelerated Death Benefits

regarding removing the limitation that the Accelerated Death Benefit form not contain exclusions that are not also in the policy (see [Substantive Change Item #6 under the IIPRC Office Report and Recommendation](#) located on the Docket webpage) also apply to the Exclusions provision [i.e., “The form shall not contain exclusions for an accelerated death benefit that are not also exclusions for the group term life insurance in the certificate.”] currently in the Group Term Life Insurance Uniform Standards for Accelerated Death Benefits?

During the August 20th conference call, a member state raised the concern that the IAC is requesting that the PSC consider removing or changing the Exclusions provision in the Group Term Life Insurance Uniform Standards for Accelerated Death Benefits which currently provides:

The form shall not contain exclusions for an accelerated death benefit that are not also exclusions for the group term life insurance in the certificate.

The IAC is requesting the PSC consider removing this provision in the Individual Standards for Accelerated Death Benefits as provided in their written comments under the five-year review process.

The IIPRC Office has confirmed with the IAC that it is **not** requesting this change be applied to the Exclusions provision of the Group Term Life Insurance Uniform Standards for Accelerated Death Benefits. This position is consistent with the February 20th draft of the group standards which includes a notation that the IAC’s request to remove the provision does not apply to the Exclusions provision of the Group Term Life Insurance Uniform Standards for Accelerated Death Benefits, based on the absence of underwriting at the individual level for the group product.

The PSC does not need to consider whether or not to remove or change the Exclusion provision in the Group Term Life Insurance Uniform Standards for Accelerated Death Benefits as the request from the IAC only applies to the Individual Standards for Accelerated Death Benefits. The PSC will consider this item when it reviews Substantive Change Item 6 in the IIPRC Report on the Five-Year Review Process.

PSC OUTCOME: On 9/24, the PSC reviewed and accepted the recommendation that no revisions were necessary because the comment received during the 5-year review process does not apply to the uniform standards at issue.

Issue 4. Further, the IIPRC Office was contacted on Monday, August 19th by a member state that is not on the Product Standards Committee and asked how the provisions of the chronic illness definition addressing federal requirements of IRC §7702B and IRC §101(g) interacted with other provisions of the uniform standard specifically:

- a. **Must the insured wait 180 days under the interaction between 5(1)(e)(ii)(I) -- “chronic illness may also be defined . . . [f]or activities of daily living, requiring**

the inability to perform such activities to be for a period of at least 90 days” – and the provision under §2(H)(4) “Qualifying Events” elimination period – “[t]he term ‘elimination period’ means a specified period of time not to exceed 90 days during which the Covered Person meets the terms of the qualifying event. The elimination period begins on the first day that the Covered Person meets the terms of the qualifying event and ends at the end of the specified period.”

- b. How does the federal requirement in the §7702B requirements for chronically ill individuals (i.e., §5(b) of the Qualifying Events definition of the Group Term Life Insurance) that “chronic illness may also be defined . . . [f]or periodic payments, requiring a re-certification at the end of each benefit period” – interact with the provision under §C(2)(a) “Benefit options” that “[p]eriodic payments based on the continued survival or institutional confinements of a Covered Person are prohibited.”?**

As explained above, the term and definition for “elimination period” was added during the PSC’s review of this uniform standard and was intended to operate concurrently with the 90-day period specified in the IRC §7702B definition of “chronically ill individual”. However, the wording of the “elimination period” provision could be interpreted to mean that the elimination period starts on the first day after the Covered Person satisfies the IRC §7702B definition of chronically ill individual, i.e., inability to perform such activities for a period of 90 days.

Proposed for PSC consideration is to revise the definition of “elimination period” to clarify that the 90-day period in IRC §7702B is the same 90-day period in the elimination period provision. Informal feedback from the Industry Advisory Committee confirms this interpretation. Further, it is important to remember that the current proposed uniform standards permit an elimination period only for the qualifying events of institutional confinement, chronic illness and cognitive impairment. Proposed changes in §2(H)(4) of the Group Term Life Insurance Uniform Standards for Accelerated Death Benefits are in bold below:

- (4) The form may include an elimination period for the qualifying events described in items 3 and 5 of the qualifying event definition in these standards. The term “elimination period” means a specified period of time not to exceed 90 days during which the *Covered Person* meets the terms of the qualifying event. ~~The elimination period begins on the first day that the meets the terms of the qualifying event and ends at the end of the specified period.~~ The 90-day period specified in the definition of “chronically ill individual” for purposes of IRC §101g and §7702B shall run concurrently and not be in addition to the elimination period specified in the form. If at the time of applying for the accelerated death benefit, the *Covered Person* meets the terms of multiple qualifying events that are subject to elimination periods, the elimination period for each applicable qualifying event shall run concurrently. During the elimination period, the *Covered Person* is required to continuously meet the terms of the qualifying event without interruption. If at the end of the elimination period the *Covered*

Person continues to meet the terms of the qualifying event, the *Covered Person* may apply for the accelerated death benefit.

