DATE: November 5, 2013
TO: IIPRC Product Standards Committee
FROM: Industry Advisory Committee
SUBJECT: Group Accelerated Death Benefits (Dated 10/29/13)

We submit the following comments, but due to late notification of the PSC proposed changes we may need additional time to further vet some of the comments.

**Item D.(e)(i), Page 2 [Definition of “Qualifying Event”]**

The intent of the proposed change is to prohibit companies from requiring the permanent inability to perform more than 2 ADLs, yet the proposed language is requiring individuals to not be unable to perform more than 2 ADLs. We suggest that you reinstate “a specified number of activities of daily living” and add the following sentence at the end of the item:

“The insurance company’s definition shall not require the inability to perform more than two activities of daily living.”

**Item D.(e)(ii)(II), Page 2 [Definition of “Qualifying Event” – 101(g) Chronic Illness Trigger]**

The proposed change has grammatical issues and should be worded in a manner consistent with items (I) and (III), such as:

(II) for periodic payments, requiring that a licensed health care practitioner certify that the individual has met the chronic illness requirements within the preceding 12 month period; and

Please note that not all benefit periods will be 12 months. For example, if an individual has selected 24 months, the re-certifications must still occur at the end of each 12 month period.

**C. BENEFIT OPTIONS, Item (2)(a), Page 5**

Since periodic payments will end if the individual dies or is not re-certified for the purposes of IRC Section 101(g) chronic illness benefits, we believe the intent of this item was so say the following:

“The amount of periodic payments shall be determined without regard to the Covered Person’s continued survival, institutional confinement, or recertification under definition item (D.(1)(e)(ii)(II) of these Uniform Standards.”
It appears that there is some misunderstanding regarding how the election of lump sum is administered under the IRC Section 101(g) chronic illness triggers. For all other triggers, “lump sum” means that you collect the entire amount that you requested to accelerate, up to the maximum amount stated in the certificate. Under 101(g), there are per diem limits which must be met in order to get the tax preferential treatment. If an individual elect to have the monthly payments spread out over each 12 month period, this is the “periodic” option; if the individual elects to receive a lump sum, this requires that the per diem maximum be annualized so that the lump sum payment in each 12 month period does not exceed the maximum permitted for tax preferential treatment. Since an individual has to be re-certified at end of each 12 month period, a lump sum election will result in installment payments once every 12 months.

To clarify this, we suggest adding the following items (d) and (e) to follow (c) at the top of page 6:

“(d) For purposes of complying with the requirements of IRC Section 7702B and IRC Section 101(g) (“federal requirements”), lump sum payments may be subject to the per diem specifications of the federal requirements to avoid tax consequences. In this situation, the per diem specifications will be annualized to determine the maximum lump sum amount payable every 12 months. If the application of the federal 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.”

(e) For purposes of complying with the requirements of IRC Section 7702B and IRC Section 101(g) (“federal requirements”), if before the payment of the full acceleration benefit, whether periodic or lump sum, a Covered Person dies, the payments shall cease and the remaining accelerated benefit shall be paid as a death benefit pursuant to the certificate. If before the payment of the full acceleration benefit the Covered Person is not re-certified as having met the federal requirements for chronic illness, the remaining accelerated benefit will be returned to the death benefit available under the certificate.

We note that Item (6) on page 7 addresses some of this proposed item (e), but it does not address the “lump sum” issues.

F. EFFECT OF BENEFIT PAYMENT ON OTHER BENEFIT PROVISIONS
Item (1), Pages 7-8
Item (2), Page 8

While we support disclosures, we have some serious concerns about the need to add another layer to the disclosures already required in Item (2), and there also appears to be an overlap/conflict with item (2) since it also requires disclosure “(a) prior to ... the election to accelerate”. We see the accelerated death benefit as allowing someone with specified physical or mental conditions to access the death benefit before they die - a good thing – so why is it necessary to provide disclosure 4 times – as proposed in (1), as included in the provisions describing accelerated benefits, concurrent with the election to accelerate and upon payment of the accelerated benefits?
With regard to proposed Item (1), the term “certificate” is a defined term, so no need to say “certificate of coverage”. We seek clarification of what is meant by “or any related document furnished by the insurance company to the certificateholder”? Note that “insurer” should say “insurance company”.

We believe that the proposed Item (1) is not necessary. The accelerated death benefit will be issued as a built-in provision of the certificate or the provisions will be attached to the certificate at issue or on a later date as a rider, amendment or endorsement. In either case, the provisions will include items (a), (b), (d), (f), (g), (h), and (i). We question the appropriateness of requiring (e) since this is best illustrated when a Covered Person elects to accelerate, at which time the specifics will be known, as provided for in Item (2).

We note that item (f) requires disclosure of “expense charge” but in Item (2) disclosure is required for “expense and interest charges”.

We do not object to adding the first phrase of (j), but this can be better handled as a brief description requirement in C. COVERED PAGE OF FIRST PAGE Item (1)(a).

We believe that the second phrase of (j) should be deleted. First, the insurance company is not allowed to have a say with regard to how an individual uses the accelerated benefit payments. Second, the insurance company should not be required to become a benefits adviser and give advice regarding what the accelerated payments may or may not cover with regard to the individual’s expenses or costs – the insurance company is not privy to these expenses/costs, and such advice may be perceived as intended to discourage someone from electing to accelerate. The amounts elected, subject to the maximum permitted, should be the sole decision of the certificateholder, his tax advisor, or others that may provide counsel.

With regard to Item (2), the words “prior to or” overlap the disclosure required in Item (1).

**H. QUALIFYING EVENTS, Item (4), Page 9**

Regarding the first sentence:

We believe that an elimination period should be allowed for (b) (c) (d) and (e)(i). Note that (e) needs to be qualified to (e)(i) only.

If we qualify applicability to (e), we do not need the added yellow highlighted phrase – this is misleading since for ADLs there is a permitted elimination period by the IRS.

Regarding the fourth sentence, the intent is to have this apply if the Covered Person meets the terms for more than one qualifying event on the same day. Accordingly, we suggest that you add these 4 words after “elimination periods,”.
Submitted by:

IIPRC Industry Advisory Committee:

Bill Anderson, NAIFA
Jason Berkowitz, IRI
Joe Muratore, New York Life
Mary Keim, State Farm Insurance Company
Miriam Krol, ACLI
Amanda Matthiesen, AHIP
Jill Morgan, Symetra
Marie Roche, John Hancock