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Printed in the United States of America.
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CHAPTER 1: INSURANCE REGULATION

Introduction

"Regulation" has become a loaded word, especially among financial professionals. Get just a few insurance executives, producers and policyholders in a room, and you could probably get them to argue for hours about government involvement in the industry.

Are insurers regulated too much? Too little? And assuming they can all agree that at least some regulation is necessary, should the power to regulate insurance belong to the federal government, each state or a combination of national and local authorities?

Despite our personal opinions regarding the specifics or degree of regulation in our business, we should never forget that the core goal of laws, rules and other restrictions is to protect the public. In insurance, the public includes not only the people who purchase insurance but also the people who sell it. The public might need protection from the following dangers:

- Deceptive sales practices that take advantage of uninformed consumers.
- Unethical marketing techniques that unfairly restrict competition among producers and carriers.
- Unreasonably high prices that prevent insurance from being purchased by buyers who really need it.
- Unreasonably low prices that jeopardize an insurer's claims-paying ability and the economy at large.

To better understand the current state of insurance regulation, consider these statistics from the National Association of Insurance Commissioners and the Federal Insurance Office:

- Insurance companies collected $1.1 trillion in premiums in 2012.
- Roughly 11,600 people had jobs as insurance regulators in 2010.
- There were approximately 7,800 licensed insurers in 2010 (with roughly 350 insurers having their license revoked or suspended that year).
- There were more than 2 million insurance producers in 2010 (with roughly 5,000 of them having their license revoked or suspended that year).
- State insurance departments received more than 300,000 formal complaints from consumers in 2010.
- States collected $18.6 billion as a result of regulatory actions in 2010. Approximately 7 percent of those dollars was earmarked for future regulation, while the rest generally went to other state funds.

With so many jobs and so much money tied to our field, the debate regarding the best way to regulate insurance should be on all of our minds. This course material will help you engage in that important debate by explaining where we are today in terms of regulation, how we got there and where we might be headed.

Federal vs. State Regulation

From as far back as the 19th century, the question of whether insurance should be regulated at the national level or the state level (or perhaps both) has prompted strong responses from a variety of interested parties.

People who support federal regulation of insurance (as opposed to state regulation) typically make the following arguments:

- Federal regulation would allow for a uniform set of rules for insurers and producers, which might simplify compliance for licensees who conduct business in multiple states.
- Federal regulation would provide a baseline of protection for consumers, regardless of where they live, and wouldn't create an incentive for insurers to operate only in states where regulation is relatively modest.

Supporters of state regulation (as opposed to federal regulation) tend to emphasize at least a few of the following points:

- State regulation helps lawmakers and businesses focus on the needs of local communities, which might have different insurance-related concerns than the rest of the country.
- State regulation allows lawmakers and regulators to make experimental changes to the insurance market without impacting markets in other states. Presumably, experiments that work well in one state will be copied by other states, and experiments that fail can be discontinued and ignored by the rest of the country.

Traditionally, the insurance community and local regulators have favored state regulation instead of federal regulation. In fact, it is not uncommon for state regulators and trade groups to reform their rules and requirements in order to preserve the state-based system. Following federal investigations of alleged misconduct in insurance, a collection of state insurance directors (known as the National Association of Insurance Commissioners) often creates model laws or rules that each state is encouraged to adopt. Meanwhile, producer groups will often revise their codes of ethics and insist that members comply with consumer protections that go beyond the requirements of state laws. These steps commonly quiet the debate over federal regulation, but the break in the argument rarely lasts long.

The traditional preference for state regulation has undergone at least a modest shift in recent years. Particularly in regard to licensing, carriers and producers who do business in multiple states have expressed support for a streamlined and more uniform set of requirements from either the federal government or a non-governmental national organization. You'll read more about national licensing later in this chapter.

Before exploring some of the modern issues related to insurance regulation, let's step back into the past and review some of the regulatory history behind our business.

Early Insurance Regulation

According to the Federal Insurance Office, U.S. insurers have been regulated by state laws from as far back as the late 1700s. New Hampshire, in particular, noted the expansion of the insurance industry within its borders and, in 1851, appointed the first insurance commissioner in the country. Within another 20 years, all states had their own insurance department with their own insurance commissioner at the helm. Arguably the most famous of these commissioners was Massachusetts' Elizur Wright, who instituted solvency

requirements for life insurance companies and developed actuarial tables that influenced the life insurance underwriting practices of today.

Paul v. Virginia

One of the first major U.S. court cases involving insurance is a good example of how much views on regulation have evolved. The 1869 case Paul v. Virginia centered on the ability of an insurance company to sell its products in multiple states. Virginia law, at the time, required all insurance companies selling insurance to Virginia residents to be licensed with the state and for all agents of out-of-state insurers to have a Virginia license. A Virginia man (Paul) was appointed to transact business in the state on behalf of a New York insurance company, which hadn't satisfied the state's financial requirements for licensure. Despite living in Virginia and meeting the licensing requirements for individuals, Paul was denied a license on the basis of the New York insurer's lack of compliance. Paul sold insurance in Virginia for the company anyway and was fined $50 by the state.

Contrary to insurers' general belief today, Paul and his supporters argued that the individual states couldn't fine him because his selling of insurance was a form of interstate commerce and, therefore, an activity that should only be regulated by the federal government. Regardless of the specific facts of the Paul case, many of the era's insurers supported federal regulation of insurance because they believed it would exempt them from having to pay various state-level taxes.

The case went all the way up to the U.S. Supreme Court, where a majority of the justices disagreed with Paul's argument. To them, the selling of insurance was essentially a contractual transaction rather than commerce and was, therefore, subject to state laws. Virginia's fine was ruled constitutional, and the case set a precedent for the next several decades. However, although the court determined that state regulation was permissible under some circumstances, it did not specify which aspects of insurance could and could not be regulated at the national level.

The Armstrong Commission

By the early 20th century, problems at U.S. life insurance companies had earned national attention. Several carriers had gone out of business since the Paul case, and those that remained were accused of financial irresponsibility by the popular press. The rivaling newspaper empires of Joseph Pulitzer and William Randolph Hearst targeted companies that had failed to increase policyholder dividends in spite of increased profits. Readers of those publications were made to believe that much of a life insurance company's earnings were going to playboy executives and crooked politicians instead of to "widows and orphans."

Those concerns and others led President Theodore Roosevelt to endorse greater federal regulation of insurance as part of his 1904 State of the Union speech. According to the Federal Insurance Office, Roosevelt's ideas were incorporated into a failed Congressional bill that would have created a federal Bureau of Insurance, including a presidentially appointed Comptroller of Insurance.

The pushes for more regulation culminated in the three-month investigation conducted by New York's Armstrong Commission. Following 57 high-profile hearings on life insurance practices, the state implemented several new restrictions on life insurance companies. Under the new laws and rules, insurers were prohibited from engaging in certain kinds of high-risk business, making certain political contributions and selling certain products (including those that provided unfair dividends to policyholders and beneficiaries). Within

a few years, the rebating of premiums and the twisting of life insurance policies were prohibited, too. The state also began mandating regular audits of insurers' finances.

The Armstrong Commission's efforts brought changes beyond the New York market. Since companies that were licensed to sell insurance in New York were also required to abide by the state's standards when doing business in other parts of the country, many of the state's reforms become the norm in the industry. Meanwhile, the commission's main prosecutor against the insurance companies, Charles Evans Hughes, became a revered public figure, eventually obtaining the position of Chief Justice of the Supreme Court and launching a failed presidential bid as the Republican Party's candidate against Woodrow Wilson in 1916.

United States v. South-Eastern Underwriters Association

The issue of state vs. federal regulation, originally addressed in the Paul case, was revisited in the Supreme Court's 1944 ruling in United States v. South-Eastern Underwriters Association.

In the years leading up to the case, some states had allowed insurance companies to share loss-related data and set property insurance rates together. This collaborative work generally helped strengthen smaller and newer carriers that lacked enough of a history to predict their future liabilities, but it wasn't permitted in all parts of the country and, even where permissible, sometimes had legal limits.

By 1944, a rating bureau known as the "South-Eastern Underwriters Association" had roughly 200 member insurers, which, in total, comprised approximately 90 percent of the property insurance market within a six-state territory. Carriers that didn't join the bureau and set their prices in accordance with its standards were allegedly prohibited from receiving industry-wide loss data and were subjected to boycotts by reinsurance companies. (Reinsurance, in essence, is insurance for insurance companies.) When bribes were allegedly made by the bureau to state regulators in order to maintain existing rates, the U.S. government stepped in and accused the association of violating federal antitrust laws.

South-Eastern didn't strongly deny the accusations regarding monopolies, price fixing and boycotts. Instead, it leaned on the aforementioned Paul v. Virginia ruling and claimed that, regardless of the conduct in question, insurance transactions across state lines weren't commerce and, therefore, weren't required to follow federal interstate commerce laws (including antitrust laws).

The Supreme Court's ruling in United States v. South-Eastern Underwriters Association effectively reversed the earlier precedent set by Paul v. Virginia by concluding that insurance sales across state lines weren't merely contractual arrangements. Instead, they were a form of interstate commerce and, as a result, had to comply with federal antitrust laws.

Despite a dissenting opinion by Justice Harlan Stone, the Court also clarified its stance on the separate regulatory powers of states and the federal government. In general, the mere fact that something is deemed interstate commerce wouldn't automatically make it an entirely federal issue, and the mere fact that something wasn't deemed interstate commerce didn't automatically make it a state issue. Furthermore, subjecting insurers to federal antitrust laws didn't impose on the states' regulatory authority since none of the states explicitly permitted monopolies, price-fixing and other activities prohibited by federal laws. Instead of federal regulation being a contradictory substitute for state regulation and

vice versa, the two regulatory systems were intended, in the court's view, to complement each other.

The McCarran-Ferguson Act

In response to the insurance community's negative reaction to the South-Eastern ruling, Congress quickly passed the McCarran-Ferguson Act. Through this 1945 law, the federal government emphasized the public benefit of having insurance regulated primarily by each state rather than by national authorities.

The McCarran-Ferguson Act specifically exempted insurance companies from federal antitrust laws. However, in order for this federal exemption to apply, states must proactively regulate the activities addressed in the federal Sherman Act, Clayton Act and Federal Trade Commission Act. In general, this means each state must enact its own measures that prohibit boycotts, coercion or intimidation in the insurance market. If a state fails to create these barriers to fair markets, the federal antitrust laws mentioned earlier in this paragraph can be applied to insurance companies. By setting such standards on their own, the individual states have limited the federal government's ability to stop insurers from sharing loss-related data and using industry-wide standard policy forms, such as those property and casualty forms written by the third-party, non-governmental entity known as the "Insurance Services Office" (ISO).

Besides providing antitrust exemptions, McCarran-Ferguson clarified the extent to which other federal laws would be applied to the business of insurance. Specifically, according to the act, "No act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any state for the purpose of regulating the business of insurance (…) unless such act specifically relates to the business of insurance."

The McCarran-Ferguson Act pushed most aspects of insurance regulation away from the federal government and toward the individual states. However, consumer discontent with the industry tends to rekindle conversations about whether the law should remain in place. After Hurricane Katrina, for example, some prominent federal legislators openly questioned whether the antitrust exemption was being abused and resulting in widespread price fixing and unfair claims practices.

One criticism of McCarran-Ferguson has been its alleged inability to create strong competition in all states. Insurers generally claim that their federal antitrust exemption facilitates the sharing of important loss-related data, which is supposed to help new or smaller carriers make responsible underwriting decisions. Yet detractors point out that some insurance markets are dominated by only a small handful of carriers and aren't inviting to small insurers in the first place.

The occasional movement to amend McCarran-Ferguson is typically also accompanied by some admittedly confusing arguments about the effectiveness of repeal. Some proponents of ending the law focus on the antitrust exemption and believe that repeal would prevent misdeeds such as price fixing. But as supporters of the law point out, the federal antitrust exemption only applies if the states already prohibit this kind of conduct. Since states have already made it illegal for insurers to engage in price fixing, coercion, intimidation and other kinds of market conduct, the real question to ask isn't "Should insurers need to comply with antitrust laws?" Instead, observers who are considering the effectiveness of McCarran-Ferguson must ask themselves, "Are the states enforcing their own antitrust laws effectively without extra enforcement from the federal government?"

This course material won't take a stand on either side regarding the usefulness of McCarran-Ferguson. But since this law has been so instrumental in shaping today's regulatory environment, it is important for you to understand the core pieces of the debate.

The Gramm-Leach-Bliley Act

For centuries, legislation in the United States kept banks out of what were believed to be risky businesses so that depositors' funds were not put in danger. In effect, this meant there were relatively few chances for banks to become involved in the underwriting of insurance or securities.

All the way back in 1864, for example, banks were given the power to carry out tasks directly necessary and incidental to their business. At the time, however, selling insurance was not considered an incidental activity and was therefore prohibited within banking circles. Later, in an attempt to boost faith in banks after the stock market crash of 1929, Congress passed the Glass-Steagall Act, which prevented commercial banks (generally those that take deposits and make loans) from affiliating with any entity that was principally engaged in the sale of securities.

Yet at other important moments, the walls separating the various sections of the financial world crumbled bit by bit. By 1916, state banks in some parts of the country were being allowed to sell insurance. Meanwhile, the Office of the Comptroller of the Currency (OCC) had determined that too many national banks were failing in small towns and decided that federal depository institutions needed to become more competitive. With these economic conditions in mind, the federal government ruled that a national bank could enter into the insurance business if it was located in a town with 5,000 residents or less.

Restrictions have lessened at a swifter pace over the past 30 years. In 1986, the OCC started letting national banks sell insurance products in larger towns and cities if the transaction was conducted through a subsidiary in a town of under 5,000 people. A decade later, the U.S. Supreme Court's ruling in NationsBank of North Carolina v. Variable Annuity Life Insurance Co. upheld the right of commercial banks to sell annuities. All the while, local laws were sometimes allowing state banks into the insurance game, and loopholes in federal laws were often big enough for the occasional bank-sponsored insurance product to slip its way through the market. The insurance industry challenged many of these developments in court, but the challenges were ultimately ineffective.

During the 1980s and early 1990s, Congress debated the deregulation of financial industries on a number of occasions. These legislative attempts at regulating the entry of banks into the investment and insurance businesses generally did not amount to any real change, but two significant events near the end of the 20th century helped force the government's hand.

The first of the two events was the Supreme Court's ruling in Barnett v. Nelson, a Florida case centering on conflicts between federal insurance laws and state insurance laws. In 1974, Florida had enacted a statute that made it illegal for agents to sell insurance in any part of the state if they were affiliated with a "bank holding company," which can be defined as an entity with a controlling interest in one or more banks. Some 20 years later, plaintiffs argued the state statute was unlawfully ignoring the provisions of the 1916 federal statute regarding permissible insurance activities in small towns.

The state responded with a two-part argument that touched on the federal statute as well the McCarran-Ferguson Act, which generally says that a state insurance statute can be pre-empted by a federal law only if the federal law relates specifically to insurance.

In Florida's eyes, the 1916 statute related specifically to banks but not to insurance. The Supreme Court interpreted the matter differently, reasoning that the federal statute related specifically to insurance and that the intent of the 1916 Congress had been for the statute to reign over conflicting state laws. In short, the McCarran-Ferguson Act, which had kept federal regulators out of insurers' hair for years, proved to be more penetrable than expected.

The second significant event occurred on April 6, 1998, when the world was alerted to a merger between Citicorp (a bank holding company) and Travelers Group (a multifaceted entity that, among other things, was engaged in the underwriting of insurance). Although this merger that gave us Citigroup was technically in violation of the Glass-Steagall Act, provisions in the Bank Holding Act of 1956 gave the newly formed financial organization at least two years to divest itself of its insurance business and avoid criminal charges.

Rather than pushing Citigroup to make a few extra deals and comply with federal law, the two-year grace period was treated as a chance to rally lawmakers behind the idea of making major changes to federal financial regulations. On November 12, 1999, President Bill Clinton signed the Financial Services Modernization Act of 1999 into law, effectively repealing the restrictions within Glass-Steagall and allowing entities like Citigroup to exist concurrently as a bank, insurance company and securities broker. In time, Citigroup spun off its insurance wing into another company, but it was able to do so on its own terms.

Purposes and Expectations Regarding the GLBA

For all the attention it received in the business press and elsewhere, the Financial Services Modernization Act of 1999 (more commonly known as the Gramm-Leach-Bliley Act, in honor of its Congressional sponsors) wasn't exactly shocking or revolutionary in scope. As stated earlier, financial institutions that really wanted to dip their toes simultaneously into commercial banking, investment banking and insurance could often find a way to do it by relying carefully on technicalities in federal and state laws. So it wasn't as if, at long last, a law had finally come along and made the impossible possible.

But what Gramm-Leach-Bliley did do was give banks, insurers and investment firms a clearer path toward unification. If a bank had always wanted to purchase or partner up with an insurer but had not done so for fear of being in noncompliance with U.S. regulations, that bank could finally turn to the GLBA, follow its specifics and feel reasonably confident that it was obeying federal law.

The GLBA and Privacy

By allowing banks, insurers and securities firms to become more tightly intertwined, the GLBA also made it more likely that people's personal information would be shared among businesses. To protect against the possibility that these businesses would infringe upon individual privacy rights, the GLBA includes provisions to protect consumers' personal financial information.

There are three principal parts to the privacy requirements:

- The Financial Privacy Rule.
- The Safeguards Rule.
- The pretexting provisions.

The Financial Privacy Rule governs the collection and disclosure of customers' personal financial information by financial institutions. It also applies to companies that are not financial institutions but still receive such information.

The Safeguards Rule requires all financial institutions to design, implement and maintain safeguards to protect customer information.

The pretexting provisions of the GLBA protect consumers from individuals and companies that obtain personal financial information under false pretenses, a practice known as "pretexting." An example of pretexting would be a phone survey that claims to be gathering information to help insurance companies create new products but, in truth, will be using the acquired information to either sell insurance to the consumer or steal the person's identity.

In response to the GLBA's privacy-related provisions, the individual states updated their rules for insurance companies' handling of consumer information. Although we won't go any further into the specific requirements of the GLBA, you should be aware of the privacy and safeguard requirements in your state. These state-level requirements can be (and often are) more extensive than the Privacy Rule, Safeguards Rule and pre-texting provisions mentioned earlier in this section.

Insurance Regulators and Other Rule-Setting Entities

Now that you have an understanding of insurance's past, let's go into detail about our current regulatory system. In the next several sections, you'll read about where requirements for insurance come from and the various organizations that set the minimum standards for your business.

Laws, Rules and Rulings

In order to comply with the insurance requirements in your state, you have at least three sources that must be considered:

- Laws.
- Rules.
- Rulings.

Laws

Insurance laws are passed by legislators, such as state senators and members of the state's house of representatives. Although it is likely that at least a few legislators in your state have an insurance background, experience in the industry is not a pre-requisite for voting on these laws. Since they usually lack this practical experience, legislators may intentionally (or unintentionally) write laws by using broad or non-specific language that might be open to different interpretation. For example, a law might require that insurance producers complete 24 hours of continuing education, but it might not state exactly what qualifies as an "hour" (60 minutes of live instruction? 50 minutes with a break? 10 pages of reading?).

For the purpose of organization, the contents of most insurance laws will appear within a state's "insurance code." However, important laws that impact insurance professionals are also likely to appear elsewhere within a state's long list of statutes.

Rules

Many laws include language that requires the executive branch to establish rules about how a given law should be enforced. This is particularly common when a law is very complex or relates to a specialized field (such as insurance).

Unlike the laws that they help to implement, rules from a state's executive branch are supposed to be formulated and approved by people who have some expertise in the subject matter. Expertise is important at this stage because the rules are intended to clarify the non-specific language or other generalities found in the law. Without clear and careful rules, individuals won't necessarily know how to comply with the requirements, and law enforcement officials might have a hard time prosecuting people for alleged violations.

The rules for implementing insurance laws are usually drafted and approved by the state's department of insurance. States without an insurance department might give rulemaking authority to a department of financial institutions or some similar government agency.

Rulings

Individuals or business entities that believe they have been unfairly harmed by a law or rule may have the opportunity to pursue legal action through the court system. Lawsuits against legislators and regulators typically ask a court to answer at least one of the following questions:

- Did legislators have the constitutional right to pass the law in the first place?
- Do the rules written by the executive branch appropriately reflect the intent of the law?
- Did the executive branch follow its set of rules when penalizing the individual or business entity?

As an alternative to filing a lawsuit, parties who are disciplined as a result of alleged rule violations might have the right to a disciplinary hearing, in which the particulars of the situation can be presented to various members of the insurance department.