On 10/1, the PSC agreed to make the proposed changes as set forth in the memo.

Following the meeting, a member state observed that the definition of “chronically ill individual” uses the phrase “of at least 90 days.” If, as we believe, the definition and the elimination period are intended to run concurrently, this phrasing is inconsistent for purposes of tax qualification with the 90-day limit on the elimination period described above.

The IIPRC Office recommends further research on the interaction between these two concepts in IIPRC and state-specific filings, as well as framing a request for clarification from the Industry Advisory Committee about the elimination period provision they proposed.

On 10/8, the PSC agreed to seek clarification from the Industry Advisory Committee. Following the call, Miriam Krol with ACLI responded via email that “the elimination period concept would only be used for the morbidity triggers and non-101(g) chronic illness trigger. It will not be used for terminal illness. For 101(g), the rule already includes the 90 day elimination period concept. There is no concern about whether they are concurrent are not because the companies should not have both 90 days apply to the 101(g).”

As a result of this feedback, the IIPRC Office proposes for PSC consideration further clarification in the elimination period provision to emphasize that elimination period is not permissible for tax-preferred benefits triggered by a chronic illness qualifying event, because the 90-day period established in § 7702B serves the same purpose and no other form of elimination period applies. Newly proposed changes in §2(H)(4) of the Group Term Life Insurance Uniform Standards for Accelerated Death Benefits are in bold below:

- (4) The form may include an elimination period for the qualifying events described in items 3 and 5 of the qualifying event definition in these standards, other than chronic illness as defined for purposes of complying with the requirements of IRC § 7702B and IRC § 101(g). The term “elimination period” means a specified period of time not to exceed 90 days during which the *Covered Person* meets the terms of the qualifying event. ~~The elimination period begins on the first day that the *Covered Person* meets the terms of the qualifying event and ends at the end of the specified period.~~ The elimination period begins on the first day that the *Covered Person* meets the terms of the qualifying event. The 90-day period specified in the definition of “chronically ill individual” for purposes of IRC §101g and §7702B shall run concurrently and not be in addition to the elimination period specified in the form. If at the time of applying for the accelerated death benefit, the *Covered Person* meets the terms of multiple qualifying events that are subject to elimination periods, the elimination periods for each applicable qualifying event shall run concurrently. During the elimination period, the *Covered Person* is required to continuously meet the terms of the qualifying event without interruption. If at the end of the

elimination period the *Covered Person* continues to meet the terms of the qualifying event, the *Covered Person* may apply for the accelerated death benefit.

PSC OUTCOME: On 10/15, the PSC agreed to make the newly proposed changes shown in the paragraph immediately above and to add a drafting note for purposes of receiving public comments:

Drafting Note: The intent of the Product Standards Committee is to establish which qualifying events may be subject to an elimination period and to establish that only one elimination period may apply regardless of how many qualifying events are triggered.

Another question that has been raised to the IIPRC Office which we recommend be clarified is the interaction between the federal requirement in the §7702B requirements for chronically ill individuals (i.e., §5(b) of the Qualifying Events definition of the Group Term Life Insurance) that “chronic illness may also be defined . . . [f]or periodic payments, requiring a re-certification at the end of each benefit period” and the Benefit Option Section that provides “[p]eriodic payments based on the continued survival or institutional confinements of a Covered Person are prohibited.”

As mentioned above, part of the provision defining “chronically ill individual” in IRC §7702B is that “[s]uch term shall not include any individual otherwise meeting the requirements of the preceding sentence unless within the preceding 12-month period a licensed health care practitioner has certified that such individual meets such requirements.” This is where the recertification requirement in §5(b)(ii) of the Qualifying Events definition comes in as individuals that are receiving their benefit in periodic payments must continue to meet the tax-qualified requirements of the product such that certification every 12-month period is required. It may be clearer if the phrase “preceding 12-month benefit period” was added to be consistent with §7702B.

Proposed for PSC consideration is to clarify that the certification requirement for tax-qualified accelerated benefits is tied to the preceding 12-month benefit period (changes in bold):

For purposes of complying with the requirements of IRC §7702B and IRC §101(g) (“federal requirements”), chronic illness may also be defined as prescribed in these federal requirements, such as:

- (I) For activities of daily living, requiring the inability to perform such activities to be for a period of at least 90 days;
- (II) For periodic payments, ~~requiring a re-certification at the end of the end of each benefit period; and~~ within the preceding 12-month benefit period a licensed health care practitioner has certified that such individual meets such requirements.
- (III) For cognitive impairment, requiring substantial supervision.

PSC OUTCOME: On 10/1 the PSC agreed to make the revision suggested immediately above.

On 10/1 the PSC discussed the second part of Issue 4 at length. The discussion moved into various aspects of the periodic payment option. It was noted that a lump sum payment option is mandatory under the Benefit Options provision of the uniform standards (Section 2C(2)).