Insurance Departments and Insurance Commissioners

State insurance departments are generally intended to protect the public by monitoring market conduct and enforcing the state's various insurance requirements. More specifically, the insurance department is likely to concern itself with the following issues:

- Solvency of local insurance companies.
- Licensing of insurance producers and insurance companies.
- Consumer education regarding insurance topics.
- Fair sales and claims practices in the local insurance market.

The insurance department in most states is headed by an "insurance commissioner." In some parts of the country, this person might instead have the title of "director" or "superintendent." The commissioner is responsible for managing the insurance department, setting its priorities and enforcing the state's insurance rules and laws. He or she might also have the power to hold hearings and either approve or reject insurance rates and insurance products.

Depending on the state, the insurance commissioner will either be appointed by the state's governor or voted into office by the general public for a fixed number of years. Industry observers who prefer the concept of appointment tend to believe that an appointed commissioner will be more inclined to focus on the overall long-term health of the insurance market and less likely to make decisions based on short-term political motives. On the other hand, an elected commissioner might be very sensitive to consumer complaints and would risk being removed from office if his or her agenda isn't perceivably beneficial to a majority of local citizens. Commissioners who are elected to office often

have a legislative background, whereas appointed commissioners usually already have some experience as an insurance regulator.

The National Association of Insurance Commissioners

The state insurance commissioners, as well as their counterparts in Washington D.C. and the various U.S. territories, are members of a non-governmental non-profit organization called the "National Association of Insurance Commissioners" (NAIC). The NAIC does not have the power to regulate any aspect of insurance. But because it is comprised of individuals who each have that power, its activities can have a widespread impact on insurance laws and rules in each state.

The original and continued purpose of the NAIC is to promote uniformity in insurance regulation without sacrificing the states' regulatory authority to the federal government. In fact, according to a U.S. Treasury report, a participant at the group's first meeting in 1871 claimed that attendees were "fully prepared to go before their various legislative committees with recommendations for a system of insurance law which shall be the same in all states—not reciprocal, but identical; not retaliatory, but uniform."

In order to achieve its goal of greater uniformity, the NAIC periodically drafts and updates model laws and model rules. The models are written and amended by one of the group's many committees and then presented to the entire membership. If a model is supported by at least two-thirds of the commissioners, it is officially approved and released to the states.

The NAIC models provide a guide to legislators and commissioners who would like to address a particular insurance issue in their state. However, each state legislature (and each state insurance commissioner) retains its own authority and is not required to change its laws or rules in response to the NAIC's recommendations. Depending on the issue at hand, a state might choose to adopt an NAIC model law or model rule in its entirety, only to a certain extent or not at all. Most states, for example, have adopted the portion of NAIC model licensing laws that call for 24 hours of continuing education every two years for producers. But some states continue to require fewer or more hours, and even those that have adopted the NAIC's number of hours have almost always established their own licensing requirements that aren't found in NAIC model documents.

The NAIC holds considerable power in national legislative circles. When Congress or other federal officials threaten to take away some regulatory authority from the states, it is very common for the NAIC to revise its models and push its members to adopt them. In the past, this approach either stalled or defeated efforts to establish a federal producer licensing system, significant oversight of insurance by the Federal Trade Commission and other threats to state powers.

National Council of Insurance Legislators

The National Council of Insurance Legislators (NCOIL) receives less recognition than the NAIC but serves a similar purpose. Like the NAIC, the NCOIL creates model laws with the intent of having them adopted by the individual states. The main difference between the two organizations relates to their membership. Whereas the NAIC is a group for state insurance commissioners, the NCOIL is a group for state senators and state house members.

The Securities and Exchange Commission

The Securities and Exchange Commission (SEC) is a federal agency that regulates many kinds of variable products. In general, a variable product is a financial product that does

not guarantee a return of the amount investors put into it. Common types of variable insurance products include variable life insurance and variable annuities.

On occasion, the SEC has claimed that it should have regulatory authority over sales of indexed annuities as well. Indexed annuities generally guarantee a return of the owner's principal investment plus interest, but the amount of interest is based in large part on the performance of the financial markets. Even though most of these products have escaped SEC regulation and continue to be considered insurance products, many financial professionals who sell them have obtained securities licenses just to be safe. Common securities licenses include Series 6 (for mutual funds and variable products) and Series 7 (for stocks).

FINRA

An individual who sells variable products on behalf of an independent broker-dealer (essentially a brokerage firm) is generally known as a "registered rep." Independent broker-dealers and their representatives must comply with state securities and insurance rules as well as requirements mandated by the Financial Industry Regulatory Authority (FINRA).

Formerly known as the National Association of Securities Dealers (NASD), FINRA is a private, non-profit self-regulator for the securities industry. It is heavily involved in securities licensing and enforcement actions. It also enforces continuing education requirements for individuals who sell variable products.

According to its website, FINRA brought more than 1,500 disciplinary actions against individuals and brokerage firms and levied fines of more than $65 million in 2013. During the same year, FINRA referred more than 600 suspected instances of fraud and insider trading to the SEC and other law enforcement agencies.

Producers who sell any kind of variable product should be very careful to research their obligations under state law, SEC regulations and FINRA rules. The combinations of requirements for a particular financial professional might differ depending on the specific kinds of products being sold, the kind of entity employing the producer and whether the producer or employing firm claims it is offering financial advice or not.

The Federal Insurance Office

The massive Dodd-Frank Wall Street Reform and Consumer Protection Act did many things that have impacted various aspects of the financial industry. We will focus here on the law's creation of a new segment within the U.S. Department of the Treasury known as the "Federal Insurance Office" (FIO).

Contrary to popular belief, the Federal Insurance Office is not a regulator. Nor does it have anything to do with the implementation of the Affordable Care Act or the Medicare program. Perhaps most importantly, the FIO was not created in order to shift insurance regulatory power away from the individual states. Instead, the FIO is charged with the following tasks, among others:

- Representing the United States at international insurance forums.
- Administering the federal government's terrorism-risk insurance program.
- Monitoring access to insurance in underserved communities.
- Identifying insurance entities that might merit additional regulation.

- Making recommendations to Congress and other branches of the federal government in order to modernize insurance markets.

Recommendations from the FIO come from the Federal Advisory Committee on Insurance, an appointed group that is supposed to include consumer advocates, academics, insurance professionals and insurance regulators.

The following is an abbreviated list of recommendations from the FIO's first major report to Congress (The full report is available from the U.S. Treasury):

- *For material solvency oversight decisions of a discretionary nature, states should develop and implement a process that obligates the appropriate state regulator to first obtain the consent of regulators from other states in which the subject insurer operates.*
- *States should develop a uniform and transparent solvency oversight regime for the transfer of risk to reinsurance captives.*
- *State-based solvency oversight and capital adequacy regimes should converge toward best practices and uniform standards.*
- *States should move forward cautiously with the implementation of principles-based reserving and condition it upon: (1) the establishment of consistent, binding guidelines to govern regulatory practices that determine whether a domestic insurer complies with accounting and solvency requirements; and (2) attracting and retaining supervisory resources and developing uniform guidelines to monitor supervisory review of principles-based reserving.*
- *States should develop corporate governance principles that impose character and fitness expectations on directors and officers appropriate to the size and complexity of the insurer.*
- *In the absence of direct federal authority over an insurance group holding company, states should continue to develop approaches to group supervision and address the shortcomings of solo entity supervision.*
- *State regulators should build toward effective group supervision by continued attention to supervisory colleges.*
- *States should adopt and implement uniform policyholder recovery rules so that policyholders, irrespective of where they reside, receive the same maximum benefits from guaranty funds.*
- *States should assess whether or in what manner marital status is an appropriate underwriting or rating consideration.*
- *State regulators should pursue the development of nationally standardized forms and terms, or an interstate compact, to further streamline and improve the regulation of commercial lines.*
- *In order to fairly protect consumers in all parts of the United States, every state should adopt and enforce the National Association of Insurance Commissioners Suitability in Annuities Transactions Model Regulation.*
- *States should reform market conduct examination and oversight practices and: (1) require state regulators to perform market conduct examinations consistent with the National Association of Insurance Commissioners Market Regulation*

Handbook; (2) seek information from other regulators before issuing a request to an insurer;(3) develop standards and protocols for contract market conduct examiners; and (4) develop a list of approved contract examiners based on objective qualification standards.

- *States should monitor the impact of different rate regulation regimes on various markets in order to identify rate-related regulatory practices that best foster competitive markets for personal lines insurance consumers.*
- *States should develop standards for the appropriate use of data for the pricing of personal lines insurance.*
- *States should extend regulatory oversight to vendors that provide insurance score products to insurers.*
- *States should identify, adopt, and implement best practices to mitigate losses from natural catastrophes.*
- *Federal standards and oversight for mortgage insurers should be developed and implemented.*
- *To afford nationally uniform treatment of reinsurers, FIO recommends that Treasury and the United States Trade Representative pursue a covered agreement for reinsurance collateral requirements based on the National Association of Insurance Commissioners Credit for Reinsurance Model Law and Regulation.*
- *FIO should engage in supervisory colleges to monitor financial stability and identify issues or gaps in the regulation of large national and internationally active insurers.*
- *The National Association of Registered Agents and Brokers Reform Act of 2013 should be adopted and its implementation monitored by FIO.*
- *FIO will convene and work with federal agencies, state regulators, and other interested parties to develop personal auto insurance policies for U.S. military personnel enforceable across state lines.*
- *FIO will work with state regulators to establish pilot programs for rate regulation that seek to maximize the number of insurers offering personal lines products.*
- *FIO will study and report on the manner in which personal information is used for insurance pricing and coverage purposes.*
- *FIO will consult with Tribal leaders to identify alternatives to improve the accessibility and affordability of insurance on sovereign Native American and Tribal lands.*
- *FIO will continue to monitor state progress on implementation of Subtitle B of Title V of the Dodd-Frank Act, which requires states to simplify the collection of surplus lines taxes, and determine whether federal action may be warranted in the near term.*

The International Association of Insurance Supervisors

The International Association of Insurance Supervisors (IAIS) is a Switzerland-based organization of insurance representatives from over 140 countries. The IAIS tends to have little direct impact on the average producer because it doesn't concern itself with issues like licensing or market conduct. However, it does play a major role in establishing global

financial standards that are important to the overall health of the world's insurance community.

Assorted Federal Offices and Departments

In the relatively rare instances in which a federal law relates directly to the business of insurance, regulation can be the responsibility of a U.S. Cabinet department or some subsidiary agency. The department or agency with regulatory authority will generally depend on the kind of insurance addressed in the law. Federal health insurance laws are usually enforced by the Department of Health and Human Services. The National Flood Insurance Program is administered by a segment of the Department of Homeland Security. And as was alluded to in our explanation of the FIO, the federal terrorism-risk insurance program is overseen by the U.S. Treasury.

Common Regulatory Issues and Responsibilities

Now that we know who our regulators are, let's turn our focus toward what these various departments and other entities actually do.

Above all else, the purpose of insurance regulation is to protect the public. The next several sections explain some of the most common tasks that are meant to fulfill this important purpose.

Solvency Regulation

When an insurer's assets are enough to honor its liabilities, the company is considered to be "solvent." Solvency is an immeasurably important issue because financially mismanaged carriers might not have enough assets to make good on their promises to pay legitimate claims. An insolvent insurer harms consumers, of course, who might not receive fair compensation for insured losses, but it also has a negative impact on the other insurers in the market. When one carrier fails, other companies might be required to contribute to a state fund in order to pay for the insolvent insurer's liabilities or, at least, might be required to absorb some of the insolvent insurer's customers.

Insurers aim to prove their solvency by submitting annual reports to state regulators. Additional audits might be conducted by the state insurance department every few years for each company or might be done on a more frequent basis if a particular carrier seems financially unhealthy.

In general, states want to know that an insurer has enough "admitted assets" in order to withstand mistakes in underwriting and potential economic downturns. Common admitted assets include the values of stocks, bonds, cash and real estate. But depending on the state and the type of insurance, a carrier might be prohibited from using too much of a particular type of asset in order to prove solvency. For example, most life insurance companies aren't allowed to own significant amounts of stock, although this limit tends to be less stringent for property and casualty companies. An insurer's personal property (such as office furniture and supplies) generally won't qualify as an "admitted asset."

Guaranty Funds

State guaranty funds are used to compensate claimants whose insurance is from an insolvent company. These funds might be financed through periodic fees paid by all insurers in the state, or they might require financial contributions from all carriers once an insolvency actually occurs.

Regardless of how they are structured, guaranty funds are not ideal for consumers or insurers. They often limit a harmed consumer's compensation to a certain amount (such

as $100,000) and involve long waiting periods (usually including a liquidation process) before any benefits become available. They also risk penalizing responsible insurers by making them pay for the mistakes of irresponsible carriers. For these reasons and more, regulators and insurance professionals should take solvency requirements very seriously.

Approval of Forms

Before they can market an insurance policy to the public, insurers generally must have the policy's language (or "form") approved by the state insurance department. The approval of forms is meant to ensure that the products in the market contain the consumer protections required by law (or by rule).

Though not necessarily a roadblock to a form being approved, the policy's readability will sometimes be evaluated, too. Regulators have long believed that insurance policy language is too complex for the average purchaser and have encouraged carriers to revise their forms in ways that increase comprehension. The Insurance Services Office, in particular, has revised its many property and casualty forms over the past several decades in an attempt to make them more understandable. (Many property and casualty carriers utilize these ISO forms as a model for their own forms.)

Approval of Insurance Rates

Rate regulation has multiple goals and, therefore, can be a tricky balancing act. On one hand, regulating the amount insurers can charge for coverage can be a valuable tool that makes insurance more affordable for those who need it. But because of fears about insolvency and other kinds of market disruption, state regulators need to avoid making rates so low that an insurer's ability to cover its liabilities is jeopardized.

There are many types of insurance rate regulation in the United States. The type utilized will depend in large part on the state doing the regulating and the type of insurance in question. States have been active in the regulation of health insurance, property insurance and auto liability insurance but have often been more flexible when dealing with life insurance rates or the price of annuities.

Some of the most common rate-filing methods are summarized below:

- **Open rating:** Rates are generally assumed to be appropriate and will not be reversed by the insurance department unless there is an extreme case.
- **State-made or mandatory bureau rating:** Rates are established by the insurance department or a state-approved panel of experts but not by insurers.
- **File and use rating:** The insurance department receives an insurer's proposed rates but only has a limited amount of time to reject them. If the department does nothing, the rates remain in effect.
- **Prior approval rating:** Rates cannot be used by an insurer until they have been officially approved by the insurance department.
- **Flex rating:** Rates generally don't need to be pre-approved unless they are beyond a particular threshold (such as a rate increase of 15 percent or more).

Assorted Market Regulation

States typically prohibit a number of activities in order to keep the insurance market fair and transparent. When done properly, this helps consumers (who might otherwise be taken advantage of by slick sales gimmicks) and the good-hearted insurance professionals who would otherwise lose business to unethical competitors.

Commonly prohibited activities include (but are not limited to) the following actions:

- "Twisting," in which consumers are encouraged to change insurers for no good reason.
- "Churning," in which consumers are encouraged to change their policies for no good reason.
- "Commingling of funds," in which collected premiums are held in the same account as an agency's general operating funds.
- "Conversion," in which collected premiums are stolen.
- "Baiting and switching," in which false advertising is used to lure new customers into the door, after which they are encouraged to purchase a completely different product.
- "Fraud," in which material facts are misrepresented in order to steal money from the insurance company.
- "Unfair discrimination," in which people pay more for insurance (or aren't offered insurance) for reasons other than their data-supported risk profile.
- "Unfair claims practices," in which insurers wrongfully refuse to give insurance claimants the contractual amount owed to them.
- "Libel," in which false and defamatory statements about competitors or other people are made in writing.
- "Slander," in which false and defamatory statements about competitors or other people are said out loud.

Company Licensing

Insurance companies that want to do business in a particular state generally must have the appropriate license. Among other things, the licensing process might involve auditing the company's finances and investigating the financial and personal histories of its top-level personnel. Unless the insurance department becomes aware of misconduct and initiates more frequent investigations, licensed carriers can generally expect to be subjected to a thorough state audit every three to five years.

Specific licensing requirements might depend on whether the company is a "domestic insurer," "foreign insurer" or "alien insurer." These terms relate to where an insurer has its home office, but their definitions aren't as simple as they might seem.

In regard to licensing, a licensed insurance company is considered a domestic insurer in its home state but is a foreign insurer in any other state where it also has a license. An alien insurer is an insurance company from another country. Since they are all licensed entities, domestic, foreign and alien insurers are collectively known as "admitted carriers."

When insurance cannot be easily obtained in a given state, a consumer might be able to purchase coverage from a "non-admitted carrier." Although they might be licensed elsewhere, non-admitted carriers are not licensed to sell insurance in the buyer's state. In order to provide some consumer protections against an unlicensed carrier, insurance from a non-admitted carrier can only be purchased with the help of specially licensed professionals and only under special circumstances. In general, the producer selling the insurance must be licensed as a "surplus-lines broker" in the buyer's state and must be

able to show that adequate coverage from an admitted carrier was not reasonably available.

Producer Licensing

Insurance producers, including agents and brokers, must be licensed in order to sell insurance. However, many states allow someone with an expired license to receive a commission when a consumer renews a policy, as long as the initial sale occurred while the license was in effect. Despite a push for greater uniformity and reciprocity in the licensing process, each state is responsible for enforcing its own licensing requirements.

According to the Federal Insurance Office, more than 2.3 million individuals are licensed to sell insurance. Those 2.3 million people hold over 6 million licenses. The difference in those numbers is the result of many individuals having licenses in multiple states. A license from a producer's home state is the person's "resident license," and any licenses from other states are known as "non-resident licenses."

In order to become licensed as a producer, a person must complete pre-licensing education, pass a state exam, pay various fees and undergo some kind of background check. A few states also require a licensee to already be affiliated with a particular insurance company. This relationship is sometimes called an "appointment." Even if an appointment isn't a mandatory part of the licensing process, each insurance company might have its own requirements and procedures before a licensee can sell the company's products.

Individuals who are interested in obtaining a producer license must choose one or more "lines of authority." The line of authority is the kind of insurance that a license allows someone to sell. At the very least, a state will have a life/health line of authority and a property/casualty line of authority. Many states don't combine life and health or property and casualty and also have additional lines of authority (such as personal lines and limited lines automobile). The chosen line of authority will dictate the kinds of pre-license coursework that must be completed and the type of state exam that must be passed.

Upon the conclusion of a license term, a producer can usually renew his or her license by submitting documentation to the department of insurance, paying required fees and completing continuing education. Many states have followed the NAIC's continuing education standard, which requires a producer to complete at least 24 hours of continuing education (including three hours of ethics training) every two years. Individuals selling annuities or long-term care insurance are likely to have additional continuing education requirements. And of course, as in most things related to insurance regulation, each state is likely to have its own rules regarding hours, course content and course delivery.

Multi-State Regulation

Despite their generally strong belief that insurance should be regulated at the state level, many producers and carriers have softened their stance in recent years due to the challenges of multi-state requirements. If an insurer wants to offer the same product across the country, it might have 50 different approval processes to complete (one for each state), including the payment of fees and the tedious completion of paperwork. Similarly, if an insurer or a producer wants to become licensed in more than one state, obtaining the additional licenses might be a long, strenuous process with different requirements across different jurisdictions.

At least in regard to licensing, the federal government and the NAIC have supported greater reciprocity among the states so that producers doing business in different places

don't need to jump through so many bureaucratic hoops. In fact, the aforementioned Gramm-Leach-Bliley Act addressed this very issue by suggesting the creation of a national licensing entity.

The National Association of Agents and Brokers

In response to complaints from insurance trade groups whose members wanted to become licensed in multiple states, Congress inserted producer licensing language into the Gramm-Leach-Bliley Act. Under the law, the states were given an ultimatum: Either enact reciprocity laws that would allow out-of-state producers to easily obtain a non-resident license, or risk the formation of the National Association of Agents and Brokers (NARAB).

NARAB was initially viewed not only as a clearinghouse where producers could easily apply for licenses from multiple states but also as a threat to each state's licensing powers. Fears over federal oversight prompted nearly every state to adopt reciprocity agreements among themselves, as well as many standard licensing rules proposed by the NAIC. For example, the NARAB threat contained in the Gramm-Leach-Bliley Act was at least partially responsible for the implementation by many states of a three-hour ethics training requirement as part of a producer's continuing education.