A key issue is the effect of missing the re-certification requirement, either because the chronic illness condition no longer exists or otherwise. It was confirmed that in the case of the covered person's death, the uniform standards require periodic payments to be converted into a lump sum payment of the remaining death benefit (Section 2E(6) and (7)). Furthermore, Section 2C(2)(a) of Benefit Options provides, "Periodic payments based on the continued survival or institutional confinement of a Covered Person are prohibited."

Different expectations were expressed in the case of a missed re-certification: (1) convert periodic payments into lump sum on the basis that the covered person originally qualified for the full acceleration applied for and was eligible for a lump sum payment of the accelerated amount; or (2) periodic payments continue but lose tax-preferred status due to expired certification.

Additional feedback from the IIPRC Office following the Oct. 1 call indicates that most, if not all, filers offering a periodic payment option offer only a 12-month periodic payment period for chronic illness qualifying events, structured with subsequent sequential accelerations that coincide with each recertification. In this way, there are no payments to "cut off" if the tax-preferred requirements are no longer being met.

Proposed for PSC consideration could be to add to Section 2C(2)(a) as follows, with the result that the full amount authorized under each acceleration is payable during each respective certification period:

Periodic payments based on the continued survival, institutional confinement, or recertification under definition § D(1)(e)(ii)(II) of these Uniform Standards are prohibited.

PSC OUTCOME: On 10/8, the PSC agreed to add the language proposed immediately above. There was further discussion about the tax-qualification implications of various product designs, such as monthly periodic payments and annual periodic payments. It was recognized that there is flexibility within the uniform standards as to amount and frequency of periodic payments and accelerations, provided that all installment payments must be for a period certain. A single acceleration spanning more than 12 months would be subject to re-certification to remain tax-qualified, but under the proposed language, absent a required re-certification, the periodic payment must continue even if it loses tax-qualified status. Additionally, the uniform standards require disclosure of limits on amount or frequency of acceleration. The PSC concluded discussion of this issue.

Issue 5. In the context of the five-year review process, a member of the Product Standards Committee raised a concern about the disclaimer provision regarding eligibility for Medicaid or other government benefits or entitlements, and possible tax consequences of acceleration. The concern is that a company would construe a warning about creditor-coerced acceleration as condition of eligibility, either directly by placing a condition in the form or indirectly by referring to the disclaimer in denying an application to accelerate. The member state requested that the standards address the issue of creditor coercion as a condition of eligibility.

A member state has pointed out that language commonly found in both state-approved and Compact-approved individual accelerated death benefit forms could be construed as a condition of eligibility such that a company could deny a request to accelerate if they learn it is being used to pay for Medicaid-eligible benefits or if the covered person is being coerced to apply for acceleration by a non-governmental creditor such as a nursing home.

The following language has appeared in Compact-approved accelerated death benefit riders and according to the Compacting State that raised this issue is similar to the language that was approved in a state form where this issue arose:

Accelerated benefits will be made available to you on a voluntary basis only. Therefore: (a) If you are required by law to use this option to meet the claims of creditors, whether in bankruptcy or otherwise, you are not eligible for this benefit, and (b) If you are required by a government agency to use this option in order to apply for, obtain, or keep a government benefit or entitlement, you are not eligible for this benefit.

It appears the above language may be a common way that companies have addressed the general principle that a policyholder cannot be forced to collect accelerated benefits from their life insurance policy before qualifying for Medicaid or from claims of creditors. Insurers have expressed this practice as a consumer protection to ensure the benefit is used on a voluntary basis only.

Medicaid eligibility is addressed in the Effect of Benefit Payment on Other Benefit Options section of the Individual Standards for Accelerated Death Benefits as follows: “The statement shall include a disclosure that receipt of an accelerated death benefit may affect eligibility for Medicaid or other government benefits or entitlements and may have income tax consequences.” Similar language is found in the NAIC Accelerated Benefits Model Regulation under in the section entitled Disclosures (although the term “adversely” is not used in the uniform standards provision): “The statement shall disclose that receipt of accelerated benefit payments may **adversely** affect the recipient’s eligibility for Medicaid or other government benefits or entitlements.”

A discussion of the Medicaid eligibility requirement can be found in the legislative history for the NAIC Accelerated Benefits Model Regulation as follows:

A new section was added by the working group to provide information on Medicaid eligibility. The suggested wording indicated that a rider on the policy might require the funds to be received and spent prior to eligibility for Medicaid or other governmental assistance programs. 1990 Proc. II 568.

One draft of the regulation contained a statement that purchase of an accelerated benefit policy or rider could affect eligibility for Medicaid. This was changed after receipt of letters from the Department of Health and Human Services expressing the opinion that eligibility to receive an accelerated benefit would not affect government benefits under Medicaid or supplemental security income. The governmental agencies involved would not require policyholders to apply for and spend down the accelerated benefit before becoming eligible for aid. After receiving this information, the model provision was modified. 1991 Proc. IA 590-591.