The response to the original version of NARAB resulted in greater licensing reciprocity across the United States, but producers have since realized the difference between reciprocity and uniformity. While reciprocity allows a licensee in one state to become licensed in another state without having to complete all of the same steps as an unlicensed person, the steps that can be skipped often still differ across state lines. Furthermore, even if a producer is only required to complete a few forms and submit fees in order to obtain a non-resident license, someone applying in multiple states hasn't been able to send all the forms and all the fees to one central location. So, a non-resident's application in one state might be approved quickly, while the same person's application in another state might remain unapproved until certain items are delivered or other requirements are satisfied.

The drive for more uniformity was strong enough for NARAB to be reconsidered and supported by both houses of Congress in 2014. This new version of NARAB (sometimes referred to as "NARAB II") would create a licensing clearinghouse and an online portal through which producers would be able to submit all non-resident licensing applications and fees at the same time. Membership would be contingent on having met various requirements established by a board of directors (such as completion of continuing education and a background check) and would be entirely voluntary. A producer who is only licensed in one state or in only a few states might opt against joining NARAB, but producers who want to sell in several states might choose to join.

Since NARAB II does not call for states to lose any of their regulatory authority (and is meant to be more of a facilitator in the licensing process than anything else), the NAIC and several producer organizations supported its creation. However, even though the basics of NARAB II were signed into law in 2015, this attempt at greater licensing reciprocity had not yet been implemented at the time this course was written.

Conclusion

By now, it should be obvious to you that insurance regulation is both an important and dynamic issue. Theories about how to best protect consumers can change just as often as the products being offered to the masses. But no matter what changes ultimately occur,

insurance professionals must always be aware of the many regulators who set rules for conduct.

CHAPTER 2: INSURING CYBER RISKS

Introduction

Modern technology has blessed us with many conveniences and efficiencies. Among other things, we can access a wealth of information from our phones or other small devices, purchase a wide range of products and services over the internet, and store large amounts of electronic data on "clouds" from practically any computer at any time.

Unfortunately, those advances have redefined the nature of various risks for businesses and individuals. The handy gadgets that contain all sorts of private information about ourselves or our customers can be lost or stolen. The payment information we submit to an online business might be intercepted by an untrustworthy person and used to steal our identity. And no matter how much a vendor might advertise its services as "safe," all the information we upload to a cloud provider has the potential of being viewed by pesky and anonymous hackers.

For today's modern businesses, the risks associated with technology can become very real very quickly. Practically every day, we hear stories about a retailer that has had its customers' credit-card information stolen or a health care provider that has experienced a security breach and jeopardized the privacy of its patients. These occurrences can ruin a company's reputation and can cost a business untold amounts of money in the form of lawsuits, regulatory fines and crisis management.

Recognition of these sorts of "cyber" risks has inevitably led to changes in the insurance industry. Carriers specializing in commercial lines have attempted to protect themselves by adding and clarifying cyber-related exclusions in their basic property and casualty products. Yet they've also acknowledged the demand for an insurance-related solution to cyber risks and have introduced new options for security-conscious organizations. These options are part of an emerging market for what is sometimes known as "cyber insurance."

The market for cyber insurance is still practically in its infancy. In fact, experts still aren't even in complete agreement about whether to call this type of coverage "cyber insurance," "cyber-risk insurance" or something else. (For the sake of consistency, we will use the term "cyber insurance" from this point forward.)

The newness of the market makes it a great subject for continuing education. At a time when relatively few producers are paying attention to cyber insurance, your knowledge of the topic might help separate you from the competition.

The next several pages will guide you through the evolution of cyber insurance. You'll learn about the ways in which insurers addressed cyber risks in the past and how you can help prospects and policyholders in the present. We'll even look a bit ahead and raise some key questions that are likely to be integral to cyber insurance's future.

All the while, we'll emphasize the overall importance of risk management in regard to cyber threats. This message ought to apply not only to those producers who plan to sell cyber insurance but also to those who collect any type of client information and want to keep it secure. As former FBI director Robert Muller once warned, "I am convinced that there are only two types of companies: those that have been hacked and those that will be."

The Birth of Cyber Insurance

According to a report from the U.S. Department of Homeland Security, the first insurance product designed specifically to address cyber-related risks debuted in the 1970s. Most businesses, though, either didn't concern themselves much with these types of risks or

assumed they had adequate coverage against technology-related threats via the standard forms of commercial property and casualty insurance. Over the next 30 years, stand-alone cyber insurance was purchased occasionally by banks but hardly ever by anyone else.

The first major movements toward a cyber insurance market were made by insurance carriers near the start of the 21st century. In response to widespread fears surrounding Y2k and what might happen to all sorts of computer systems in the year 2000, insurers began taking a hard look at their own cyber-related liability and began adding strict exclusions to their policy language. Commercial property forms began limiting coverage to "tangible property" and made it seemingly impossible for a business to be compensated for the loss of valuable data. Then, slowly but surely, policies for business interruption and general liability began using benefit triggers such as "direct physical damage to property," thereby making it harder for businesses to utilize their insurance following a technology-related shutdown or the accidental disclosure of customers' private information. Increased vigilance regarding terrorist threats and the possibility of widespread cyberattacks added to insurers' concerns and became an extra incentive for carriers to enforce the new and narrower language.

Businesses can still insure themselves against certain types of cyber risks, but they should expect to pay extra for it by either purchasing a stand-alone cyber insurance product or having a cyber-specific endorsement added to a pre-existing insurance policy. Either option has the potential to help manage cyber risks, but companies that care less about the size of premiums and more about obtaining broad coverage with high dollar limits tend to choose a stand-alone product. This is particularly true when a business is equally concerned about first-party losses (such as those related to an unexpected shutdown) and third-party losses (such as those related to liability for a data breach).

Note, however, that generalizations about cyber insurance are difficult to make and might become inaccurate in the years to come. This course material was written at a point when the market for this type of coverage was still finding its footing and hadn't produced much uniformity.

Unlike many of the major types of property and casualty insurance being sold, cyber insurance still has no "standard form" with common provisions and exclusions that are worded similarly from carrier to carrier. A major component of one carrier's cyber insurance product might not be available from a competing carrier. Similarly, the process for evaluating applicants for cyber insurance might be fairly complex at one insurance company and relatively simple at another. Significant differences in coverage, pricing, and underwriting are likely to continue until the insurance industry has had adequate time to measure the severity of cyber risks and learn more about customers' needs. (Note, however, that some insurers were pushing for a unified standard form at the time this course was being written and have made the case that standard coverage would make the industry more capable of managing its exposure to various cyber risks.)

The differences and inevitable changes in the cyber insurance market increase the importance of dedicated, knowledgeable insurance professionals to concerned businesses. When a business expresses an interest in cyber coverage, the business's insurance broker should evaluate all of the available options and carefully confirm that the product being purchased will, in fact, address the business's goals. Once coverage has been issued, the broker should pay close attention to changes in the market and not assume that the business's existing cyber insurance will always be the most comprehensive or affordable option. Although businesses certainly have a responsibility

to implement reasonable security measures in order to reduce cyber risks, they should not be expected to navigate this new sector of the insurance market on their own.

Common Cyber Insurance Customers

In general, a business's willingness to purchase cyber insurance will depend on answers to the following questions:

- How big is the business?
- How much personal or financial information does the business store about its customers or clients?
- Is the business highly regulated and required by law to keep personal or financial information secure?

A large business that collects a significant amount of data about its customers and is subject to federal privacy laws is generally more likely to purchase cyber insurance than a small business that maintains relatively little data and has no extraordinary obligation to keep that data private.

So far, some of the most common purchasers of cyber insurance have been as follows:

- Cities and municipalities.
- Health care providers.
- Financial institutions.
- Insurance companies.
- Law firms.
- Major retailers.
- Technology firms.

Though on the rise, cyber insurance is not purchased by a majority of businesses. Some businesses continue to believe that their basic property and casualty insurance packages will adequately protect them against cyber-related losses. Many others have taken the important step of discussing cyber insurance with insurance experts but have ultimately determined that the cost of coverage is too big for their budget.

Individual producers can help widen the cyber insurance market by educating business owners and risk managers about the potential gaps in commercial property and commercial general liability policies. Meanwhile, carriers may be able to stabilize pricing of cyber insurance by advocating for more sharing of information about cyber threats and any related losses. Both of these approaches to expanding cyber insurance's popularity are explained in later sections of this course.

The Role of Loss-Related Data

Insurers have long believed in the "law of large numbers," which essentially says that larger amounts of data are more reliable than smaller amounts of data. If an insurer lacks enough data about a particular type of risk, it cannot price related coverage accurately and will usually either refuse to cover the risk or only agree to cover it in exchange for high premiums. Conversely, if the insurance community believes it has significant amounts of data about a risk, it is easier for carriers to arrive at a fair price for a related insurance product and less risky to enter the market.

Access to and analysis of more data is critical to the future of the cyber insurance market. This is one major reason why the insurance community has expressed support for greater sharing of cyber-related information and greater uniformity in regard to reporting cyber breaches. While insurers and other interested parties have learned a great deal about security lapses at major health carriers and the theft of credit-card information from major retailers, less is known about the frequency and cost of similar incidents at smaller businesses or in other sectors of the economy. Such incidents tend to receive fairly little publicity or might not even become public at all. The gap in information puts insurers at a disadvantage and ultimately hinders competition in the insurance marketplace.

With more data at their disposal, insurance companies should be able to form a firmer understanding of cyber risks and adjust their pricing accordingly. More information can create clearer distinctions between high-risk and low-risk applicants and might make carriers more inclined to dangle cost-related incentives to those businesses that are willing to demonstrate a firmer commitment to privacy and security. In an ideal scenario, those incentives will ultimately benefit society at large because businesses that want to lower their cyber insurance costs will be more inclined to implement strict security plans in the first place.

The Role of Government

Since 2012, the U.S. Department of Homeland Security has sponsored a series of workshops and roundtables that emphasize the important link between insurance and data security. These events—which have included significant participation from insurance carriers, risk managers, government officials and experts in information technology—have suggested that there is broad agreement regarding the need for greater sharing of information and the manner in which a healthy insurance market can lead to a better-protected public.

At the time this course material was being written, the federal government was in the process of drafting a set of security standards that, if implemented by a business or other organization, would signify an elevated commitment to data security and cyber-risk prevention. Insurance companies have been viewed as valued consultants in the drafting of these standards due to the amount of sensitive information they typically collect and their own experiences with risk management. Though the national standards aren't intended to be used specifically by insurance companies, it is certainly possible that some carriers will consider them when evaluating an applicant for cyber insurance.

So far, the federal government has generally supported the idea of a bigger and more stable market for cyber insurance. The government has assumed that insurers can play an important role in educating businesses about cyber risks and in using the threat of high insurance premiums to improve businesses' behaviors.

In addition to requests to facilitate more sharing of information about cyber threats and actual breaches, the government has been asked by insurers to help stabilize the market by creating a federal backstop for cyber insurance risks. Presumably, this type of backstop would work in a manner similar to the federal terrorism-risk insurance program, with insurers agreeing to offer cyber insurance on a wider basis in exchange for the government agreeing to cover catastrophic losses above a certain dollar amount. However, this type of government-backed cyber insurance program would likely require legislative action and has not yet gained significant support in Congress.

More information about the relationship between cyber risks and the federal government can be found later in this course.

Contemplating First-Party and Third-Party Losses

A business that is concerned about cyber risks should consider its susceptibility to "first-party losses" and "third-party losses."

First-party losses are the financial losses or costs that a business might encounter after a cyberattack or data breach regardless of whether any of its customers, clients or other third parties might have been harmed. Examples of first-party losses include the following:

- The business's temporary loss of income resulting from the unexpected shutdown of its computer systems.
- The business's temporary or permanent loss of valuable proprietary information, such as trade secrets, resulting from cyber theft.
- The cost to replace stolen or misplaced computer hardware.
- The cost to repair and re-secure the business's breached computer systems.
- The amount demanded by a hacker in exchange for either "unfreezing" a business's computer systems or agreeing to not disclose sensitive data.

Third-party losses are the financial losses or costs that a business might encounter if it is held liable for a potentially harmful cyberattack or data breach. Examples of third-party losses include the following:

- Amounts paid to customers, clients or other third parties in lawsuits stemming from a cyberattack or data breach.
- Amounts paid by the business to defend itself in lawsuits stemming from a cyberattack or data breach.
- Amounts paid as part of "crisis management" in order to minimize potential lawsuits stemming from a cyberattack or data breach (such as the cost of notifying impacted customers and providing credit-monitoring services to them).
- Amounts paid to the government in the form of regulatory fines.

Be aware that even an excellent cyber insurance product is unlikely to address all of these potential losses. Some losses (such as the first-party loss of data) are difficult to translate into dollar amounts and are therefore practically uninsurable. Others (such as amounts paid to criminals and amounts paid in the form of regulatory fines) are potentially incompatible with insurance because compensation for them could be perceived as an indirect endorsement of illegal activity.

Regardless of the specific loss being contemplated, producers who advise businesses about cyber insurance should carefully review all policy language before recommending a particular product.

Coverage Under Other Insurance Policies

In addition to their common concerns about cost, businesses often choose not to purchase cyber insurance because they believe they already have adequate protection under their existing commercial insurance package. Whether these business are correct about the scope of their commercial property and casualty insurance is currently a matter of heated debate among lawyers, courts and carriers. Arguments for and against coverage of cyber-related losses tend to depend on the type of policy being discussed.

Cyber Coverage and Commercial Property Insurance

Successful claims of cyber-related property damage are relatively rare due to language found in standard policy forms from a private company called the Insurance Services Office (ISO). Though insurance companies aren't required to use ISO language, many carriers choose to do so.

Since roughly the start of the 21st century, most ISO commercial property policy forms have made distinctions between damage to "tangible property" and damage to "intangible property." Standard policy language includes coverage for damage to tangible property but excludes damage to intangible property. For clarity, today's ISO forms will typically state that data is intangible and is, therefore, not insured against property damage.

Cyber Coverage and Commercial General Liability Insurance

Commercial general liability insurance is purchased by businesses that want to protect themselves from the following risks:

- Bodily injury to another person (such as a client, a customer or a visitor to the business's premises).
- Damage to another person's property (such as the property of a customer or client).
- Personal or advertising injury (including, but not limited to, the violation of someone's privacy rights).

Bodily Injury or Property Damage and CGL Insurance

Though relatively rare, claims of bodily injury after a data breach or cyberattack tend to focus on the alleged stress and other mental health issues that are sometimes experienced by victims, such as customers whose privacy has been breached. Most commercial liability insurers use policy language based on wording from the ISO, which typically defines "bodily injury" to mean "bodily injury, sickness or disease sustained by a person, including death resulting from any of these at any time." In general, claimants who have asserted that this definition includes temporary bouts of stress (such as the kind that might be felt by a customer after learning about a data breach) have received little support from carriers and the courts. Similarly, businesses that expect their commercial general liability insurance to cover them for cyber risks on the basis of property damage will typically run into the same issue of tangible vs. intangible property mentioned earlier.

Personal and Advertising Injury and CGL Insurance

Businesses have had greater—albeit still mixed—success when claiming that their commercial general liability insurance policy's coverage of "personal and advertising injury" would include cases in which their customers' private information is breached or improperly exposed. Common ISO language defines "personal and advertising injury" to mean, in part, "oral or written publication, in any manner, of material that violates a person's right of privacy." Until recently, unlike the aforementioned definition of "bodily injury," the definition of "personal and advertising injury" did not include a specific exclusion related to electronic data.

Despite some earlier court decisions that upheld coverage for businesses after data breaches, recent developments seem likely to make cyber-related coverage under the "personal and advertising injury" definition far less common. Two relatively recent court cases, for example, have focused on the word "publication" and have ultimately resulted in policyholders having to pay significant amounts out of pocket in order to manage

customer backlash. In one case, computer tapes containing the personal information of thousands of customers and employees fell out of a vehicle. Although the business spent money to notify those individuals and get ahead of a potential crisis, the Connecticut Supreme Court ruled there was no "publication" of the information (and therefore no coverage for personal and advertising injury) because the tapes were ultimately returned without being accessed. In a separate case out of New York, information about a business's customers was, indeed, published by computer hackers, but the court ruled that insurance for personal and advertising injury would have only applied if the insured business—not the hackers—had done the publishing.

In order to clarify the limits of coverage even further, the ISO released several new endorsements in 2013 and 2014 that are to be used in conjunction with its standard commercial general liability policy form. These endorsements, while many in number, are all designed to clarify that cyber-related risks (including those related to personal and advertising injury) are not supposed to be covered by commercial general liability insurance.

Not all carriers use ISO language as the basis for their policies, and those that do are sometimes slow to implement the organization's revisions to its coverage forms. However, the ISO's actions and insurers' willingness to take their customers to court send the same signal: Even if their customers don't like it, carriers are not inclined to cover cyber losses under traditional types of commercial insurance.

Getting Approved for Cyber Insurance

The level of scrutiny given to an applicant for cyber insurance will depend on the chosen carrier and, to a certain extent, the recent history of cyber threats. In a manner similar to setting the prices for coverage, it is widely assumed that the industry will arrive at a more uniform way of evaluating cyber insurance applicants if and when more data about cyber risks becomes available.

Carriers seem to have already arrived at the collective conclusion that many instances of cyber breaches or attacks can be traced back to human error. This understanding is likely to be reflected in the kinds of questions that applicants are asked and the weight that will be given to a business's answers. In the past, some carriers would evaluate applicants on the basis of advanced technological audits, sometimes at applicants' own expense. Today, there might be a more balanced approach to the underwriting process that emphasizes the applicant's character and overall commitment to risk reduction. A carrier might care less about the details of an applicant's computer systems and more about whether the applicant can speak intelligently about cyber risks. A reasonably fair assumption is that the business's systems will ultimately evolve along with technology but that an applicant's obvious commitment to security is unlikely to change.

Here are some questions that might be important to a carrier when it is evaluating an applicant for cyber insurance:

- Does the applicant have any written internal policies related to data security?
- Has the applicant demonstrated a commitment to enforcing its written security policies?
- Does the applicant train and periodically retrain its employees regarding data security policies?
- Does the applicant already have a plan that will be followed in the event of a security breach?

- Does the applicant have a clearly defined managerial structure with clear lines of accountability?
- What type of data does the applicant collect and store?
- How much data does the applicant collect and store?
- How many people have access to the applicant's data?
- What is the applicant's cyber-related loss history?
- What is the loss history of businesses that are similar to the applicant?
- Do any vendors share, store or receive data on the applicant's behalf? If so, what procedures or protections are in place to manage the applicant's liability for data breaches and cyberattacks?
- How much insurance is the applicant requesting?

Policy Features and Exclusions

The next several sections will summarize the provisions and exclusions that might be contained in a cyber insurance policy. But as was mentioned earlier in these materials, there is no "standard form" for cyber insurance. When advising businesses about how to manage cyber risks, producers should make no assumptions regarding what a particular product will cover or exclude.

Notice to Potential Victims

If a security incident has made it possible for someone's personal information to be accessed inappropriately, the impacted business should take steps to notify everyone whose information may have been compromised. In some cases, this might be a legal requirement. In others, it is simply a smart form of crisis management that keeps clients and customers informed of the situation. As much as customers don't like having to cope with breaches of their data, their opinion of a business is likely to deteriorate even more if they believe the business is trying to hide a very serious problem.

The costs of notifying potential victims of a cyber breach can be expensive, particularly if there are thousands of people to contact. In many cases, those costs will be covered by cyber insurance.

Identity Theft Protection

In order to reduce the amount and impact of class-action suits after a data breach, cyber insurers will often provide a limited form of identity-theft protection to a business's customers who might have been affected by a cyber-security incident. This protection is typically in the form of credit-monitoring services, which are meant to catch instances in which exposed data is used to take out loans or create other forms of debt in a victim's name. Depending on the policy, the carrier might get to choose the vendor who will provide the credit-monitoring services.

Acts of War and Terrorism

Since 2001, the federal government and the insurance community have wrestled over how to insure businesses against terrorism-related risks. A federal reinsurance program was eventually established so that commercial policyholders could have access to some terrorism-risk coverage (albeit at a cost) and so insurers wouldn't be responsible for all losses that might arise from a catastrophic event. However, the general requirement to offer terrorism-risk insurance to commercial insurance applicants and commercial

policyholders is limited to certain types of insurance products and does not extend to cyber insurance policies.

A stand-alone cyber insurance policy is unlikely to respond in cases where cyberattacks are clearly an act of war or terrorism. Yet it is important for producers and their clients to clearly understand how those war and terrorism exclusions are defined.