Proposed for PSC consideration is to clarify that the statement regarding the voluntary nature of an accelerated benefit, including that the policyholder cannot be required or coerced to accelerate benefits under a life insurance policy for purposes of becoming eligible for Medicaid or other governmental benefits or entitlements or to satisfy claims of creditors, must appear in the form as a disclosure statement and cannot be a condition of eligibility for the accelerated benefit.

On 9/24, the PSC reviewed this issue and asked for further research on relevant case law and clarifying language. Proposed for PSC consideration is the adding the following item in the Effect of Benefit Payment on Other Benefit Options section of the Individual Standards for Accelerated Death Benefits provision:

(2) The form may also state that a Covered Person cannot be required to apply for the accelerated death benefit before qualifying for Medicaid, or be required by creditors to apply for the accelerated death benefit.

The Committee should also consider clarifying in the uniform standards whether it is permissible for the form to include a condition of eligibility that the application for acceleration is being submitted free of claims of creditors or government benefit administrators.

PSC OUTCOME: On 10/1, the PSC approved making the revisions indicated above.

There was significant discussion of the eligibility issue. A member state provided the example of its existing policy form requirement that, if the policy includes a provision on claims of creditors, the insured's creditors are prohibited from asserting claims on proceeds of a lawful beneficiary and the policy is exempt from execution of any court and from legal proceedings in the event of bankruptcy. IIPRC uniform standards do not contain an equivalent provision. It

was recommended that other member states review their requirements and practices with regard to this type of provision, and the condition of eligibility issue in general. The PSC did not reach a decision about the condition of eligibility issue.

PSC OUTCOME: On 10/8, the PSC discussed the eligibility issue further. The Committee considered the statutory provision and ultimately determined not to further address the claims of creditors based on existing treatment of proceeds of life insurance in state law both inside and outside of the insurance code.

STEP 6—REVIEW THE IIPRC OFFICE REPORT REGARDING ITEMS AFFECTING THE INDIVIDUAL STANDARDS FOR ACCELERATED DEATH BENEFITS

When the PSC reaches this step, the IIPRC Office will provide additional materials including excerpting the items from the IIPRC Office Report which can be found in its entirety on the IIPRC [Docket](#).

STEP 7—DETERMINE IF RECOMMENDED CHANGES FROM STEP 6 SHOULD BE APPLIED TO THE GROUP TERM LIFE INSURANCE UNIFORM STANDARDS FOR ACCELERATED DEATH BENEFITS

Substantive Change Item 5. **ACCELERATED DEATH BENEFITS – NOTICE OF EFFECT OF BENEFIT PAYMENT**

APPLIES: Standards for Accelerated Death Benefits.

CURRENT PROVISION:

The form shall state that prior to or concurrent with the election to accelerate the policy death benefits, the owner and any irrevocable beneficiary will be given a statement demonstrating the effect of the acceleration of the payment of death benefits on the cash value, death benefit, premium, COI charges, and policy loans (including policy liens) of the particular policy involved. The statement shall display any premium or COI charges necessary to continue coverage following the acceleration, and shall display all expense and interest charges associated with accelerating the death benefit. Statements for use with liens shall say that future due and unpaid premiums or COI charges may be included in the lien if the provision so provides. The statement shall be based only on guaranteed values. No projected or nonguaranteed values or benefits may be shown. The statement shall include a disclosure that receipt of an accelerated death benefit may affect eligibility for Medicaid or other government benefits or entitlements and may have income tax consequences.

COMMENTS:

Industry Advisory Committee (IAC) Comment: The IAC did not offer a comment on this provision in connection with the 5-year review process. The IAC participated in the drafting and consideration of the pending Group Term Life Insurance Uniform Standards for Accelerated Death Benefits. In connection with the pending Uniform Standards, the IAC requested clarification as to the differences between the Uniform Standards and the NAIC Accelerated Benefits Model Regulation (#620) and worked with the PSC on revisions. The IAC has not offered an objection to the Management Committee on the recommended language in the pending Uniform Standards.

IIPRC Office Comment/Observation: The disclosure requirements in this provision have generated comments from Compacting States and member companies. It is desirable to strengthen the disclosure requirements to avoid state-specific filings intended to comply with the timing of state-specific disclosure provisions that may apply to IIPRC-approved forms. It will be beneficial to consider addressing the extent to which eligibility for the accelerated death benefit may be conditioned upon the risks stated in the disclosure regarding eligibility for Medicaid or other government benefits or entitlements.

IIPRC Office Recommendation: At a minimum, the IIPRC Office recommends revising the provisions to conform to the timing requirements of the pending Group Term Life Insurance Uniform Standards for Accelerated Death Benefits as follows.

The form shall state that (a) prior to or concurrent with the election to accelerate the policy death benefits and (b) upon the payment of the accelerated death benefit, the company shall provide a statement to the owner and any assignee of record or irrevocable beneficiary of record ~~will be given a statement~~ demonstrating the effect of the acceleration of the payment of death benefits on the cash value, death benefit, premium, COI charges, and policy loans (including policy liens) of the particular policy involved. The statement shall display any premium or COI charges necessary to continue coverage following the acceleration, and shall display all expense and interest charges associated with accelerating the death benefit. Statements for use with liens shall say that future due and unpaid premiums or COI charges may be included in the lien if the provision so provides. The statement shall be based only on guaranteed values. No projected or nonguaranteed values or benefits may be shown. The statement shall include a disclosure that receipt of an accelerated death benefit may affect eligibility for Medicaid or other government benefits or entitlements and may have income tax consequences.

PSC OUTCOME: On 10/29, the PSC supports the revisions already recommended to the Management Committee and is prepared to recommend an additional disclosure requirement in the individual and group versions of the standards for accelerated death benefits.

The additional disclosure would be consistent with the requirement in the NAIC model (#620) for a generic disclosure to be provided at the time of application. For group benefits, the disclosure is to be provided as part of the certificate or any related document furnished for the certificateholder. The PSC reviewed state laws and regulations regarding this early disclosure, as well as sample disclosures currently in use and NAIC materials tracking state requirements. The PSC believes adding this requirement will improve consistency among disclosure requirements and alleviate any confusion about whether state-specific disclosures have been required in the absence of a uniform standards requirement.

Survey responses were 50/50 on whether such disclosure is required by states for group certificates.

The PSC is prepared to recommend an additional disclosure in the Group Term Life Insurance Uniform Standards for Accelerated Death Benefits as follows:

- (1) A written disclosure including, but not necessarily limited to, the following elements shall be provided as part of the certificate of coverage or any related document furnished by the insurer for the certificateholder:
 - (a) A brief description of the accelerated death benefit;
 - (b) Definitions of all qualifying events that can trigger payment of the accelerated benefit;
 - (c) A description of any circumstances when the insurance company might refuse to accelerate the benefit;
 - (d) A description of the effect of payment of accelerated benefits on the policy's cash value, accumulation amount, death benefit, premium, policy loans and policy liens, as applicable;
 - (e) A description and generic illustration of any additional premium or cost of insurance charge the *Covered Person* may be required to pay;
 - (f) A description of any administrative expense charge the *Covered Person* may be required to pay;
 - (g) A statement whether the accelerated benefits are intended to qualify for favorable tax treatment;
 - (h) A statement that, unlike conventional life insurance proceeds, accelerated benefits could be taxable and that assistance should be sought from a personal tax advisor;
 - (i) A statement that receipt of accelerated benefits may adversely affect the recipient's eligibility for Medicaid or other government benefits or entitlements; and
 - (j) A statement that the accelerated benefits do not and are not intended to qualify as long-term care insurance, and that the money received from the product may not be enough to cover medical, nursing home or other bills.

Substantive Change Item 6. **ACCELERATED DEATH BENEFITS --
EXCLUSIONS/RESTRICTIONS**

APPLIES: Standards for Accelerated Death Benefits

CURRENT PROVISION:

EXCLUSIONS/RESTRICTIONS

The form shall not contain exclusions or restrictions for an accelerated death benefit that are not also exclusions or restrictions in the policy.

COMMENTS:

Industry Advisory Committee (IAC) Comment: The provision is a disincentive to file with the IIPRC, as a majority of states do not limit exclusions or restrictions applicable to accelerated death benefits to those applicable to the policy because underwriting is different. This limitation can result in benefits not being issued rather than being issued with an exclusion based on alcoholism or drug addiction, for example. IAC suggests reconsidering the provision.

IIPRC Office Comment/Observation: This provision has not been the subject of inquiries or objections from filers. The pending Group Term Life Insurance Uniform Standards for Accelerated Death Benefits contain an identical provision. The provision in the group Uniform Standards was not subject to comment or discussion during the drafting process.

IIPRC Office Recommendation: The IIPRC Office has no specific recommendation.

PSC OUTCOME: On 10/29, the PSC will defer a decision on this comment until the individual Standards for Accelerated Death Benefits are considered for purposes of the 5-year review. As reviewed earlier, this provision is not problematic in the Group Term Life Insurance Uniform Standards for Accelerated Death Benefits.

Substantive Change Items 7. **BENEFIT DESIGN OPTIONS, Item (8) -- Aggregate limit**

APPLIES: Standards for Accelerated Death Benefits.

CURRENT PROVISION: (8) The form shall not include an aggregate limit provision that caps the accelerated death benefit payable for all policies issued by the company and its subsidiaries and affiliates.

COMMENTS:

Industry Advisory Committee (IAC) Comment: The provision is a disincentive to file with the IIPRC. The IAC requests the provision be eliminated or a limit be permitted for terminal illness only benefits, as there is no additional charge paid by the insured.