For example, consider a cyberattack that is widely rumored to be connected to a particular foreign government. Would those facts alone be enough to either deny a cyber insurance claim or provide benefits under a cyber insurance policy? Or would other factors contribute to a carrier's decision, such as the specific country rumored to be involved, whether the attack leads to retaliation by the United States, or whether the federal government officially classifies the attack as an act of terrorism?

As was mentioned earlier in these materials, many insurance professionals have suggested that the federal government's existing program for terrorism risk be expanded or used as a template in order to stabilize the cyber insurance market and eliminate some of the coverage-related confusion. After all, they argue, the federal government is responsible for keeping the country safe from foreign attacks, often makes policy decisions that increase the threat of attacks, and likely has more information about potential attacks than anyone at an insurance company.

So far, the federal government has expressed interest in strengthening the cyber insurance market but has not endorsed a national insurance program meant to manage cyber risks.

Acts by Employees

Whether a concern relates to accidental loss of a laptop, the inadvertent infection of company data or outright theft of a company's information, it is important to understand how claims involving employees will be handled. Depending on the policy, there might be an outright exclusion for breaches and attacks caused by a business's own workers. Alternatively, a carrier might make a distinction between breaches and attacks caused by unintentional employee error and those that were caused with clear intent to harm the organization. When this distinction is made, acts that are clearly crimes by employees are less likely to be covered by cyber insurance.

Regulatory Fines

Since insurers don't want to encourage illegal activity, they are often hesitant to sell products that allow their customers to be reimbursed for regulatory fines. In the event that a cyber insurance policy includes coverage for regulatory fines, the policy will usually have a sublimit associated with those fines. The sublimit attempts to find a middle ground on this issue by providing some help to policyholders but also making it likely that a business will still suffer some out-of-pocket losses in the event of a major regulatory violation.

Note, however, that certain laws and rules don't allow violators to use insurance in order to cover regulatory fines. Businesses that are concerned about whether insurance can be used to pay fines associated with a particular state or federal law should consider consulting an attorney.

Forensic Investigations

A forensic investigation can help a business and the insurance company determine how a breach or cyberattack actually occurred. One obvious benefit of an investigation is that it can identify potential solutions to the business's cybersecurity problems and make it less

likely that a similar scenario will arise again. In some cases, an insurance company might agree to pay for a forensic investigation and will even choose the vendor to conduct it.

Business Interruptions

Some cyber insurance products will cover the kinds of first-party losses that might occur if a cyberattack forces a business to temporarily close its doors. Though this might seem like valuable protection for businesses engaged in e-commerce, careful consideration should be given to any waiting or "elimination period" contained in the policy's language. As part of this evaluation, the business should also consider the likely length of a cyber-related shutdown.

Consider, for example, a company that is reasonably confident that a cyberattack won't force a shutdown that lasts more than three days. If the business interruption component of a cyber insurance policy calls for a seven-day elimination period before benefits can begin, the coverage is unlikely to ever be usable. However, if the same business has an elimination period of three days or less, the coverage has a greater chance of being helpful.

IT Errors and Omissions

Errors and omissions coverage can be an important part of an insurance portfolio for business that create their own software and share it with their customers. If the business's software transmits a virus to customers' computers, the business might be liable for the damage. Though cyber insurance might be part of the solution to this problem, companies that make and share their own software might want to also examine the contents of their existing product liability or errors and omissions policies first.

Computer Hardware

Certain types of damage to a business's hardware, including its computers, might actually be covered by traditional forms of commercial property insurance. Unlike data, a desktop or laptop computer can be touched and is therefore considered a type of "tangible" property. You'll recall, however, that the data stored on a computer is "intangible" property and is usually exempt from coverage under common commercial property and casualty policy forms. So even if an insurer agrees to replace a computer, it won't necessarily agree to replace everything stored on it.

Even though a computer can, to a certain degree, be considered tangible property and be covered by traditional types of insurance, a claim for a damaged computer might be denied if the damage relates to a cyberattack rather than to a fire, a natural disaster or a burglary. In order to insure hardware that becomes unusable because of a cyberattack, special cyber insurance might be necessary.

Breaches Experienced by Vendors

Many businesses use vendors in ways that require the sharing or collection of customers' data. Though sometimes unavoidable, the sharing of data between a business and its vendors can create challenges related to effective risk management. Vendors might not take cyber security as seriously as their clients or might at least be exposed to different types of risk due to their line of work and the large amounts of data they hold. There might also be uncertainty regarding who is ultimately liable—the vendor or the vendor's client—if a vendor experiences a breach or cyberattack.

In order to provide some liability protection for themselves, businesses should consider cyber risks before cementing a relationship with a new vendor. Depending on the circumstances, this might mean adding a contractual requirement that forces the vendor

to purchase cyber insurance. It might also include making it contractually clear that the business enlisting the services of the vendor will not be liable for any data breaches or cyberattacks that occur while data is in the vendor's possession. As an extra safeguard, and as a way of dealing with cases in which those two options aren't practical, a business might consider making sure that its own cyber insurance policy includes coverage for breaches and attacks involving the business's vendors.

Defense Costs

A cyber insurance policy should include coverage of defense costs in case the policyholder is sued for wrongdoing. Ideally, coverage of defense costs should not reduce the policy's overall dollar limit and should be based on a "duty to defend" rather than a "right to defend." A duty to defend is broader than a right to defend and allows the insured to receive paid legal counsel even if the carrier later determines that a claim for damages should not be covered by the policy. A mere right to defend might force the insured to pay out of pocket for legal assistance in cases where liability is relatively ambiguous.

Dollar Limits

Since class-action suits involving data breaches typically involve millions of dollars, it might be unwise to purchase cyber insurance that caps benefits at a fairly low dollar amount. However, many carriers are worried about being too exposed in the cyber market and tend to put a cap on the amount they will sell to any single business.

Many business have responded to insurer-imposed caps by purchasing separate cyber insurance products from several different carriers. Essentially, this creates a potential scenario in which one carrier would be the primary insurer after a cyber-related loss and the other carriers would cover losses above certain amounts if the primary coverage is ever exhausted.

Regardless of whether a business purchases one or several cyber insurance products, dollar limits should be examined carefully so they match the business's specific needs. For example, if a business is primarily interested in covering itself for cyber-related business interruptions and is less interested in cyber liability coverage, it should examine how the policy's overall dollar limit addresses those specific business interruption concerns. In this case, a policy that has a $1 million dollar overall limit but puts a $1,000 limit on business interruption losses (with the rest meant to cover cyber liability) would be a misleading and potentially harmful choice.

Claims-Made vs. Occurrence Policies

The vast majority of cyber insurance policies are "claims-made" policies and are not "occurrence policies." A claims-made policy only pays claims that arise during the policy period. An occurrence policy pays claims regardless of when they are made, as long as the event that triggered the claim occurred during the policy period.

To understand the difference between claims-made and occurrence policies, consider a scenario in which a breach occurs near the end of a policy's expiration date. With a claims-made policy, the business would not necessarily be covered if impacted customers decided to sue the business after the policy's expiration date. With an occurrence policy, the business would potentially have coverage for this type of lawsuit.

When purchasing coverage for the first time, some businesses will want a long "retroactive date," which would allow them to be covered for breaches or cyberattacks that actually occurred prior to the policy's issue date but still haven't been detected. Most insurers, though, will reject this request and will make the policy's retroactive date identical to its

issue date. In other words, for coverage to be possible, both the claim and the incident leading up to the claim must occur during the policy period.

Dealing With Claims

Businesses that are aware of a situation that might result in a claim against their cyber insurance policy should contact the insurer as soon as possible. Adequate notice allows the insurer to plan for losses and to potentially minimize those losses through various forms of crisis management.

Even if a business is completely unaware of a situation that might result in a claim, the business should periodically review its security plans to ensure they are up to date and in line with the organization's current business practices. Once an applicant has been approved for coverage, security plans should not remain stagnant. In fact, failure to maintain certain security measures could jeopardize coverage of future losses.

Conclusion

By now, you should have a firmer understanding of the growing market for cyber insurance. But despite the benefits of cyber insurance products, keep in mind that even a fairly comprehensive insurance plan can't protect an organization's reputation after a breach or cyberattack. If a business is truly concerned about cyber risks, it should consider a multi-faceted strategy that not only includes insurance but also stresses the importance of training, vigilance and accountability.

CHAPTER 3: ADDRESSING LONG-TERM CARE NEEDS

Introduction

Advances in medical science are allowing Americans to live longer than ever before. However, the seemingly fortunate increase in life expectancy raises questions about an older person's continued qualify of life. While people of advanced ages can certainly find happiness and make priceless contributions to the lives of others, each passing year makes them more likely to need assistance with basic daily activities. Dealing with this need for help is often a courageous, exhausting and expensive task for both the individual and his or her family members.

The multi-faceted challenges of needing "long-term care," which can generally be defined as non-medical care that a person requires for at least 90 days, are probably already somewhat understood by most adults. Even if they haven't been directly responsible for ensuring proper care for an elderly parent, they've almost certainly observed the impact of this responsibility on other family members, co-workers and friends. The solution to long-term care is often far from obvious, and our other obligations (to our jobs, our family and ourselves) are unfortunately not likely to stop while we try to find it.

To a certain extent, practical solutions related to long-term care have been complicated by changes in society. These changes have often been necessary and even positive in some respects, but they have certainly given us more to think about when a loved one needs some extra help. For example, consider the following societal changes from the past 50 years or so:

- Fewer households feature a stay-at-home adult. This has made it less likely that an elderly person who needs long-term care will merely move from his or her own home to a younger relative's home.
- Adult children often live in different geographic areas than their parents. If adult children don't live reasonably close to their adult parents, care for the parent can be more difficult to coordinate. It may also be harder to judge whether an elderly parent can still live independently or requires some assistance with daily activities.
- Parents are having fewer children. As a result, the responsibility for a parent's long-term care is less likely to be spread out in manageable portions among several family members.
- Adults are waiting longer to marry and to have children. This has created a "sandwich generation" of people who are caring for elderly parents while also continuing to provide financial support to their own kids.

The federal government estimates that approximately 70 percent of people who reach age 65 will eventually need some kind of long-term care. Among that large majority of seniors, approximately 20 percent will need long-term care for at least five years.

Despite those striking numbers, they don't necessarily prompt more people to plan around the need for long-term care. Indeed, the statistics can have the exact opposite effect because they can provoke so much fear. The possibility of needing long-term care inevitably makes us think of unpleasant scenarios involving our physical deterioration or even incapacitation. Given the choice to either address those anxieties or think about something else, who among us wouldn't opt instinctively for the latter?

The good news is that medical providers, insurance professionals and advocates for senior citizens are working to change some of the stereotypes surrounding long-term care.

In the past, long-term care was often viewed as something that was given only to residents of nursing homes. Today, it is actively promoted as something that might be provided in private homes or in other settings that preserve as much independence for the recipient as possible. And while products like long-term care insurance might end up being extremely important for people who eventually require constant care, they can also be utilized by people who only need help with a few activities, such as getting dressed or taking a shower.

The prospect of needing long-term care isn't going to please anyone, but those who need it don't have to be stripped of their dignity and happiness.

The Purpose of Long-Term Care Insurance

Long-term care insurance helps cover the costs of skilled, intermediate and custodial care that is likely to be needed by an individual for at least 90 days.

Perhaps the best way to define long-term care insurance is to explain what it is not. For example, long-term care insurance is not insurance for medical treatment that is provided in hospitals or physicians' offices. Neither is it short-term nursing care for someone who is temporarily disabled and is likely to recover in a few weeks.

Instead, long-term care insurance might be used to pay someone who will visit an elderly or disabled person a few times a week for six months in order to help the person bathe and get dressed. Or it might be used for several years in order to pay for the daily help that is available at an assisted-living facility or nursing home.

Though long-term care insurance was technically sold as early as the 1970s, it took another 20 years or so for average consumers to take notice. By the 1990s, many financial professionals assumed that the looming retirement of the Baby Boomer generation would result in a hugely profitable market for long-term care insurance. Those expectations were spoiled by a variety of factors (including a perceived lack of affordability), but that hasn't stopped both the private and public sectors from encouraging adults to confront their possible need for good coverage. By 2012, according to the American Association for Long-Term Care insurance, more than 8 million Americans were protected by long-term care insurance products.

Levels of Long-Term Care

In general, there are three levels of long-term care, with each level representing a different degree of severity and required medical expertise. The three levels are listed below:

- Skilled care.
- Intermediate care.
- Custodial care.

The differences in each level of care can be important when evaluating a person's health situation and attempting to formulate an appropriate insurance plan for that individual.

Many objections that are raised by consumers in regard to long-term care insurance relate to Medicare, Medicaid and private insurance programs that are allegedly already in place to fund long-term care services. However, these programs typically treat each level of care differently and are therefore less of a safety net than many insurance prospects believe. For example, programs like Medicare might pay for a relatively large amount of skilled care under certain circumstances but be far less generous when asked to pay for custodial care. With the right policy in place, long-term care insurance can minimize this kind of gap.

Skilled Care

"Skilled care," is care that is prescribed by a physician and available (although not necessarily used) on a 24-hour basis. It might include various kinds of physical or speech therapy as well as the changing of dressings and bandages. Since it is available around-the-clock, most recipients of skilled care receive it in a hospital or nursing home.

Many states prohibit the sale of long-term care insurance that only covers skilled care. Similarly, some states have made it illegal to only cover lower levels of care if the insured person has already needed skilled care. This is a major difference between private long-term care insurance (which is usually meant to cover all three levels of long-term care) and programs like Medicare (which typically only cover long-term care if the person requires skilled care).

Intermediate Care

In regard to long-term care, "intermediate care" is medically prescribed care that is provided every day but is not available on a 24-hour basis. For example, an assisted-living facility might provide intermediate care from a physical therapist who works onsite for a few hours each day but is not available at any time.

Some content experts have a different definition of "intermediate care" and use this term to mean rehabilitative care that won't be needed on an indefinite schedule (such as care for a nursing-home resident who will eventually move back to a private residence).

This difference in definitions is one of at least a few reasons why the distinctions between skilled and intermediate care have become significantly less important over the past few decades. Although you might not encounter the term "intermediate care" very often, you should be careful to understand its meaning (and the potential consequences for policyholders) when it appears.

Custodial Care

"Custodial care" is the lowest level of long-term care and does not need to be supervised or performed by a medical professional. It typically involves helping someone with their basic hygiene or with housekeeping responsibilities. For example, someone who provides custodial care might help people perform the following tasks:

- Eating.
- Bathing.
- Dressing.
- Using the restroom.
- Cleaning.
- Cooking.
- Paying bills.
- Making phone calls.
- Standing up or sitting down.

Unless long-term care is needed as the result of a sudden illness or serious accident, custodial care is usually the first type of long-term care that someone will receive. Then, following an extended period of time, the person receiving custodial care will transition to needing intermediate or skilled care.

Early long-term care insurance policies were often impractical because they ignored this typical progression and would only cover custodial care if the insured person received skilled care first. Regulators responded to this problem by requiring most long-term care policies to start paying benefits to policyholders when people can no longer perform a certain number of "activities of daily living" (ADLs). Long-term care insurance contracts typically define "activities of daily living" in ways that include the following tasks:

- Eating.
- Bathing.
- Dressing.
- Transferring (such as the ability to move in and out of beds or chairs).
- Continence (for people who cannot control their bladder or bowel muscles).
- Toileting (for people who still have control over their bladder and bowel muscles but need help using a restroom).

You will learn more about activities of daily living later in this course. For now, just be aware that even though help with ADLs might be provided by non-medical professionals, most insurers won't honor long-term care claims unless someone's inability to perform these activities has been certified by a physician. Similarly, even though family members might be capable of helping with activities of daily living, some insurance companies will only cover care that has been provided by a specially licensed person or specially licensed business entity.

Common LTC Myths

Misinformation is at least partially responsible for the underwhelming amount of long-term care insurance sales in the United States. When presented with the possibility of needing this type of insurance, many prospects deflect the issue by assuming their long-term care needs can easily be addressed through other means.

Let's look at some of the most common excuses people make for not purchasing long-term care insurance and examine the level of truth in each of those excuses.

Common reasons why people claim not to be interested in long-term care insurance are listed below:

- **"I'm already covered by regular health insurance:"** Major medical insurance might be adequate to pay for skilled care, but it usually covers little to none of the custodial care that many people need.
- **"I'm already covered by Medicare:"** Medicare might pay for a limited amount of skilled care and even minor amounts of custodial care. However, the program only pays medical bills for a certain number of days and is not entirely suitable for individuals who need long-term care for more than a few months. Also, payment for custodial care might only be possible if a patient first receives skilled care.
- **"If I ever need long-term care, Medicaid will pay my bills:"** Indeed, Medicaid pays for a very significant amount of long-term care services provided in the United States. But in order to qualify for this Medicaid assistance, individuals often must first get rid of –or "spend down"—most of their assets. This and other eligibility requirements are necessary in order to ensure that Medicaid remains a need-based program intended for the poor. And since many assisted-living communities

and nursing homes do not accept Medicaid payments, patients enrolled in the program might have a limited number of options regarding where they can live or which medical providers they can use. (Be very careful not to confuse Medicaid and Medicare. Remember, Medicaid will often pay for long-term care but is reserved for the poor. Conversely, Medicare is available to practically anyone of a certain age but doesn't pay for much long-term care.)

- **"The problems associated with long-term care will eventually become too big for the government to ignore. There's likely to be some kind of long-term care insurance program for all Americans at some point, so I don't need to buy insurance for myself:"** Indeed, some legislators have attempted to implement federal long-term care insurance programs. But proposed solutions related to long-term care that would help all Americans (including the wealthy and the middle class) have a history of being dead on arrival. Instead of focusing on creating a government program for long-term care, most legislators have tried to create incentives for people to purchase private long-term care insurance.
- **"I don't need to worry about long-term care insurance until I'm much, much older:"** Long-term care insurance isn't something that is used exclusively by older policyholders. The need for long-term care can arise at practically any time. In fact, according to the National Care Planning Council, roughly 40 percent of long-term care recipients are under the age of 65. (Presumably, many of these younger people are recovering from an accident and will need care for several months as opposed to several years). Although there are reasonable debates about the best age to purchase long-term care insurance, it is generally true that consumers who wait too long will be stuck paying higher premiums or might not be able to obtain coverage at all.
- **"If I ever need care, my family will look after me:"** We've already highlighted some of the societal changes that have made care from family members less likely and harder to coordinate. But even if issues like geography and time are not significant burdens for well-meaning family members, those family members might lack the patience or physical strength to help with all kinds of necessary care. And in some cases, parents who have a lot of pride or are self-conscious about needing help with sensitive tasks (such as toileting or bathing) might prefer to receive assistance from a paid professional instead of from a close relative.
- **"If I buy long-term care insurance, there's no guarantee that I'll actually ever need to use it:"** There's some potential truth to this. However, the same statement can be made about several other kinds of insurance that consumers deem important. For example, most homeowners will never experience an event that will destroy their entire home, but this hasn't stopped them from insuring their homes up to its replacement value. Unlike other kinds of financial products that contain guarantees and can actually grow our portfolios, long-term care insurance can be viewed more appropriately as something we purchase in exchange for greater peace of mind.
- **"It's too expensive:"** This can be a valid statement for some prospects and an invalid one for others. Much depends on the person's specific financial situation, insurance-related objectives, age and health. Consumers who buy from the right company at the right time can get decent coverage at a relatively affordable price. But since there might be a limited window of opportunity for getting a great deal on

long-term care insurance, people who have an interest in this coverage should discuss it with an experienced insurance professional as soon as possible.

The Importance of LTC Planning

Regardless of whether insurance is really the answer to someone's problems, people who want to preserve as many choices and maintain as much control over their own long-term care need to start thinking about the issue long before care is ever required. In most cases, this is an effort that should include both the person who might eventually need care and his or her close family members. Topics for discussion should (at the very least) include the following questions:

- Is long-term care expected to be provided by a family member, a hired professional or both?
- If care is expected to be provided by a family member, is the family member willing and able to accept all of the responsibilities of long-term care?
- If care is expected to be provided by a hired professional, does the recipient expect to be living in his or her private residence or in a community-like setting (such as an assisted-living facility)?
- In the event that care is needed in a community-like setting, are there specific facilities where the person would prefer to reside (such as a local facility already known to the person or any facility run by members of the person's faith group)?
- Is the person likely to qualify for Medicaid fairly quickly, or will he or she need to "spend down" a significant amount of personal assets first?
- Is the person concerned about leaving a significant amount of assets untouched for a spouse, family member or charity, or is the person willing to use practically all of his her savings to fund long-term care?

Answers to those questions can play a key role in determining whether long-term care insurance should be considered and to what extent. In general, the less a person cares about qualifying for Medicaid and/or receiving care in a specific facility, the less he or she is likely to be interested in long-term care insurance. But if someone wants to avoid Medicaid for as long as possible or is adamant about wanting to receive care in a specific setting, insurance can bring those goals closer to a reality.

Care Options

Unless someone is willing to pay a tremendous amount of money out of their own pocket over an extended period of time, insurance is arguably the best tool for keeping long-term care options open. Although there are certainly many places where people without long-term care insurance receive excellent attention and services, not all of them are affordable and not all of them will accept patients or residents who are enrolled in the Medicaid program. However, practically all reputable facilities and long-term care service providers will accept payment in the form of long-term care insurance.

We will focus on the specifics of Medicaid in a later portion of this course. For now, it's important for you to understand the basic residential and institutional options for people who need long-term care. Once a prospect has decided on a preferred setting for his or her care, the plan for paying for that care can become much clearer.

Private Homes

When asked to choose between potentially receiving long-term care in their own home or in a community setting, most people would probably opt to remain in their current residence. This makes sense because home care allows people to stay in familiar, comforting surroundings and to feel like they are still relatively independent.

In fact, a significant amount of long-term care is provided in people's own homes, although it is not necessarily the kind that is covered by a typical long-term care insurance policy. According to a study referenced in 2010 in the publication Health Affairs, approximately three-fourths of home care is provided by unpaid family members at a projected unreimbursed cost of $375 billion.

While not exactly easy, providing long-term care at home is often manageable if the person only needs a minor amount of custodial care and already lives with a healthy adult. If the person needing care lives alone and does not want to move into an assisted-living facility or nursing home, some assistance is likely to be needed from a home health aide or other hired caregiver. Even if the person has a live-in family member to help with most tasks, a home health aide might be hired for a few hours each week in order to give the normal caregiver a rest.

Home care isn't always as practical or enjoyable as expected. A family member might be fully committed to providing care to a loved one but lack the physical strength or training necessary to perform certain tasks, such as moving the loved one in and out of chairs and beds. Meanwhile, someone who lives alone might receive adequate care from a home health aide but discover that there isn't enough social interaction available to make life fulfilling. As an occasional alternative, a person who receives care primarily at home might be able to enhance their social life by attending adult day care services on a periodic basis. You'll learn more about these services in the next section of this course.

Family members who hope to provide long-term care to elderly or disabled relatives should be made aware of the fact that they typically won't be compensated for their work through a long-term care insurance policy. In order for the cost of a home health aide to be covered by long-term care insurance, the person providing the care usually must be specially certified or licensed. Some insurers will pay family members who have the necessary certification or license, but families and insurance professionals should examine a policy's specific requirements about this issue instead of making assumptions.

Adult Day Care/Respite Services

Adult day care is a type of long-term care service that is usually utilized by people who live with another adult who is either working or has other major responsibilities. In exchange for a daily or weekly fee, the day care provider will help groups of people with activities of daily living, feed them, engage them in social activities and, perhaps, transfer them to and from their home.

Adult day care can be a great help to caregivers who have busy lives or who simply need some time to themselves. In fact, some states require all long-term care insurance products to cover some degree of adult day care services if they also cover home care.

Adult day care and similar services that give regular caregivers an occasional break from their duties are collectively known as "respite services." Caregivers are strongly encouraged to utilize these services when they feel overburdened. Since respite services can greatly reduce stress for a live-in caregiver, it is generally believed that utilizing these services can help elderly or disabled people maintain healthy relationships with their live-

in relatives. Healthy relationships can help the care recipient remain at home for a longer period of time, which is likely to reduce costs for the person's insurance company.

Assisted-Living Facilities

Assisted-living facilities are sometimes thought of as an intermediate step between needing home care and needing care in a nursing home. In general, residents maintain their independence by living in a private unit with their own bedroom, bathroom and perhaps their own kitchen. Residents who want to socialize can interact with other residents by eating in a communal dining area or by partaking in various scheduled activities.

Assisted-living facilities offer help with custodial care on a 24-hour basis, as well as possible housekeeping, cooking and laundry services. Access to skilled care, such as physical therapy, will not be available as frequently but might be obtained on a weekly or monthly basis from a visiting medical professional.

Assisted-living facilities can provide a good balance of freedom and socialization, but people who intend on living in them should confirm that their preferred facility will indeed accept the resident's likely type of payment. Practically all facilities will accept payment out of the resident's own pocket, but many facilities won't accept payment from Medicaid. Long-term care insurance companies might only pay for care in assisted-living facilities where there are a certain number of beds (generally the more, the better) and that are properly licensed or certified by the state.

Nursing Homes

Nursing homes provide both custodial and skilled care on a 24-hour basis. Unlike assisted-living facilities, they are generally intended for residents who aren't very independent. Due to the heightened level of care provided in nursing homes, the cost of residency is typically higher than the cost of other living arrangements. The difference in cost helps explain why, unlike residents at assisted-living facilities, people who live in nursing homes often occupy a semi-private room that is shared with a roommate. If a private room is desired, the potential resident should first conduct a thorough examination of his or her finances in order to determine affordability.

Within the context of government programs and long-term care insurance, nursing homes are sometimes referred to as "skilled nursing facilities." Medicare covers a portion of care received in a skilled nursing facility for a limited time. Medicaid and long-term care insurance are more likely to pay for care in a nursing home over longer stretches.

Continuing-Care Communities

A "continuing-care community" provides multiple levels of long-term care in the same building or same complex. For example, residents living on the facility's ground floor might live in private units and receive the kinds of care typically associated with assisted-living facilities. If and when those residents require a higher level of care (such as frequent skilled care), they might move to a higher floor in the building and become part of the facility's nursing-home wing.

The appeal of continuing-care communities is that residents can stay in the same facility for the rest of their lives even if their required level of care changes. This can ease the emotional transition from one level of care to the next because patients are already familiar with their surroundings and are likely to see many of the same neighbors or caregivers every day. These facilities are also suitable for elderly couples who want to remain in close contact with each other. For example, a couple might start living in the same room in an

assisted-living section of the community and then end up living just a few floors apart as one spouse declines in health.

One large drawback to continuing-care communities is the typically large deposit that must be made in order to secure a permanent spot in the facility. Common entry fees can run anywhere from $200,000 to $300,000 or more and are often funded through the sale of a resident's private home. In the event that a resident dies soon after entering the community (or wants to move elsewhere), the deposit might only be refundable under limited circumstances. Similarly, seniors might encounter serious financial issues if their chosen continuing-care community is mismanaged and needs to close.

In addition to an initial deposit, residents at a continuing-care community will usually be charged monthly fees. Someone who pays a large deposit and eventually runs out of money might be able to fund the monthly fees through Medicaid, but this is not an option if the facility does not accept Medicaid payments.

A person might have problems joining a continuing-care community if he or she is in poor health. Not unlike an insurance company, the community must balance its risk by accepting enough healthy residents, who will help offset the higher costs of the unhealthier residents. Therefore, it is important for people who are interested in continuing-care communities to do their research in a timely fashion and not wait to apply for residency until they need a high level of care.

Hospice Care

"Hospice care" is intended for patients who are terminally ill and have shifted their attention away from potentially curing their illness and toward managing their pain. It is available to patients who have been diagnosed with a short remaining life expectancy, such as six months or less.

Unlike the kinds of care that have already been mentioned in this course material, hospice care is often covered fairly well by Medicare, Medicaid and traditional forms of private health insurance. For this reason, we will not spend much time explaining the details of hospice care.

Common LTC Insurance Policy Provisions

The next several sections will make you aware of the common provisions, exclusions and other features of long-term care insurance policies.

Unlike many types of property and casualty insurance, there are technically no standard policy forms that are used by most long-term care insurance companies. However, standardization across various insurance carriers has become more common in recent years, perhaps because of the shrinking number of companies that are offering long-term care insurance products.

With all of this in mind, you should take the time to understand the common benefits and restrictions of long-term care insurance but also carefully read the specific policy forms that you encounter.

Benefit Triggers

Long-term care insurance policies have multiple "benefit triggers" that can make the insurance company responsible for funding the insured's care. These triggers might include the diagnosis of a particular medical condition or a demonstrated inability to perform certain daily tasks.

For insurance purposes, a triggering event must be verified by a licensed physician. The physician must then certify that the person's diagnosis or inability to perform certain activities is unlikely to change for at least 90 days. If a physician provides this certification but a patient actually improves before 90 days have passed, the patient usually won't be penalized by the insurer.

After the initial 90-day period, the patient will need to be recertified by a physician in order for insurance benefits to continue. However, if the diagnosis or inability to perform certain tasks is likely to be permanent, recertification might be required on a considerably less frequent basis, such as every six months or every year.

Activities of Daily Living

The vast majority of long-term care insurance products will go into effect if the insured is unable to perform at least two "activities of daily living," as specified in the policy. Although the inability to perform activities of daily living is not the only benefit trigger for long-term care insurance, it is the one most commonly used by policyholders who have not been diagnosed with a cognitive impairment.

Most policies in the United States define "activities of daily living" to mean at least the following tasks:

- Bathing (including the ability to wash oneself and get into and out of a tub or shower).
- Dressing (including the ability to put on clothes and equipment such as braces or artificial limbs).
- Eating (the ability to feed oneself).
- Transferring (the ability to get into and out of a bed or chair).
- Toileting (the ability to get to and from a restroom and perform tasks related to personal hygiene).
- Continence (the ability to control the bladder and bowel muscles).

Some long-term care insurance products are less restrictive and either have a longer list of activities of daily living or condition coverage on the inability to perform only one activity rather than two. Conversely, some policies in a few states might combine activities such as bathing and dressing into one, thereby making it more difficult for benefits to be triggered. However, policies that mention more than these six activities of daily living have become very rare because of tax rules that will be mentioned later in this course. Similarly, policies that combine some of these activities of daily living are prohibited in some states.

Cognitive Impairment

In the early days of long-term care insurance, some families discovered that their elderly relatives had been diagnosed with Parkinson's disease or Alzheimer's disease but still weren't qualifying for insurance benefits. Their relatives were no longer capable of being left alone for too long, but their mental illnesses hadn't yet resulted in any need for help with things like getting dressed or using the bathroom. In short, benefit triggers based entirely on the inability to perform activities of daily living were shutting out a lot of needy policyholders.

In response, regulators across the country began mandating that "cognitive impairment" be included as another possible benefit trigger for long-term care insurance. In general, a cognitive impairment is something that lessens a person's ability to reason or to remember

things. Like the trigger related to activities of daily living, cognitive impairment typically must be diagnosed by a licensed physician in order for it to trigger benefits under a long-term care insurance policy.

Independent/Instrumental Activities of Daily Living

Occasionally, a long-term care insurance policy will refer to either "independent activities of daily living" or "instrumental activities of daily living." These two terms generally mean the same thing and are used in connection with activities that are a bit more advanced than the standard activities of daily living. For example, these "IADLs" might include the following tasks:

- Cooking.
- Cleaning.
- Answering the phone.
- Paying bills.
- Balancing a checkbook.

As was mentioned in an earlier section, a few long-term care insurance products make benefit eligibility simpler by using benefit triggers besides an inability to perform basic tasks like bathing, eating or dressing. In those rare cases, these IADLs might be used as possible benefit triggers as well. However, products with this kind of flexibility are rarely sold today because they are generally deemed too generous by the Internal Revenue Service and, therefore, might result in negative tax consequences for consumers.

Medical Necessity

Another rare type of benefit trigger for long-term care insurance is "medical necessity." This is a vague concept that essentially allows benefits to be triggered if a licensed physician believes long-term care is necessary. It does not require diagnosis of a cognitive impairment or an inability to perform specific activities of daily living.

Like the use of IADLs, the use of medical necessity as a benefit trigger has become very rare in long-term care insurance. In the event that it is included in a policy, the policyholder is likely to lose certain tax-related privileges.

Prior Hospitalization

Older long-term care insurance products sometimes required the insured to spend at least three days in a hospital before insurance benefits would be provided. This requirement was somewhat similar to a requirement in the Medicare program, which only covers long-term care under limited circumstances and typically includes prior hospitalization as a pre-requisite for long-term care insurance benefits. In most states, long-term care insurance products that require prior hospitalization are now prohibited.

Elimination Periods

A long-term care insurance policy's "elimination period" is essentially a deductible based on a number of days rather than a dollar amount. Even after satisfying a benefit trigger (related to activities of daily living or cognitive impairment), the insured will not have his or her care covered by insurance until the elimination period has ended.

Perhaps the best way to understand elimination periods is to look at an example. Suppose the insured has a policy with a 90-day elimination period. A few years after purchasing the policy, the insured is deemed unable to perform multiple activities of daily living. At this

point, the insured will not have his or her care paid for by the insurance company. Instead, he or she will need to pay for care independently for the next 90 days. On the 91st day, the elimination period will end, and the insurance company will start paying for the insured's care.

Elimination periods can span anywhere from zero to 180 days or more. The duration will depend, to some degree, on the type of care needed and the amount of money the policyholder is paying for the insurance. For instance, a policy might have a relatively short (or even no) elimination period for certain types of care received at the insured's home but might enforce a longer elimination period if care is first provided in an assisted-living facility, continuing-care community or nursing home. Regardless of where care is rendered, a longer elimination period will usually entitle the policyholder to lower premiums.

Just as they should in regard to their auto, health or homeowners insurance deductibles, prospects for long-term care insurance should carefully choose an elimination period that won't overly strain their finances. If the elimination period is too short, the prospect might be overburdened with high premiums and might end up cancelling coverage at the wrong time in order to save money. But if the elimination period is too long, someone who needs care will need to pay a significant amount out of pocket at the same time that he or she is physically or mentally vulnerable.

Once they have chosen an appropriate elimination period for themselves, prospects should look carefully at how the insurer actually calculates each day. Many policies simply use calendar days to count down the elimination period, but others only use days on which long-term care is actually rendered. This is another case in which an example should help you understand an important distinction.

Suppose an insured has a long-term care policy with an elimination period of 90 days and has been certified to need assistance with activities of daily living. He and his family decide to hire a home health aide to help the insured with various tasks once per week. If his insurer uses calendar days to calculate the elimination period, the insurer will start paying for his care after 90 days have passed. However, if the insurer uses service days, the insurer will start paying for his care after the home health aide's 90th visit (in other words, after 90 weeks).

When policyholders or their families file complaints against long-term care insurance companies, the issue is often related to the policy's elimination period. Some consumers don't understand that this period exists at all and expect to be covered for care immediately. Others know it exists but believe it starts on the day the policy is purchased (rather than the day when a doctor certifies the need for care). A third group misunderstands the difference between an insurer that uses calendar days and one that uses service days. Since confusion about this issue is so common, producers should consider spending extra time explaining it.

Time and Dollar Limits

The maximum amount of benefits provided through a long-term care insurance product might be based on a specific dollar amount, a certain time period or both. For example, a policy that is considered "long and thin" will provide coverage for several years but will only pay for a fraction of the insured's long-term care costs over that long stretch. Conversely, a policy that is "short and fat" will only provide coverage for a brief period of time but will do so with little or no cost-sharing from the insured during that brief period.

Let's look at time limits and dollar limits in greater detail and examine how they might impact each other.

Benefit Term Limits

Once a long-term care insurance policy's elimination period has passed, its "benefit period" begins. In simplistic terms, the benefit period is the amount of time the insurance company will help fund the insured's long-term care. In reality, however, the initial length of the benefit period might become longer with time as the years go by. This lengthening of the benefit period is possible in cases where the policy also has dollar limits that have not been reached during the initial benefit period.

For example, if the policy's initial benefit period expires but the insured has received a total amount of care that is $12,000 less than the policy's dollar limit, the insured might be able to extend the benefit period for another year and receive up to $1,000 of covered care during those 12 months. (This is purely a simple example and is not intended to reflect the exact way in which unused long-term care insurance benefits might be carried over from one year to another.)

Many policyholders choose an initial benefit period of three years because this number is generally in line with the average stay in a nursing home. (Multiple sources say the average stay in a nursing home is roughly 2.5 years.) Of course, there might be valid reasons to disregard this figure and to choose a benefit period that is either shorter or longer than three years. Family life expectancies as well as gender (with women generally living longer and therefore needing more long-term care than men) are common considerations.

Some very old policies promised to pay benefits for as long as the insured lived, but these products quickly became impractical for insurers and are generally no longer available in today's market.

Benefit Dollar Limits

Along with a specific benefit period, payment for long-term care will be capped at a certain dollar amount by the insurance company. The cap will either be based on a daily amount or a monthly amount.

In the event that an insured needs less care than the capped dollar amount, the unused portion of the dollar amount can often be applied in ways that lengthen the policy's benefit period. However, the unused portion of the dollar amount usually can't be applied in ways that increase the dollar-based cap over a short period of time. For example, the fact that someone has $12 worth of unused care at the end of a month doesn't necessarily mean he or she can go $12 beyond his or her dollar limit during the following month. Instead, the insurer will usually keep track of unused dollars over a long period of time (such as an entire year) and eventually extend the policy's benefit period based on the unused amount.

To determine the overall maximum dollar amount that will be paid by the insurer for long-term care, multiply the benefit period by the daily or monthly dollar limit. For example, if the insured starts with a three-year benefit period with a daily dollar limit of $100, the insurance company would be liable for a maximum of $109,500. ($100 multiplied by 365 days multiplied by 3.) Again, the benefit period might change if the insured needs less care than expected, but even if the benefit period is extended, the insurance company will not need to pay more than $109, 500 to fund this policyholder's care.

You should now be able to see how benefit periods and dollar limits relate to how much will be covered by long-term care insurance. In order to ensure that a patient is not

overburdened by unexpected uninsured costs, it is very important to consider local expenses for long-term care and not rely solely on national averages. An insured who plans to receive care in Beaufort, South Carolina, for instance should base his or her benefit periods and dollar limits on the cost of care near that small-town community. Someone who intends on receiving care in the much more expensive area around New York City should use completely different figures that relate to the cost of care in that metropolitan area.

Individuals or couples who plan on relocating to other regions of the country in their senior years should probably research costs of care in their current community as well as their likely future community. In general, care received in densely populated cities will cost more than care in smaller rural areas.

Reimbursement Policies vs. Indemnity Policies

In regard to payment of long-term care insurance benefits, some policies are "reimbursement" policies and some are "indemnity" policies. Let's look at the differences between these two options.

Reimbursement Policies

Reimbursement policies tend to be more popular and more affordable than indemnity policies.

In order to receive payment via a reimbursement policy, the insured must first incur long-term care expenses. Then, the insurance company will pay a certain amount of those documented expenses up to the policy's daily or monthly benefit limit. Insurers might make such payments to the insured or send it directly to the entity that provided the covered care. Regardless of how this type of payment is made, it is important to remember that reimbursement policies pay an amount based on the actual cost of received care.

Indemnity Policies

An indemnity policy can pay a flat amount (up to the policy's daily or monthly limit) regardless of how much is actually spent on covered care. It is therefore theoretically possible for the insured to receive an amount greater than what he or she actually paid for his or her care. However, this has the potential to create tax problems and is also made indirectly undesirable by the fact that indemnity policies can be considerably more expensive than reimbursement policies.

In the event that the policyholder purchases an indemnity policy, the flat daily or monthly amount will only be paid in cases in which covered care was actually rendered. In other words, if the insured has an indemnity policy with a $100 daily benefit but only receives care twice a week, the insured will only pay $200 for the week. The five other days (on which no care was rendered) will not result in any daily benefit.

Exclusions

The fact that someone cannot perform activities of daily living isn't a guarantee that the person will be eligible for long-term care insurance benefits. Like practically every other kind of insurance product, long-term care insurance policies contain a list of exclusions that exempt the insurer from having to provide compensation for the insured under certain circumstances.

For example, a policy might state that no long-term care benefits will be provided for any of the following injuries or ailments:

- Injuries sustained during a war.
- Self-inflicted injuries and suicide attempts.
- Care linked to alcoholism or other drug abuse.
- Non-organic forms of mental illness, such as depression or anxiety (although some forms of mental illness, such as Alzheimer's disease, must be covered).
- Care that would otherwise be covered by a government health program or by other insurance (such as workers compensation insurance).
- Injuries sustained while engaging in criminal activity.
- Injuries sustained in a plane crash (unless the insured was a passenger in a commercial aircraft).
- Pre-existing health conditions.

The exclusion of pre-existing health conditions is arguably the most important exclusion in long-term care insurance policies. With this in mind, we will address it in its own special section.