IIPRC Office Comment/Observation: This provision has been the subject of inquiries from filers and objections from filers. In response to a similar IAC suggestion on the Group Term Life Insurance Uniform Standards for Accelerated Death Benefits, the PSC declined to remove the provision on the basis that an insured should be able to collect the maximum allowable benefits for which the insured has been underwritten, qualifies and has paid premiums.

IIPRC Office Recommendation: The IIPRC Office recommends the Product Standards Committee consider removing or modifying this limitation as several companies have indicated this limitation prohibits them from filing certain benefit designs with the Compact that can be filed with the states.

PSC QUESTIONS: On 10/29, the PSC listed the following questions that it would like to have feedback from industry/filers:

What is the adverse selection that occurs from limiting the accelerated benefit permitted for terminal illness? For example, on a terminal illness only benefit, it is known that the full death benefit under all policies in force on the recipient of the accelerated benefit would be payable within the next 24 months. What is the adverse selection risk to the insurance company in paying the full amount of accelerated benefits during 24-month period, when in all likelihood the accelerated benefit amount is less than the full death benefit.

Explain how an aggregate limit complies with entire contract provision. Does the aggregate limit amount to lowering the death benefit after the fact? Limiting exposure to the full death benefit in the form itself on the front end is already permitted.

If you assume a present value benefit payment recoups future interest lost on the accelerated amount and there is an administrative expense charge per acceleration, what is the risk the company is trying to avoid? The PSC reviewed the IAC's comments on the IIPRC Office's Report and Recommendation regarding the 5-year review process, but requests more information.

The PSC also requests more information about how an aggregate limit provision in the uniform standards would appear. Would it limit benefits to a dollar amount or a percentage of eligible benefits across all policies insuring the Covered Person? If an aggregate limit is acceptable, it may be desirable to clarify that it applies to policies issued on the life of the Covered Person rather than all accelerated death benefits issued by the company, its subsidiaries and affiliates.

Substantive Change Item 8. **ACCELERATED DEATH BENEFITS -- BENEFIT DESIGN OPTIONS, Item (11)**

APPLIES: Standards for Accelerated Death Benefits.

CURRENT PROVISION: If an accelerated death benefit is included in a form, the form shall include an option at the time of acceleration to reduce the accelerated death benefit payment by an amount actuarially determined to pay the remaining premiums or an option to continue to pay premiums to keep the policy in force.

COMMENTS:

Industry Advisory Committee (IAC) Comment: The provision is a disincentive to file with the IIPRC. The IAC observes that the NAIC Accelerated Benefits Model Regulation (#620) does not contain this requirement and it can pose an operational issue for companies that do not have a process to calculate and collect all future premiums due. The IAC suggests making the provision optional rather than a mandatory form requirement.

IIPRC Office Comment/Observation: This provision has been the subject of inquiries or from filers for the same reasons stated by the IAC. The introductory clause is awkward and difficult to apply. The IIPRC agrees with the IAC suggestion.

IIPRC Office Recommendation: The IIPRC Office recommends revising the provision to make it optional as follows.

~~If an accelerated death benefit is included in a form,~~†The form ~~shall~~may include an option at the time of acceleration to reduce the accelerated death benefit payment by an amount actuarially determined to pay the remaining premiums or an option to continue to pay premiums to keep the policy in force.

PSC QUESTION 10/29: Is the IAC comment applicable to the group standards? The provision in question is not present in the group standards and it is unclear how a group term policy could be forced to be paid up.

Clarification Item 19. **QUALIFYING EVENTS FOR ACCELERATED DEATH BENEFITS**

APPLIES: Individual Life Standards for Accelerated Death Benefits.

CURRENT PROVISION: (3) The form shall not include a waiting period requirement. A requirement that the individual policy or form be in force past the incontestable period is prohibited.

COMMENTS:

Industry Advisory Committee (IAC) Comment: The IAC notes that the terms “waiting period” and “elimination period” are used interchangeably for individual long-term care insurance but the terms have a significant distinction in other lines. The IAC requests these terms be specifically defined for purposes of accelerated death benefits. There is agreement that it is not permitted to impose a restriction during which the insured is not eligible for the benefit, i.e. a waiting period. In accelerated death benefits, an elimination period is a period of time during which the insured meets the terms of a qualifying event, and if the insured still meets the terms after the period expires, the insured may apply for the benefit. IAC suggests adding definitions and expressly permitting an elimination period.

IIPRC Office Comment/Observation: The IIPRC Office receives numerous inquiries about waiting periods and elimination periods in individual accelerated death benefit products. The IAC suggestions are consistent with guidance currently being provided to filers. The pending Group Term Life Accelerated Death Benefits standard contains provisions based on these suggestions and would be an improvement to the current standard.

IIPRC Office Recommendation: The IIPRC Office recommends the following changes to add the applicable definitions for “waiting period” and “elimination period” based on the pending Group Term Life Insurance Uniform Standards for Accelerated Death Benefits:

(3) The form shall not include a waiting period requirement. “Waiting period” means a period of time following the date of issue of the accelerated death benefit during which the benefit is not in effect. A requirement that the individual policy or form be in force past the incontestable period is prohibited.

(4) The form may include an elimination period for the qualifying events described in items 3 and 5 of the qualifying event definition in these standards. The term “elimination period” means a specified period of time not to exceed 90 days during which the insured meets the terms of the qualifying event. The elimination period begins on the first day the insured meets the terms of the qualifying event and ends at the end of the specified period. During the elimination period, the insured is required to continuously meet the terms of the qualifying event without interruption. If at the end of the elimination period the insured

continues to meet the terms of the qualifying event, the owner may apply for the accelerated death benefit.

PSC OUTCOME 10/29: The recommendation was already included in the Group Term Life Insurance Uniform Standards for Accelerated Death Benefits recommended to the Management Committee in April. Earlier in this memorandum, the PSC detailed further revisions to the provision.

Clarification Item 20. **DEFINITION OF QUALIFYING EVENT FOR ACCELERATED DEATH BENEFITS**

APPLIES: Individual Life Standards for Accelerated Death Benefits.

CURRENT PROVISION:

“Qualifying event” means the following:

1. A medical condition that is reasonably expected to result in a drastically limited life span for the insured. The company’s definition of a drastically limited life span shall have a minimum of “6 months or less” and a maximum of “24 months or less”, and shall be specified in the form; and, at the option of the company, may include one or more of the following:
2. A medical condition that requires extraordinary medical intervention, such as major organ transplant or continuous artificial life support, without which the insured would die;
3. A condition that usually requires continuous confinement in an institution, as defined in the form, and the insured is expected to remain there for the rest of his or her life;
4. A specified medical condition that, in the absence of extensive or extraordinary medical treatment, would result in a drastically limited life span; or
5. A chronic illness defined as permanent inability to perform, without substantial assistance from another individual, a specified number of activities of daily living (bathing, continence, dressing, eating, toileting and transferring), and/or permanent severe cognitive impairment and similar forms of dementia.

COMMENTS:

Idaho Comment: With respect to the pending Group Term Life Insurance Uniform Standards for Accelerated Death Benefits, Idaho provided the following comments: Regarding the ADLs, there are one to six criteria listed. The insurer selects the number of criteria to impose. Again, this could be an unreasonable hurdle to benefits. The DOI recommends no more than two ADL criteria. If the standard is to be adopted, there should be a limitation on the number of subqualifications required and on the ADL criteria.

Industry Advisory Committee (IAC) Comment: The IAC did not offer a comment on conforming the Scope provision to the pending Group Term Life Insurance Uniform Standards for Accelerated Death Benefits Uniform Standards, but the IAC participated in the drafting and consideration of the pending Uniform Standards and has not offered an objection to the Management Committee on the recommended language. The IAC submitted a comment letter to Idaho’s comments on July 8th and agreed with the suggestion to include no more than two ADL criteria.

IIPRC Office Comment/Observation: This definition is the subject of frequent inquiries from filers. The IIPRC Office notes that other Uniform Standards that include benefit triggers based on activities of daily living limit to a specific number of ADLs including the Core Standards for Individual Long-Term Care Insurance Policies (no more than 2 ADLs); Standards for individual Disability Income Policies (no more than 2 ADLs) and the Additional Annuity Standards for Waiver of Surrender Charge Benefits (no more than 3 ADLs). The IIPRC Office supports the inclusion of a limit on the number of ADLs under the chronic illness definition.

IIPRC Office Recommendation: The IIPRC Office recommends revising this provision to limit the number of ADLs to no more than two (2) which is consistent with applicable federal requirements and also make the other noted changes to this provision in order to conform to the pending Group Term Life Insurance Uniform Standards for Accelerated Death Benefits as follows:

“Qualifying event” means the following:

1. **Terminal Illness.** A medical condition that is reasonably expected to result in a drastically limited life span for the insured. The company’s definition of a drastically limited life span shall have a minimum of “6 months or less” and a maximum of “24 months or less”, and shall be specified in the form;

~~and, at the option of~~ **In addition to a terminal illness qualifying** event, the company, may include one or more of the following **qualifying events:**

2. A medical condition that requires extraordinary medical intervention, such as major organ transplant or continuous artificial life support, without which the insured would die;

3. A condition that **is reasonably expected to require** ~~usually requires~~ continuous confinement in an institution, as defined in the form, and the insured is expected to remain there for the rest of his or her life. The term “institution” shall be defined in the form;

4. A specified medical condition that, in the absence of extensive or extraordinary medical treatment, would result in a drastically limited life span; or

5. A chronic illness defined as permanent inability to perform, without substantial assistance from another individual, **a maximum of two** activities of daily living (bathing, continence, dressing, eating, toileting and transferring), ~~and/or permanent~~ **severe cognitive impairment and similar forms of dementia need for substantial supervision to protect the insured from threats to health and safety due to severe cognitive impairment.**

PSC OUTCOME 10/29: The PSC reviewed this issue and recommends retaining the revisions previously proposed to address Idaho’s comments, as well as the conclusion earlier in this

memorandum to define chronic illness in terms of inability to perform “no more than two” activities of daily living.