Pre-Existing Conditions

In general, a "pre-existing condition" is a health problem that had already materialized by the time the insured completed his or her application for insurance. Specific definitions will differ from state to state. For example, some states define it to mean any health condition for which symptoms were noticed and would've prompted a reasonable person to seek treatment within six months prior to the completion of the insurance application.

States also commonly set rules for how long an insurer can exclude coverage for these health problems. In most states, insurers aren't allowed to exclude pre-existing conditions for a period longer than six months or a year. If you will be selling long-term care insurance to anyone, you should research the specific rules in your state.

Although states have rules for how long-term care insurance companies can exclude coverage of pre-existing conditions, these rules only apply in cases where an applicant is otherwise deemed insurable and is issued a long-term care insurance policy. If an applicant waits too long to purchase long-term care insurance and has developed serious health problems prior to completing an application, the insurance company can deny the application outright and is not obligated to insure the person.

The federal Patient Protection and Affordable Care Act (sometimes called "Obamacare") restricted insurers from denying major medical insurance to individuals because of their health (including any pre-existing conditions). However, this law did not include similar restrictions for long-term care insurance.

Guaranteed Renewable vs. Non-Cancellable Coverage

In most states, long-term care insurance must be either "guaranteed renewable" or "non-cancellable." Though these two terms might seem similar, they are different in some very important ways.

If long-term care coverage is guaranteed renewable, the policyholder has the right to renew the coverage and keep it in force as long as premiums continue to be paid. The insurance company cannot cancel the person's coverage due to the insured's increased age or deteriorating health. The premiums for a guaranteed renewable policy can increase, but the increase must apply to all of the insurer's customers within a particular

rate class. In other words, although the insurer can raise prices on a large group of policyholders (such as all policyholders who purchased coverage more than two years ago), it cannot discriminate against a specific policyholder and impose higher prices specifically on that one person.

If long-term care coverage is non-cancellable, both the coverage itself and the cost must remain the same as long as premiums continue to be paid. Unlike guaranteed renewable coverage, non-cancellable coverage cannot be subjected to price increases unless the policyholder decides to make changes to the policy and opts for better insurance.

Non-cancellable long-term care insurance was available several years ago and was typically purchased with a large, lump-sum premium. Insurance companies eventually realized they had priced these products incorrectly and have since made non-cancellable coverage very difficult to find.

Carriers and producers must be aware of the differences between guaranteed renewable and non-cancellable coverage. Using the wrong term in advertising or in conversations with consumers can create serious confusion and can lead to disciplinary actions.

Inflation Protection

Since the cost of health care is almost certain to rise over time, consumers might struggle to determine whether their benefit limits (daily, monthly or cumulative) will be enough to eventually pay for their care. Insurance companies have responded to this concern by offering various "inflation protection" riders for their long-term care products.

At the time this course was being written, the most common form of inflation protection for long-term care insurance provided a 5 percent increase in a policy's benefit limit every year. Usually, the increase is compounded, meaning the 5 percent increase for a given year will include any 5 percent increases from previous years, too. This form of compounded interest is the opposite of "simple interest." Inflation protection based on simple interest will result in lower increases in daily benefits but will generally be cheaper than protection based on compounded interest.

Other forms of inflation protection might be based on increases in an economic index—such as the Consumer Price Index—rather than on a specific, predetermined percentage. However, it should be noted that this type of index tends to look at inflation across several sectors of the economy and won't necessarily match the level of inflation in health care.

Many financial professionals advise consumers to purchase inflation protection for their long-term care insurance, especially if coverage is purchased at a relatively young age. In fact, some states require inflation protection to be included in long-term care policies unless the consumer signs a waiver and refuses the protection. But regardless of the generally positive opinions surrounding inflation protection, it is still important to conduct a needs analysis for consumers and determine whether this important feature is worth the relatively high cost.

Similarly, it is important to be clear about how inflation protection actually works and to not allow prospects to be confused by its name. Purchasing inflation protection can reduce the risk of coverage not keeping up with inflation, but it does not guarantee that a policy's benefit limit will constantly be increased at the same rate as health care costs.

Future Purchase Options

A "future purchase option" is often viewed as an alternative to inflation protection. When included in a long-term care insurance policy, this feature allows someone to purchase more insurance (such as a higher benefit limit) without needing to medically qualify for it.

This can be beneficial for policyholders who bought insurance many years ago, realize they need more coverage and would otherwise not qualify for it based on their worsened health status.

While a future purchase option can solve problems related to insurability, it won't necessarily make additional coverage affordable. When the insured decides to exercise a future purchase option, the price for the additional coverage will be based on the person's age at that point (known as the person's "attained age") and not on the person's age when the initial policy was purchased (known as the person's "issue age").

Consider, for example, someone who buys a policy at age 50 and chooses to include a future purchase option. At age 75, the policyholder realizes he is close to needing long-term care and that his benefit limits won't be nearly enough to fund his expenses. If he opts to exercise the future purchase option, the cost of the additional benefits will be based on him being 75. They will not be based on his issue age (50).

Future purchase options often have limits regarding when they can be exercised. For example, the insurance company might require that the option either be exercised or forfeited by the time the insured reaches a certain age, such as 65 or 70. The option generally cannot be exercised if the insured is already in need of long-term care. In other words, if the policyholder wants to take advantage of this option, he or she must do so while still relatively healthy.

Waiver of Premium

A "waiver of premium" is an important part of a long-term care insurance policy, particularly for people who already need care. Under this provision, the insured is exempt from having to pay premiums once he or she has started to receive benefits from the insurer.

In addition to the financial help that a waiver of premium can facilitate, it provides practical relief, too. Although some individuals who need long-term care might be capable of managing their own finances, others will lack the physical or mental ability to keep track of their bills, including premium-related notices from their insurance company. The waiver makes it less likely that coverage will end when a claimant is most vulnerable.

Free-Look Periods

A "free-look period" gives policyholders a chance to review their recently purchased long-term care insurance policy and get their money back if they notice something they don't like. The deadline for returning the policy to the insurer and requesting a refund of any paid premiums is often set by state rule and might depend (to a certain degree) on the applicant's age. For example, a state might require at least a 30-day free-look period for all long-term care purchases but extend the requirement to 45, 60 or 90 days if the applicant is a senior citizen.

Care Coordination

Some insurers will pay for assistance from "care coordinators." These trained individuals do not provide skilled, intermediate or custodial care but have a thorough understanding of long-term care services in their geographic area. They can assist consumers by providing referrals to qualified local providers, and they can help insurers by making sure that long-term care services are being delivered in an efficient, cost-effective manner.

Alternative Plan of Care

A long-term care insurance policy might agree to pay for costs related to an "alternative plan of care." When present, this provision allows certain kinds of long-term care to be

covered by the policy even if the policy language doesn't address them. For example, a policy issued prior to the popularity of assisted-living facilities might not specifically mention these residential options but might pay for them anyway. Similarly, a policy that doesn't mention coverage of ramps, bars and other types of home modifications for disabled people might still pay for their installation as an alternative plan of care.

Coverage of an alternative plan of care usually requires the insurer and a licensed physician to agree that the care is the most appropriate option for the insured. Usually, the insurer will defer to the physician's judgment as long as the recommended alternative plan of care is likely to save the insurer money. In most cases, the insurer will save money if the insured remains in a setting other than a nursing home for as long as possible.

Bed Reservation Benefit

A bed reservation benefit is sometimes included in a long-term care insurance policy. When available, this benefit will continue to cover payment in a nursing home even if the bed's usual occupant is temporarily residing elsewhere. The benefit might be exercised if the resident of a nursing home enters the hospital for an extended period of time or decides to go on a long trip.

Home Modification Benefit

Home modification benefits can cover the installation of wheelchair ramps and various pieces of equipment that help weak or disabled people shower, bathe or use the restroom. When they are not specifically included in a policy, these benefits might be available indirectly via an alternative plan of care. (Alternative plans of care are explained in an earlier portion of these materials.)

Geographic Limits

Applicants who are toying with the idea of living overseas should think carefully before settling on a long-term care insurance product. Most policies will pay for care anywhere in the United States but might offer no (or very few) benefits if care is needed in other countries. On occasion, the insurer will offer coverage that extends to other parts of North America (such as Canada or Mexico).

Even if a policy will remain in force across state or even national lines, geographic location needs to be part of a long-term care insurance prospect's decision. It will be very difficult (if not impossible) to select an appropriate benefit limit if the potential policyholder has no knowledge of local health care costs.

Cancellations and Non-Renewals

For various reasons, a long-term care insurance policy might be cancelled or not renewed. Non-renewal occurs when either the insurance company or the policyholder decides to stop coverage at the end of the policy period (such as at the policy's annual anniversary date). Cancellation, on the other hand, might occur at other times as long as proper notice is provided and other rules are followed.

Policyholders might choose to cancel or not renew their coverage because premiums have become too high. In this case, a state might require that the insurer offer to keep a smaller amount of coverage in place in exchange for lower premiums.

On occasion, insurance will be on the verge of cancellation because the policyholder merely forgot to pay the insurer on time. In addition to sending a warning to people who have missed a premium payment, notice might be given to a friend of family member. The option to alert a friend or family member is often given to applicants when the policy is

issued and is meant to avoid situations in which payments are missed due to extended vacations or even the early signs of cognitive impairment.

In relatively rare cases, an insurance company can cancel someone's long-term care coverage with proper notice for reasons beyond nonpayment. Grounds for cancellation typically only exist if the policyholder misrepresented facts to the insurer when applying for insurance. Depending on state law, an insurer's ability to cancel based on an applicant's misrepresentations might decrease over time. For instance, the insurer might have the ability to cancel based on an unintentional (but still important) misrepresentation if the policy has only been in force for a few months. But once the coverage has been in effect for a few years, the insurer might only be allowed to cancel if the applicant obviously engaged in an intentional type of fraud.

Reinstatement For Cognitive Impairment

You just learned about how the insured has the option of having cancellation notices sent to a friend or family member and how this can manage the possible risk of cognitive impairment. Regardless of whether the aforementioned third-party notice is desired, a policyholder who misses premium payments due to cognitive impairment and ultimately loses coverage is typically allowed to regain the insurance within a certain timeframe. This is known as "reinstatement for cognitive impairment" and is typically possible within the first few months after long-term care coverage has lapsed.

When this option is exercised, the insurer will need to receive a letter from a licensed physician who can verify the impairment. The policyholder will need to pay all premiums that were missed or would have been due during the lapse, but the person won't be charged more or denied coverage because of any changes in his or her health. In other words, both the insurance and the price for it must remain the same, as if the lapse in coverage had never occurred.

Non-Forfeiture Options

Depending on the state where it is purchased, a long-term care insurance policy might automatically include "non-forfeiture benefits" or at least give the policyholder a chance to add them for an additional charge. Non-forfeiture benefits are provided when the policyholder has paid premiums for the insurance but decides to cancel coverage before long-term care services are ever needed. They can be particularly appealing to applicants who worry about paying for a policy that they might never actually use.

Typical non-forfeiture benefits will allow the insured to remain covered for a period of time after cancellation without having to pay any additional premiums. The length and size of the non-forfeiture benefit will be chosen either by the policyholder or the insurer. One option might be to cover the insured for the remainder of the policy's benefit period but to lower the daily benefit. Alternatively, the daily benefit might stay the same but only allow coverage to continue for a brief period of time. Or instead of receiving some kind of reduced coverage, the policyholder might simply receive a partial refund of premiums.

The size and variety of non-forfeiture benefits will depend on what a particular state requires, how much the policyholder has already paid in premiums, and how much the insured is willing to pay for the flexibility of a particular non-forfeiture option.

Covering Multiple People With LTC Insurance

So far, our focus has been on long-term care insurance intended for one person. However, some products can insure two or even more people at the same time. Let's spend a few moments learning about these options, including group plans and spousal coverage.

Group Plans

Though relatively rare, it is possible to purchase long-term care insurance as part of a group plan. Group plans involve little or no medical underwriting, making it is easy for relatively unhealthy people to join.

Unfortunately, many long-term care insurance plans in the workplace experience "adverse selection," which occurs when insurance is too commonly purchased by people who are considered "bad" risks for the insurance company. Younger and healthier employees almost always decline to join these group plans, so the insurer must price the coverage at a relatively high rate. The relatively high prices make group plans unattractive to those employees who might otherwise be interested in some form of long-term care insurance. Furthermore, hardly any employers supplement the cost of group plans by paying a portion of the premiums. (This is true even though employer contributions to group long-term care insurance plans might be tax-deductible for the employer.)

Group long-term care insurance plans might entice participation from employees who are interested in some coverage and don't have the time to shop for it. However, many potential participants in group plans are likely to qualify for an individual policy that is more customized to their needs at (perhaps) a more affordable price. Employees who are presented with offers to join a group plan might want to explore all of their available options, including those in the individual market.

Spousal Coverage

Spouses who are interested in obtaining long-term care insurance have the option of purchasing a completely separate policy for each spouse or purchasing a product that allows for "shared care." If a policy allows for shared care, benefit periods and benefit limits can be transferred from one spouse to another on an as-needed basis. This is particularly helpful in cases where one spouse eventually needs care but the other is likely to live a longer, largely independent life.

In cases where shared care is possible, the insurer might still put limits on the amount of benefits that can be transferred from one spouse to the other. For example, an insurer might prohibit any more sharing of care if the spouse giving up his or her benefits would be left with less than three years of coverage.

LTC Producer Licensing and Training

Individuals who wish to sell long-term care insurance must first be properly licensed and complete any required coursework.

A producer who wants to sell long-term care insurance must already be licensed to sell accident and health insurance. Then, the producer typically must complete a special training course about long-term care. Note that the requirements for this course are set not only by the state's licensing division but also (in some cases) by the insurance company that the producer plans to represent. For example, a state regulator might only require that producers take a long-term care insurance course that is at least a certain length. However, a particular insurance company might require all of its agents to complete a specific course from a specific education provider. So it's possible (but not guaranteed) that a producer who represents multiple insurance companies might need to satisfy the coursework requirement multiple times by taking multiple courses.

Many states require producers to complete additional long-term care insurance training on a regular basis. In most cases, this continued training will be tied to a producer's continuing education requirements as part of the license renewal process. As is the case

with the initial training requirement, each insurance company might have its own rules regarding which long-term care courses must be completed.

Please note that although the course you are reading has been approved for insurance continuing education credit, it is not intended to satisfy the specific long-term care insurance training requirements mentioned in this section.

Underwriting and Pricing of LTC Insurance

Affordable long-term care insurance isn't available to everyone who wants it. Insurance companies absorb significant risks when they issue a long-term care policy, so each applicant for coverage is likely to be evaluated carefully.

Underwriters of long-term care insurance consider the information provided on a person's application and are also likely to delve further into the applicant's medical history. When evaluating an applicant's health, the insurer might request access to files from the person's physician as well as data from an industry database called the "Medical Information Bureau."

Depending on the information on the application, the insurer might also require the person to undergo either a paramedical exam or a brief phone interview. Paramedical exams and interviews are especially common for older applicants and are generally intended to help the insurer determine early signs of cognitive impairment. As part of this process, some insurers test the applicant's memory and ask the person to solve basic math problems.

Morbidity Risk

Although long-term care insurance is sold by many life insurance companies, underwriting guidelines for long-term care coverage are not identical to underwriting guidelines for life insurance. Whereas life insurers are generally concerned about "mortality risk" and focus on a person's life expectancy, long-term care insurers are generally concerned about "morbidity risk" and want to know how long a person is likely to have a debilitating health condition.

Due to the differences between mortality risk and morbidity risk, it is possible for an applicant to be eligible for affordable life insurance but not affordable long-term care insurance and vice versa. Consider, for example, someone whose family history suggests a long life expectancy but the possibility of eventual Alzheimer's disease. In this case, the applicant might live long enough (and pay enough in premiums) to be considered a good risk for a life insurance company but is less likely to remain cognitively healthy and be considered a good risk for a long-term care insurance company.

Despite the differences between morbidity risk and mortality risk, long-term care insurers and life insurers both place some significance on an applicant's age. Since morbidity risk tends to increase as people grow older, applicants will pay higher premiums the longer they wait to sign up for coverage. This doesn't necessarily mean that a young person should purchase long-term care insurance as soon as possible, but it does create a challenge for healthy consumers who believe long-term care insurance is a valuable product. If they buy long-term care insurance too soon, they might end up spending a significant piece of their income on insurance that they're unlikely to use until several decades later. On the other hand, if someone puts off the decision to purchase long-term care insurance for too long, the premiums might be prohibitively high or the insurer might deny the person's application outright. The best time to purchase insurance is right before you need it, yet none of us knows exactly when that will be.

Unfortunately, many people with serious health conditions have already waited too long to purchase long-term care insurance. An insurance company is likely to decline an application for long-term care insurance if the applicant has been diagnosed with the following ailments:

- AIDS.
- Cancer.
- Multiple sclerosis.
- Parkinson's disease.
- Alzheimer's disease.
- Stroke.
- Diabetes.
- Extreme obesity.

Admittedly, not all insurance carriers view all applicants in the same way. Someone who was diagnosed with skin cancer but went into remission five years ago might be denied a policy from one insurer but qualify for coverage from a different company. However, being denied insurance by one insurance company is often a warning sign or "red flag" to other insurers. In order to steer applicants to the most appropriate carrier, producers should make an effort to learn the underwriting standards of each insurer they represent.

Issue Age vs. Attained Age

The impact of age on premiums for long-term care insurance will depend on whether the cost of coverage is based on the insured's "attained age" or "issue age."

If premiums are based on the insured's attained age, they are nearly guaranteed to increase on a regular basis as the insured grows older. Increases in cost might occur on an annual basis or on some other regular schedule. However, some states put caps on premiums for issue-age coverage and don't allow insurers to increase costs based purely on age after the insured reaches a certain birthday (such as 65).

Most long-term care insurance products sold today are priced on the basis of the insured's issue age. The insured's issue age is his or her age at the time when coverage was originally purchased. In practice, this can lock the size of premiums for an extended period of time and provide more cost-stability for the insured than an attained-age policy. However, someone who purchases coverage based on his or her issue age isn't fully shielded from future premium increases. Unless the coverage is "non-cancellable" (as opposed to "guaranteed renewable"), the insurer will retain the option to increase premiums for entire classes of policyholders if business ends up being less profitable than expected. More details about non-cancellable and guaranteed-renewable coverage appear in an earlier section of this course.

As was mentioned previously, it is possible to wait too long to purchase long-term care insurance. This is true even if the applicant is relatively healthy and is only considered a high risk due to his or her age. Most insurers have a cutoff point for issue ages, meaning that they won't accept applicants who have lived beyond a certain number of years. Maximum issue ages might fall anywhere from 75 to 85 years old but are likely to differ from carrier to carrier.

Rate Increases

When shopping for the most affordable long-term care insurance policy available, the buyer might be tempted to merely go with the carrier offering the lowest price. Though current prices for coverage are a wise place to begin the shopping process, the low prices offered today are not guarantees of low prices tomorrow. Consumers and insurance producers should consider whether further research is required to determine the likelihood of stable pricing across several policy years. Here are some questions to consider when evaluating a quoted price:

- Does the carrier have a history of rate increases?
- Is the company new to the market and pricing its products in ways that are seemingly unrealistic?
- When a carrier has initiated a rate increase, has the increase usually been applied only to new policyholders or spread across the insurer's entire clientele?

Taking a long-term approach to affordability is particularly important for long-term care insurance applicants because of the market's frequent instability. When the insurance first became popular, carriers wrongly assumed many policyholders would eventually let their insurance lapse and never force an insurer to pay any claims. They also misjudged the overall future of the global economy and assumed they would be able to earn much more income from invested premiums than what was ultimately possible.

As a result, many insurers realized they could no longer price long-term care insurance confidently and stopped selling it. The companies that remained were sometimes forced to impose rate hikes on existing customers in order to remain solvent and achieve a relative degree of financial health. The older a policy was, the more likely it was to experience an increase in cost. Rate increases in the neighborhood of 40 percent to even 90 percent over a period of time weren't uncommon and were bad news for many senior citizens on fixed incomes.

In order to lessen the impact of possible price increases, many states have rules regarding disclosure of rates and the steps people can take to cope with the extra costs. For example, pending rate increases might need to be reported to policyholders several weeks in advance of their effective date. Also, an insured who is confronted with a rate increase might be entitled to a revised policy that reduces some benefits but allows the person to keep some insurance in force at the same, usual price.

Single-Premium Plans

A few older long-term care insurance products allowed consumers to purchase them with a single premium. For the reasons mentioned earlier in this material (including misjudged lapse rates and unexpectedly low investment returns), these products rarely turned a profit for insurance companies and are almost never sold anymore. Instead, most long-term care insurance is funded through monthly or annual premiums that must be paid until the insured qualifies for long-term care services.

Should Everyone Buy LTC Insurance?

Planning for potential long-term care is something that hardly anyone should ignore. But the importance of long-term care planning shouldn't be confused with the importance of long-term care insurance. Insurance can play an immensely important role in long-term planning, but it isn't the obvious answer for all or even most people.

This doesn't mean producers should dismiss long-term care insurance as an option or feel guilty about selling it. It merely means they should carefully examine each prospect's unique situation and not view the product as a one-size-fits-all form of protection. If an insurance professional is open and honest when a product isn't especially suitable for someone, the professional's recommendations to purchase other products are likely to carry more weight.

The truth of the matter is that long-term care insurance isn't suitable for everyone. However, consumers and their financial advisers might struggle with the concept of suitability because there are no clear rules about who should purchase coverage and who should either save their money or spend it on other things. An online search will likely reveal several conflicting pieces of advice that are tied to specific dollar amounts. For example, some alleged experts suggest consumers purchase long-term care insurance if their personal assets are worth at least $200,000. Others might make a distinction between liquid assets (such as savings accounts) and illiquid assets (such as a home) and say that adults with illiquid assets of at least $50,000, $100,000 or maybe as much as $300,000 should consider a long-term care policy.

One potential problem with these types of broad recommendations is that they don't consider the differing costs of care across various parts of the country. They also pay little attention to a prospect's current income and the person's other financial goals and obligations. In all likelihood, care in a New York City nursing home is likely to cost a different amount than care in a rural setting. Furthermore, a middle-aged parent with a mortgage and no disability insurance or life insurance might want to make other kinds of coverage a higher priority than a long-term care policy.

Although making blanket statements about the value of assets and the appropriateness of long-term care insurance can be tricky (or even unadvisable), two common pieces of advice are too widely accepted to ignore:

- People who are likely to qualify for Medicaid either before or within a few months of needing long-term care services generally aren't good candidates for long-term care insurance. Presumably, the value of their assets won't justify the premiums paid for a good policy.
- People who are very wealthy and have a significant amount of money in liquid assets might not be good candidates for long-term care insurance because they might be able to pay for their care out of their own pockets.

Despite those two widely accepted pieces of advice, there will almost certainly be exceptions to them. For example, perhaps someone with a small amount of assets would otherwise qualify for Medicaid but is adamant about staying a in a specific long-term care facility that does not accept Medicaid payments. Or maybe a very wealthy person has a very large family or children with special needs and therefore lacks as much financial flexibility as we'd expect. In both cases, it might be wise to consider long-term care insurance.

Performing a Basic Needs Analysis

Making insurance recommendations that are suitable for a prospect isn't just a matter of good, ethical business. Many states have made suitability a compliance issue, too, and have developed lists of factors that must be considered before encouraging someone to purchase long-term care insurance. Specific factors to consider tend to differ from state to state but are still likely to include answers to the following questions:

- Why is the person interested in long-term care insurance, and will this product help the person achieve his or her goals?
- Will the person be able to afford the amount of recommended coverage (both in the present and in the future)?
- Does the person already have other insurance or other legitimate means of paying for long-term care services?

Alternatives to Long-Term Care Insurance

When planning for the potential of needing long-term care services, people need to carefully explore all of their available options. This is important not only because of the few disadvantages of long-term care insurance (such as cost) but because these options are often misunderstood by the public and leave many prospects with the incorrect belief that an insurance-focused long-term care plan isn't right for them.

The next several sections will summarize many of the possible products and programs that might be used as alternatives or supplements to long-term care insurance. Just as we have attempted to be transparent about the plusses and minuses of long-term care insurance, we will address each option's strengths and weaknesses. Perhaps most importantly, we will attempt to clarify some of the myths or half-truths that might be having an unfair influence on potential insurance buyers.

Medicare

Medicare is the popular federal insurance program that is intended mainly for Americans who are at least 65 years old. Practically every legal resident of the United States who has reached his or her 65th birthday is either eligible for some level of free Medicare coverage or can at least join the program by paying premiums. The program also is available to Americans of any age if they have certain disabilities or illnesses. Unlike the similarly named "Medicaid" program, Medicare is not a need-based program and is open to Americans regardless of whether they are rich, poor or members of the middle class.

Medicare Part A

There are several different parts to the Medicare program, each with its own eligibility requirements and list of benefits. In general, each part is known by a particular letter of the alphabet. The part that is most relevant to a discussion about long-term care services is "Part A."

In addition to paying for care received in hospitals, Medicare Part A can be utilized to pay for brief confinement in a "skilled nursing facility" or nursing home. In order for a stay in a nursing home to be covered by Medicare, a Medicare recipient must need skilled care and must have moved into the nursing home after at least three days of hospitalization. Assuming those two requirements have been met, Medicare Part A will pay for practically all of a nursing-home stay that lasts up to 20 days and will cover smaller amounts of nursing-home bills up to the patient's 100th day of confinement. Someone who needs to stay in a nursing home for more than 100 days will not have his or her care covered by Medicare anymore.

These restrictions make Medicare an inadequate alternative to long-term care insurance for the following reasons:

- Most people who need long-term care mainly need help with custodial care (such as eating, bathing, dressing and toileting) and will usually need this assistance for several years before needing the skilled care covered under Medicare Part A.

Long-term care insurance will cover custodial care once a policy's elimination period has ended.

- Many people need long-term care because of the gradual aging process and not because of a serious illness or injury. However, Medicare will only pay for nursing-home care if the person has first been hospitalized for at least three days. Long-term care insurance generally doesn't require prior hospitalization in order for benefits to begin.
- Medicare stops paying for nursing-home care after 100 days, but care might be required for a much longer period of time. Long-term care insurance can help pay for care that lasts several months or years.
- The Medicare benefits mentioned here apply only to skilled nursing facilities and not to assisted-living facilities or home care. Long-term care insurance can be used to pay for care provided in a variety of different settings, including nursing homes, assisted-living facilities, private homes or continuing care communities.

Medigap Plans

Millions of senior citizens purchase private insurance products called "Medigap policies" or "Medicare supplements" in order to fill in some of the holes in the popular Medicare program. These supplemental policies can reduce cost-sharing for Medicare recipients by covering Medicare deductibles, copayments and co-insurance fees.

Medigap policies generally do not pay for categories of care that aren't already covered in some form by the Medicare program, and they don't change Medicare eligibility rules. This includes the rules about skilled care, custodial care and prior hospitalization. So if someone is ineligible for long-term care coverage through the Medicare program, a Medigap policy is almost certainly not going to solve the problem.

Medicaid

Medicaid (as opposed to Medicare) is a health care program intended for people with few or no assets. Costs under the program are shared by the federal government and the individual states. In exchange for paying some of Medicaid's bills for the states, the federal government sets minimum standards for the program. States can then implement the program in their own ways as long as the federal standards are met. For example, the federal government requires all state Medicaid programs to pay for certain forms of long-term care provided in nursing homes but allows states to exclude coverage of home care.

Believe it or not, most long-term care that is provided in the United States is paid for by Medicaid. However, this doesn't mean that reliance on Medicaid should be everyone's solution to their long-term care needs.

In order to qualify for the plan in the first place, individuals must satisfy some strict requirements that are likely to impact their financial future. They are also likely to lose some of the choices that are available to people who either have long-term care insurance or are paying for services out of their own pocket. Still, since so many people already receive long-term care through Medicaid, it isn't easy to dismiss the program's usefulness.

Medicaid Income Requirements

Medicaid is a need-based program, meaning it is intended only for people who truly cannot afford services on their own. In order to qualify for help through the Medicaid program, a person must satisfy certain requirements related to income and financial assets.

The specific income-related requirements for Medicaid eligibility will depend on state rules. Some states have a "hard" income cap that forbids anyone from receiving Medicaid assistance if he or she has a monthly income above a set amount, such as $2,000. However, in a majority of states, seniors with higher incomes can qualify for long-term care via Medicaid if they "spend down" their excess income by paying for some medical services out of their own pocket.

When evaluating a senior's income, the state's Medicaid program will usually consider the following sources:

- Social Security benefits and other retirement income.
- Pension benefits.
- Veteran's benefits.
- Disability benefits.
- Salaries or wages.
- Interest income.

In general, food stamps and federal housing assistance are not counted as income for the purposes of eligibility.

Be aware that meeting an income limit is merely one step in qualifying for long-term care services from Medicaid. Even people with low incomes (such as less than $2,000 per month) or who "spend down" their excess income will typically need to satisfy additional requirements and will not be allowed to spend all of their money as they please. This point is explained in more detail in the next section.

How Much Income Can Medicaid Recipients Keep?

Regardless of how much money they technically earn, seniors whose long-term care is funded by Medicaid will only be allowed to keep a small amount of their income. All but a small piece of it must be used to pay a portion of the person's medical bills. The amount that can be used for non-medical purposes is the senior's "personal allowance" and is intended to cover personal items, phone bills and insurance premiums.

The exact size of the personal allowance will differ from state to state and might depend on whether long-term care services are being provided in a nursing home, a continuing-care community or a private residence. Though states are not required to pay for long-term care in settings other than nursing homes, those that will pay for home care will often allow for higher personal allowances. In these states, it is assumed that someone in a nursing home will not need to pay separately for necessities like food, heat and electricity, whereas someone who lives in a private home might still need to fund those expenses on his or her own.

Medicaid Asset Requirements

Even if they have low incomes, seniors who want to qualify for long-term care services via Medicaid cannot have a significant amount of financial assets. This requirement, paired with those related to income, are intended to ensure that Medicaid remains a need-based program and is not used by people who might otherwise be capable of paying for their own medical care.

Like the income requirements for Medicaid, the threshold for financial assets can differ from state to state. Seniors wanting long-term care services through the Medicaid program

are generally not allowed to have assets worth more than a few thousand dollars. This includes, but is not limited to, the following types of assets:

- Checking and savings accounts.
- Stocks, bonds or shares of mutual funds.
- Certificates of deposit.
- Real estate (with the possible exception of the person's primary residence).
- Automobiles (other than one vehicle driven by the person or used to transport the person).

Some types of assets are exempt from Medicaid's rules and can be kept even if the senior has other assets worth up to a few thousand dollars. For example, the following items are generally not included when determining whether someone has too many assets for Medicaid purposes:

- The person's primary residence.
- The person's primary automobile.
- Clothing, jewelry and other personal or household items.
- Pre-paid funeral plans.
- Small life insurance policies (usually worth no more than a combined $1,500).
- A small amount of cash intended for burial and other final expenses.

Understanding the Exemption for Primary Residences

The exemption for a person's primary residence is very important and deserves special attention here. Although the person's primary residence can be excluded from Medicaid's asset-related calculations, this exemption might not apply if the senior is already in a long-term care facility, does not have a spouse or dependents, and is unlikely to ever leave the facility.

The exemption for a person's primary residence might also be unavailable if the senior has a large amount of equity in his or her home. To determine the amount of equity in a home, subtract the balance of any remaining mortgage loan from the home's fair market value.

In 2016, the asset-related exemption for a Medicaid applicant's primary residence was generally unavailable to people with home equity above $552,000 or $828,000. The exact cutoff point for the residence exemption tends to change from year to year and varies among the states. Each state has the option of using either the lower or higher of the two numbers. It is common for a state's choice to be based on local property values. States with higher property values tend to use the higher number, while states with lower property values tend to use the smaller one.

When considering how the residence exemption might impact a potential Medicaid applicant, it is important to understand how the home is currently owned and who currently lives there. The limits on home equity only apply to the person applying for or receiving Medicaid assistance. Therefore, if a home is owned by multiple people and only one of them is applying for Medicaid, a residence that is worth a lot of money might still qualify for an exemption. As an example, consider a home that is owned outright by two unmarried people, one of whom is applying for Medicaid. The owners live in a state where Medicaid's

residence exemption doesn't apply if home equity is more than $600,000. The owners collectively have home equity of $700,000. But because they own their home jointly (with $350,000 of equity per owner), the Medicaid applicant might be eligible for benefits without selling his or her home.

Even in cases where a Medicaid applicant owns his or her home independently, the limits on home equity can be waived in either of the following scenarios:

- The applicant's spouse lives at the property.
- The applicant's dependent (such as an adult child with special needs or a son or daughter who is a minor) lives at the property.

Medicaid Spousal Impoverishment Rights

Many married people are interested in long-term care insurance because they worry about how Medicaid's eligibility rules might impact their spouse. Since Medicaid puts limits on a person's income and assets, there is the concern that the healthy half of a couple will need to make tremendous financial sacrifices in order to help an unhealthy spouse qualify for the need-based program.

In fact, previous decades included cases in which some healthy spouses decided to divorce their unhealthy spouses in order to satisfy Medicaid's requirements and not put themselves in poverty. Such cases resulted in the passage of "spousal impoverishment laws," which allow the non-Medicaid spouse (known as the "community spouse") to keep a certain amount of the couple's assets and income.

Income and Non-Medicaid Spouses

In general, income received solely in the community spouse's name for his or her own benefit can be kept by the community spouse and won't impact the other spouse's Medicaid eligibility.

If the community spouse has no independent income or only earns a small amount, the community spouse might be able to keep a portion of the unhealthy spouse's income. The amount of allowed income from the unhealthy spouse might be capped at a certain amount, such as $3,000 per month.

Assets and Non-Medicaid Spouses

When a married person applies for Medicaid, the government will consider the combined assets of both spouses. Then, the amount of assets that can be kept by the community spouse will be based on state rules.

In most states, the community spouse will be allowed to keep half of the combined assets but will not be allowed to keep more than a certain dollar amount. (The exact amount can change from year to year. In 2016, the amount was approximately $119,000.) In other states, the community spouse will be allowed to keep 100 percent of the combined assets but will not be allowed to keep more than a certain dollar amount. (The exact amount can change from year to year. In 2016, the amount was approximately $119,000.)

States that generally have a 50-percent rule might allow a community spouse to keep 100 percent of combined assets if those combined assets are lower than a certain dollar amount. (The exact amount can change from year to year. In 2016, the amount was approximately $24,000.)

Also, as was mentioned previously, a Medicaid applicant's home is excluded from the program's rules regarding assets if the community spouse lives there.

Medicaid Planning and Look-Back Periods

If they believe Medicaid is likely to be their best option for long-term care services, some seniors might attempt to structure their finances in ways that make it easier to qualify for the need-based program. This process is known as "Medicaid planning."

One popular goal of Medicaid planning is to transfer financial assets to family members, charities or trusts so that they don't actually need to be spent on medical services. This is a controversial practice because it can result in people qualifying for the need-based Medicaid program without fully forfeiting their money or other things of value. On the other hand, many people don't see a problem with Medicaid planning as long as they aren't directly violating any laws and are simply taking advantage of loopholes in the eligibility rules.

In order to police certain types of Medicaid planning, the government requires Medicaid applicants to disclose practically any transfer of assets that were made in the preceding five years. The five-year timeframe is known as the "look-back period." If an asset was transferred during the look-back period for less than its fair market value, the applicant will be penalized.

To determine the penalty for an inappropriate transfer of assets, the government will start by determining the asset's fair market value. For the sake of an example, let's assume an inappropriate transfer involved an asset worth $10,000.

Next, the amount actually received in exchange for the asset (if any) will be subtracted from the fair market value. Going back to our example, imagine that the $10,000 asset was transferred to the Medicaid applicant's son in exchange for only $1,000. This means an inappropriate transfer of $9,000 occurred.

Now, we need to divide the amount of the inappropriate transfer by the average monthly cost of long-term care services in the Medicaid applicant's community. Assuming a local monthly cost of $3,000, we'd divide $9,000 by $3,000 and get a quotient of 3.

The quotient, measured in months, is the amount of time the Medicaid applicant will be forced to still pay out of pocket for long-term care services until Medicaid benefits will begin. So in our example, even if the applicant seems to have otherwise satisfied all of Medicaid's eligibility requirements, he or she won't be covered by the program until another three months have passed.

Exceptions to the Transfer Rules

Some kinds of transfers, such as certain transfers between spouses or dependents, can be made even if they occur less than five years before someone applies for Medicaid. For example, transfers of home equity might be possible if they are made to the following individuals:

- A spouse.
- A child who is under 21 years old.
- A blind or disabled son or daughter, regardless of age.
- A brother or sister who already owns part of the home and lived in it for at least one year before the person applied for Medicaid.
- A son or daughter who cared for the person and lived in the home for at least two years before the person applied for Medicaid.

Estate Recovery

Even if someone is allowed to keep certain assets and still remain eligible for Medicaid, states might have the right to access or sell those assets after the person dies. This process is called "estate recovery" and is designed to repay the state and federal governments for the amount that was spent on the person's long-term care services.

Estate recovery is a highly controversial issue because it can prevent family members or other survivors of a deceased Medicaid recipient from inheriting the person's money or other property. It's also a very complicated issue due to the different ways each state exercises its estate-recovery powers.

States have had the ability to engage in certain types of estate recovery ever since the beginning of the Medicaid program. However, going after a deceased Medicaid recipient's estate was optional and was often deemed overly complicated or at least too politically unpopular. For decades, most states only engaged in estate recovery in rare cases.

In the early 1990s, Congress determined that estate recovery was beneficial to Medicaid's long-term stability. Based on this premise, laws were passed that made estate recovery mandatory under certain circumstances. Under federal law, states are generally required to engage in estate recovery when a Medicaid recipient dies and received long-term care services through the need-based program. Although federal law only requires that states attempt to recoup the amount paid by Medicaid for long-term care services, states are allowed to recoup the cost of other Medicaid services (such as hospital bills or physician charges) if they choose.

Although estate recovery can be a scary consequence for Medicaid recipients, there are several limits on how and when it can be done. For example, despite Medicaid being available to many different types of low-income people, estate recovery is only allowed in regard to the following classes of Medicaid recipients:

- People who received financial assistance from Medicaid at or after age 55.
- People who received long-term care services in an institutional setting (such as a nursing home) at any age through the Medicaid program.

The federal requirement that states engage in estate recovery applies to a Medicaid recipient's probate-eligible assets. Assets that are exempt from the probate process are exempt from the federal estate recovery rules and will only be subject to estate recovery if a state chooses this option. In practical terms, this means the following types of assets might be exempt from estate recovery:

- Life insurance owned by the Medicaid recipient (unless the person's estate is the beneficiary).
- Retirement accounts owned by the Medicaid recipient (unless the person's estate is the beneficiary).
- Certain kinds of property owned together by a Medicaid recipient and a spouse. (This exemption might vary depending on the state and the type of property.)
- Certain kinds of property held in a trust.

Even if an estate has assets that would ordinarily be subjected to estate recovery, federal law requires that estate recovery be delayed in any of the following circumstances:

- The spouse of the Medicaid recipient is still alive.

- A son or daughter of the Medicaid recipient is still a minor.
- A blind or disabled son or daughter of the Medicaid recipient is still alive (regardless of age).
- Estate recovery would cause undue hardship. (Specifics regarding undue hardships are left up to the individual states.)

Estate recovery must also be delayed under the following circumstances if it involves the potential sale of the Medicaid recipient's home:

- The recipient's sibling owns part of the home, helped care for the recipient for at least one year before the recipient's entry into a nursing home and has lived in the home ever since.
- The recipient's adult child helped care for the recipient for at least two years before the recipient's entry into a nursing home and has lived there ever since.

Although federal law mandates these delays in estate recovery, many states treat a required delay as something permanent. For example, let's assume a Medicaid recipient received long-term care services and would ordinarily have his remaining assets subjected to estate recovery. However, because his wife is still alive, the state is required to delay the estate recovery process until she dies. Even when the wife passes away, the state might choose to ignore its right to estate recovery because of the administrative costs associated with re-examining the family's remaining assets.

The same might be true if, for example, a mandatory delay is due to the Medicaid recipient having a surviving son or daughter who is a minor. Even when the son or daughter becomes an adult, the state might choose not to pursue the deceased Medicaid recipient's assets because of the administrative burden. In general, states do not need to engage in estate recovery if doing so is likely to be unprofitable or not worth the effort.

Liens on Private Homes

In order to facilitate eventual estate recovery, the state can put a lien on a Medicaid recipient's private home. A lien gives the state certain rights in connection with the property, such as the right to share in the proceeds from an eventual sale, but it doesn't necessarily result in the home being sold against the owner's will.

The state can put a lien on a Medicaid recipient's home even while the person is still alive but only if he or she is receiving an institutional form of long-term care (such as care in a nursing home) and is not expected to ever return home. In fact, if the person is first deemed unlikely to ever return home but eventually recovers and is able to move back to his or her private residence, the state must remove its lien.