Clarification Item 21. **DEFINITION OF CHRONIC ILLNESS QUALIFYING EVENT FOR ACCELERATED DEATH BENEFITS**

APPLIES: Individual Life Standards for Accelerated Death Benefits.

CURRENT PROVISIONS:

SCOPE: A chronic illness defined as permanent inability to perform, without substantial assistance from another individual, a specified number of activities of daily living (bathing, continence, dressing, eating, toileting and transferring), and/or permanent severe cognitive impairment and similar forms of dementia.

PAYMENT OPTIONS, Item (1): The form shall describe the payment options available to the owner. The description shall include the option to receive the accelerated death benefit payment in a lump sum, and may include an option to receive the benefit in periodic payments for a period certain only. (Periodic payments based on the continued survival or institutional confinement of the insured are prohibited.)

COMMENTS:

Industry Advisory Committee (IAC) Comment: The IAC requests that the standards recognize and incorporate current Internal Revenue Code provisions regarding chronic illness definitions and per-diem limits on benefits for purposes of tax qualification.

IIPRC Office Comment/Observation: This provision is the subject of frequent inquiries from filers. Per directions from the PSC, the IIPRC Office permits tax qualification language and Internal Revenue Code references in this area. The IIPRC Office prefers that the Uniform Standards clearly address tax qualification in a manner that comports with current industry standards.

IIPRC Office Recommendation: The IIPRC Office agrees with the IAC suggestion to insert the following provisions.

SCOPE:

- (b) For purposes of complying with the requirements of IRC Section 7702B and IRC Section 101(g) (“federal requirements”), chronic illness may also be defined as prescribed in these federal requirements, such as:**
 - (i) For activities of daily living, requiring the inability to perform such activities to be for a period of at least 90 days;**
 - (ii) For periodic payments, requiring a re-certification at the end of the end of each benefit period; and**

(iii) For cognitive impairment, requiring substantial supervision.

PAYMENT OPTIONS, Item (1):

For purposes of complying with the requirements of IRC Section 7702B and IRC Section 101(g) (“federal requirements”), the periodic benefit may be subject to the per diem specifications of the federal requirements to avoid tax consequences. If the application of the federal cap requirement results in a reduced accelerated benefit from that requested, the remaining death benefit that can be accelerated will be available for acceleration in future months.

PSC OUTCOME 10/29: The PSC supports adding the recommended provisions to the Group Term Life Insurance Uniform Standards for Accelerated Death Benefits.

Clarification Item 22. **ACCELERATED DEATH BENEFIT DESIGN OPTIONS, EXPENSE CHARGES**

APPLIES: Individual Life Standards for Accelerated Death Benefits.

CURRENT PROVISIONS:

ADDITIONAL SUBMISSION REQUIREMENTS, Item (3)(b): [The actuarial memorandum shall include] A description of and justification for expense charges associated with the accelerated death benefit and the maximum expense charges.

BENEFIT DESIGN OPTIONS, Item (5): The company may deduct a reasonable expense charge for accelerating the death benefit and shall state the maximum expense charge in the form.

COMMENTS:

Industry Advisory Committee (IAC) Comment: The IAC highlighted two state law requirements limitations on expense charges, one \$250 and one \$500, and requested clarification as to whether the requirements would be pre-empted by the Uniform Standards. The IAC did not suggest any revisions to the Uniform Standards; however, the IAC participated in the drafting and consideration of the pending Group Term Life Insurance Uniform Standards for Accelerated Death Benefits and has not offered an objection to the Management Committee on the recommended language.

IIPRC Office Comment/Observation: The Uniform Standards do not contain a dollar amount limit on expense charges associated with acceleration of the death benefit. The IIPRC Office has not received questions about state law limits on expense charges directly from filers. The pending Group Term Life Insurance Uniform Standards for Accelerated Death Benefits contain more specific provisions that address the IAC's comments.

IIPRC Office Recommendation: The IIPRC Office recommends revising the provisions to conform to the pending Group Term Life Insurance Uniform Standards for Accelerated Death Benefits as follows:

ADDITIONAL SUBMISSION REQUIREMENTS, Item (3)(b): [The actuarial memorandum shall include] A description of and justification for expense charges associated with the accelerated death benefit and the maximum expense charges. **If such charges exceed \$250, include a detailed explanation.**

BENEFIT DESIGN OPTIONS, Item (5): The company may deduct a **one-time** reasonable expense charge for accelerating the death benefit, **as applicable,** and **if an expense charge will be deducted, the company** shall state the maximum expense charge in the form.

PSC OUTCOME 10/29: Revisions based on this recommendation were already included in the Group Term Life Insurance Uniform Standards for Accelerated Death Benefits recommended to the Management Committee in April.