A state cannot put a lien on a Medicare recipient's home while any of the following individuals is residing there:

- The Medicaid recipient.
- The Medicaid recipient's spouse.
- The Medicaid recipient's son or daughter (if the son or daughter is blind, disabled or a minor).
- The Medicaid recipient's sibling. (This might depend on how long the sibling has lived at the property and whether he or she was involved in providing at-home care for the Medicaid recipient.)

A Disclaimer Regarding Medicaid Information

If the information provided here about Medicaid eligibility, estate recovery and the imposition of liens on property seem very confusing to you, you are not alone. It is important that long-term care insurance producers understand the general concepts of Medicaid and estate recovery, but the specific rules and laws related to these topics are very complex and are made even more intimidating by a lack of consistency across all parts of the Medicaid program.

For example, although we are focusing here on Medicaid and long-term care services, many people use Medicaid for other purposes, such as for help with hospitalization costs and doctor visits. The rules for people who want Medicaid for these other purposes tend to be different than the rules for people who merely need long-term care. In addition, each state has flexibility in regard to Medicaid eligibility and estate recovery rules.

For specific guidance about Medicaid eligibility and estate recovery, consumers and even insurance professionals should rely on local experts, such as elder-law attorneys in their community.

Medicaid vs. Private Pay

So far, our examination of Medicaid has centered on eligibility requirements and an applicant's likely desire to keep as much of his or her assets as possible. But for some people, particularly in their later years, asset protection isn't such a major concern.

Senior citizens who are single and either don't have any family or have relatives who don't rely on them for financial assistance might determine that spending down his or her assets in order to qualify for Medicaid isn't such a big deal. To paraphrase a common saying, "You can't take your money to the grave." So why not spend it on long-term care?

For families who aren't concerned about avoiding Medicaid for financial reasons, the choice between relying on Medicaid or purchasing long-term care insurance might relate more to the perceived differences in the quality of care. Some advocates of long-term care insurance warn their prospects that not having long-term care insurance will increase the likelihood of receiving substandard care in state-run nursing facilities where staff members are incompetent and inattentive.

Despite occasional stories about mistreatment of patients in nursing homes, this particular method of encouraging long-term care insurance sales is arguably close to being a scare tactic. Medicaid, after all, pays for more long-term care services than any other source in the United States (including long-term care insurance companies). The suggestion that a Medicaid recipient is likely to receive inadequate care not only ignores the vast majority of cases in which Medicaid patients are monitored by dedicated caregivers but also omits the fact that elder abuse is more common in private homes than in nursing facilities.

What's true, however, is that many excellent long-term care facilities either do not accept payments from Medicaid or will only do so if the resident in question is receiving Medicaid after an extended period of paying out of pocket. The decision to not accept Medicaid payments is generally tied to the formulas that the government uses to compensate skilled nursing facilities. Even if a facility agrees to accept Medicaid payments, the formula used to calculate the payment might be significantly less than what the facility would normally charge. Unless significant amounts of funding are made available from other sources, facilities that rely almost exclusively on Medicaid payments tend to have a hard time making a profit.

Due to many facilities' decision to limit the number of Medicaid recipients that they will accept, it is generally fair to say that being on Medicaid can limit a person's options for long-term care services. A senior who is insistent on eventually receiving care in a particular facility might find that the facility does not accept Medicaid recipients. Similarly, a senior might discover that while Medicaid will pay for care in a nursing home, the program might not pay for a private room or for services provided in assisted-living facilities.

If long-term care planning is conducted at a fairly early stage, the people who are likely to eventually need care might want to conduct research about various facilities in their area. Among other things, answers to the following questions can be very important:

- Does the facility accept new residents who are having their long-term care funded through Medicaid?
- If a resident starts living at the facility and initially pays out of pocket, will the resident be allowed to stay in the facility if his or her assets are ever depleted and the person becomes eligible for Medicaid?
- If the facility allows private-paying residents to eventually pay for their care via Medicaid, will the shift to Medicaid result in any changes for the resident (such as relocation to a non-private room)?

Long-term care insurance is viewed favorably by assisted-living facilities, nursing homes and continuing-care communities. In cases where space in a preferred facility is limited and/or only available to people who aren't receiving Medicaid assistance, a good long-term care insurance policy can make the admission process fairly simple.

Disability Insurance

The general consensus among long-term care insurance professionals is that coverage should be purchased several years before a person's health starts to decline. Buying at a relatively young age makes it easier to qualify for good coverage at lower prices.

Though it might seem reasonable, the recommendation to purchase long-term care insurance at a young age might not make as much practical sense if the prospect is woefully underinsured in other areas, including in regard to disability insurance.

Disability insurance is designed to replace most of a working person's income if the person is unable to perform his or her job duties because of an illness or injury. Though benefits are triggered by some kind of medical evaluation, money received from a disability insurer can be used in practically any way that the recipient sees fit and doesn't need to be used to pay for medical costs. Furthermore, benefit triggers are based on an inability to work rather than on an inability to perform activities of daily living. In effect, this means that disability insurance benefits tend to be easier to obtain and more flexible than the benefits provided by long-term care insurance.

Working people who are in good health might be able to qualify for a decent disability insurance product until they near their retirement. If long-term care services are required during middle-age, this disability insurance might be used to pay for those services and any other assistance that the person requires. But since practically no disability insurance products will provide benefits to someone older than 65, coverage for long-term care in a person's later years will need to be found elsewhere. Long-term care insurance can serve this purpose and can cover the insured beyond age 65.

Cash-Value Life Insurance

Some types of life insurance can be used to indirectly pay for long-term care insurance premiums or for long-term care services. Types of life insurance known as "cash-value life insurance" can be purchased with the intent of providing a death benefit for a loved one but can also be surrendered prematurely for a lump sum. This kind of insurance might also offer loan provisions that let the policyholder borrow against the policy's death benefit and use the borrowed funds to either pay for long-term care or fund a long-term care insurance policy.

Be aware that not all types of life insurance are cash-value products and, therefore, don't all contain loan provisions or allow policyholders to surrender their policy in exchange for cash. For example, term life insurance is a common life insurance product with no cash value.

Despite the possible use of cash-value life insurance in long-term care planning, it is very rare for someone to purchase this kind of policy with the full intent of cashing it in or borrowing money against it. If this kind of product is used at all in long-term care planning, it is generally reserved for cases in which the policyholder purchased it years ago to fill a life insurance need that no longer exists.

In most cases, life insurance products—including cash-value life insurance—should be purchased in order to provide financial protection against premature death. If there is a need to insure for long-term care but no need for a death benefit, life insurance is usually not a suitable product.

Accelerated Death Benefits

Applicants for life insurance can sometimes pay an additional amount in exchange for potential "accelerated death benefits." When purchased, these optional benefits allow the insured to access a portion of the policy's death benefit in order to pay for medical care and other private expenses. When the insured person dies, the death benefit paid to the policy's beneficiary will be reduced by the amount already paid as accelerated death benefits.

One potential drawback to accelerated death benefits is that they might only be accessible to people who have been certified as "terminally ill." In insurance terms, this often means the person's remaining life expectancy is believed to be no longer than two years. Though accelerated death benefits could technically be used to pay for long-term care services for a terminally ill person, they are unlikely to provide much help to seniors who aren't terminally ill.

Viatical Settlements

A viatical settlement is a financial transaction in which the owner of a life insurance policy sells the policy (including the right to receive death benefits) to someone else in exchange for a large lump sum. In general, viatical settlements are for insured people who are terminally ill with less than two years to live.

A viatical settlement might be suitable if a terminally ill person doesn't have long-term care insurance, doesn't have dependents who are relying on a death benefit and is fairly certain to need custodial care for less than two years. Compared to surrendering a life insurance policy for its cash value or utilizing a life insurance policy's accelerated death benefits, a viatical settlement will usually result in more money going to the insured.

Life Settlements

A "life settlement" is almost exactly the same as a viatical settlement, except that life settlements are for senior citizens who are not terminally ill. Because an insured who seeks a life settlement is likely to live longer than a terminally ill person (and require investors to pay a longer stream of premiums in order to keep life insurance coverage in force), life settlements result in less money for the insured than viatical settlements. However, they typically still allow the insured to receive more money compared to surrendering a cash-value life insurance policy to the insurance company.

Annuities

Annuities allow people to give large sums of money to insurance companies in exchange for a long-term stream of income at a later date. For example, an individual might purchase an annuity with a lump sum of $100,000 and then be entitled to receive $1,000 per month from the insurer for the rest of his or her life.

Long-term investors and long-term savers are also sometimes won over by an annuity's tax features. Most annuities go through an "accumulation period," during which the value of an annuity can grow on a tax-deferred basis and earn a compounded amount of interest. So, in simplistic terms, no one pays taxes on the money until it comes out of the account, and interest can be credited to both the amount invested (known as the "principal") and any previously earned interest. Consumers receive these positive benefits in exchange for less liquidity than they might find in CDs or mutual funds.

Basic Kinds of Annuities

Almost every annuity can be categorized in at least two different ways, depending on how the insurer invests the buyer's premium and when the owner expects to dip into the annuity for payments. In regard to investment of premiums, an annuity can be either "fixed" or "variable." In regard to the timing of payments to the owner, an annuity can be either "deferred" or "immediate." Most annuities are fixed and deferred, but we will examine the other main combinations here as well.

Fixed and Variable Annuities

People who care more about saving money than engaging in high-risk, high-return ventures tend to prefer fixed annuities over variable annuities because fixed contracts contain more guarantees. The traditional fixed annuity guarantees a return of all money given to the insurance company plus a guaranteed amount of compounded interest, such 3 percent or 4 percent. Regardless of the minimum interest-rate guarantee for a fixed annuity, the amount of guaranteed interest might be higher during the first few years of a contract's term.

The risk to the fixed annuity purchaser is minimal because the insurance company invests the owner's premiums in conservative bonds and government securities. The consumer is responsible for picking the right contract and insurer, while the insurer is responsible for investing the principal in a manner that will satisfy the contract's guarantees. As long as the insurance company does not become insolvent, the annuity owner's money will be safe. However, the owner must accept the possibility that the guaranteed interest from a fixed annuity will not keep up with inflation.

Variable annuities appeal to investors who are willing to put some of their money at risk in exchange for potentially higher returns. The owner typically shoulders the responsibility of investing his or her money in one or several "subaccounts" (which are similar to mutual

funds), and the annuity's account balance will go up or down depending on how those subaccounts perform.

In addition to absorbing market risks, owners of variable annuities will usually be charged account management fees on an annual basis. Most variable annuities contain some basic guarantees, such as a guarantee that the owner's annuity will never be worth less than the original principal amount, but most of these guarantees are only available if buyers are willing to pay extra fees that reduce their potential return.

Deferred and Immediate Annuities

The annuity shopper's choice between an immediate annuity and a deferred annuity will depend on when the person wants to start receiving payments from the insurance company. This is true regardless of whether the annuity is fixed or variable. Let's go over the options.

Deferred Annuities

A "deferred annuity" is often favored by individuals who don't need consistent, additional income at the time of purchase but envision needing it in the future. When people buy a deferred annuity, their goal at that moment is to watch their principal expand for several years. Presumably at a much later date, they'll cash in their deferred annuity for a lump-sum payout or for divided payouts that will be disbursed throughout their remaining lifetime. Often upon the conclusion of a deferred annuity's contract term, the money in an existing deferred annuity is transferred to a new deferred annuity.

Between the time it's purchased and the time payments begin, a deferred annuity goes through an accumulation period. During the accumulation period, the owner's account is expected to grow without negatively affecting the person's tax situation.

Immediate Annuities

An "immediate annuity" creates an income stream for the owner soon after the sale date. In general, the owner starts receiving payouts within one year of entering into the contract.

People who buy immediate annuities might care less about growing their principal and more about maintaining their current income level for as long as possible. An immediate annuity can help them achieve their goals by giving them payouts on a monthly, annual or other set schedule rather than in a lump sum.

Immediate annuities don't go through a traditional accumulation period because money is being taken out of them at the same time that the account would otherwise be growing in value. Also, opportunities for tax deferral with an immediate annuity are relatively minimal because taxation on an annuity begins when money is taken out of the owner's account. Since they are generally meant to serve as a source of immediate cash payments and not as a long-term savings vehicle, immediate annuities are also known as "income annuities."

The amount of money a person receives regularly from an immediate annuity will be determined by the principal, the person's life expectancy and the fixed or variable status of the annuity. With all other factors being equal, a larger principal will translate to bigger immediate payouts because the insurance company will have more money to give out in the first place. But because annuities are designed as supplementary sources of income that last a lifetime, immediate payouts offered to a younger person can be lower than those offered to an older person. This can be true even if the younger individual pays more principal to the insurance company.

Most immediate annuities are fixed and give budget-conscious owners the security of knowing that their scheduled payouts will not dip below a guaranteed minimum dollar amount. However, because immediate fixed annuities lock the owner into a room where the ceiling on interest rates is only so high, some people worry that these products will not keep up with inflation. In efforts to confront that concern, insurance companies have designed some riders (add-on features in insurance contracts) that can either automatically increase annuity payouts every year or at least ensure that payouts will temporarily keep pace with consumer price indices.

A minority of annuity owners choose to receive variable immediate payouts, which can combat inflation without the help of a rider. Variable immediate annuities will not help someone craft a budget because, without riders, they offer no minimum guarantees. The insurance company calculates an initial payout for a variable immediate annuity, based on life expectancy and economic conditions, but subsequent payouts can rise or fall with the financial markets.

An immediate annuity might be purchased outright with a large principal sum, or it might be bought with proceeds from an old deferred annuity that has reached the end of its contract term. Either of these options is possible, regardless of whether the old or the new annuity is fixed or variable. For example, a variable deferred annuity that has reached the end of its contract term might be converted to an immediate fixed annuity. However, once an owner has purchased an immediate annuity, it generally cannot be converted or "rolled over" to a deferred annuity. Instead, the immediate annuity will continue to make payments for the rest of someone's life or on some other schedule, as determined by the owner.

Also, due to the speed and frequency with which payments are made by the insurance company, an immediate annuity can be problematic if a buyer changes his or her mind and wants to surrender the annuity and receive a substantial refund. Deferred annuities might offer a simple surrender process but still might require the buyer to pay penalties in order to receive refunds or early withdrawals of their money.

Annuities and LTC

If the owner of a deferred annuity requires long-term care services, the person might consider cashing in the annuity for a lump sum. If the annuity has been in place for several years, the owner might be able to receive a lump sum from the insurer without being subjected to financial penalties. However, most annuities impose "surrender charges" if money from an annuity is withdrawn earlier than expected. Even if an annuity can be cashed in without the threat of surrender charges, the federal government might tax the money received from the annuity as income. Withdrawals from annuities before the owner's 60th birthday might also be reduced by a federal tax penalty.

Annuity owners who need long-term care services might be able to withdraw money from their annuity without having to worry about surrender charges or tax penalties. To determine whether a surrender charge will be enforced by the insurance company, the producer must carefully review the annuity contract and any relevant policy riders. To determine whether IRS penalties and the taxation of annuity income can be avoided, the insurance producer might want to consult a tax professional.

Reverse Mortgages

A "reverse mortgage" allows a homeowner to receive income from a lender in exchange for the equity in his or her home. In general, a homeowner with a reverse mortgage receives either a large lump sum or a series of regular payments from the lender until the property is no longer the person's principal residence. When the property is no longer the

homeowner's principal residence, the home can be sold, and the lender will be entitled to a large portion of the proceeds.

Reverse mortgages can be beneficial for senior citizens who are considered "house rich but cash poor." Money received from a reverse mortgage can be used by the homeowner for practically any purpose, including for long-term care insurance premiums.

Though reverse mortgages might be used to purchase a fairly expensive long-term care insurance product, these mortgages might not be as helpful in regard to paying directly for long-term care services. Since payments from the lender can stop when the home is no longer the senior's primary residence, a reverse mortgage might not be helpful if the senior ever needs to be transferred to a nursing home. Similarly, by transferring property rights to a lender in exchange for payments, the senior won't necessarily be able to use the sale of the property to finance a stay in an assisted-living facility, continuing-care community or other setting that requires a large deposit.

For more about reverse mortgages, consult a loan officer, loan originator or other mortgage professional.

Government Encouragement of Long-Term Care Insurance

Many consumers resist suggestions to purchase long-term care insurance because they believe the federal government will eventually develop its own long-term care insurance program. This assumption makes some sense when you consider the number of people—particularly Baby Boomers—who will eventually require care. Presumably, if millions of voters are likely to have concerns about receiving adequate long-term care services, elected officials would benefit by attempting to address the issue.

Yet the federal government has generally shied away from implementing major entitlement programs focused on long-term care services. Some people question whether government can deliver or manage long-term care services efficiently. Others are concerned that even a well-run government program for long-term care will strain the country's finances.

Regardless of whether you agree or disagree with those concerns, they have been largely responsible for the types of federal responses to the issue of long-term care over the past several decades. In general, these responses have centered on encouraging consumers to purchase private long-term care insurance. The hope is that this encouragement will ultimately result in good care for the elderly while also reducing financial stress on Medicaid.

LTC Insurance For Federal Employees

The Long-Term Care Security Act led to the implementation of a long-term care insurance plan for federal employees and their spouses. The group plan involves no premium contributions from the federal government. Employees pay their own premiums, and enrollment in the plan is optional.

When the Long-Term Care Security Act was passed, some legislators hoped the federal plan would raise awareness of long-term care insurance and result in more insurance sales in the individual market. So far, the federal plan hasn't had this type of impact. According to a 2006 report from the Government Accountability Office (issued roughly five years after the plan's debut), only 5 percent of eligible employees had signed up for the plan.

The CLASS Act

In 2010, Congress passed the Affordable Care Act, which resulted in significant changes to health insurance across the country. Although the majority of the debate surrounding this legislation had nothing to do with long-term care services, the law actually called for the implementation of a federal long-term care insurance program called "CLASS."

Under the CLASS program, citizens and legal residents who were 18 or older were supposed to be eligible for daily benefits of $50 or more when they became cognitively impaired or could no longer perform multiple activities of daily living. Program participants would've needed to have paid into the program for roughly five years before being eligible for benefits. Premiums were supposed to have been approximately the same for all participants regardless of a person's health status.

In contrast to the partisan battles surrounding the rest of the Affordable Care Act, experts on both side of the political spectrum looked closer at the details and quickly determined that the CLASS program was unworkable. Since participation was voluntary and because premiums couldn't be higher for people who were already in poor health, it was widely assumed that the program would be overused by high-risk enrollees and would be unattractive to younger, healthier people. This problem, generally known in insurance as "adverse selection," could have led to high premiums for everyone. As a result, the pieces of federal law that called for implementation of the CLASS program were repealed in early 2013.

LTC Partnership Programs

In the first few years of the 21st century, four states (California, Indiana, Connecticut and New York) received funding to implement a "long-term care partnership program." Partnership programs allow people to qualify for long-term care services under Medicaid without having to surrender or "spend down" most of their assets. In exchange for being allowed to keep more of their money, participants in partnership programs must purchase a particular type of long-term care insurance. In 2006, Congress passed laws to expand partnership programs into other states.

Long-term care partnership programs differ by state. Many states have "dollar-for-dollar" programs, in which the amount of assets that can be shielded from Medicaid will be based on the amount of long-term care insurance that the Medicaid applicant has purchased. In a simple example, consider someone who has purchased a partnership policy with a $100 daily benefit and a two-year benefit period. By multiplying the daily benefit by the benefit period, we arrive at a policy worth $73,000. So if a state has a dollar-for-dollar partnership program, the policyholder in our example might be allowed to keep an additional $73,000 in assets and still qualify for Medicaid if the policy's benefits run out. A few states might structure their partnership programs differently and allow participants to keep assets that are worth more or less than their policy's value.

Even if they live in a state with a partnership program, consumers who want to participate shouldn't assume that just any long-term care insurance product will satisfy the programs requirements. Requirements for partnership policies, while often similar across the country, can differ among the various states. For example, a state might have its own rules about whether a policy must include inflation protection and whether it must be a "tax-qualified" policy under IRS rules. (You'll read about the differences between tax-qualified policies and non-tax-qualified policies in the next few sections.)

The differences in state requirements for Medicaid and partnership programs have created uncertainty regarding policyholders who buy a partnership policy in one state but

eventually move elsewhere. In most cases, the insurance provided by partnership policies is likely to still work upon the policyholder's move, but the ability to shield assets from Medicaid might be put in jeopardy. Reciprocity among the states has improved since the expansion of partnership programs in recent years, but it is still an important issue to consider before purchasing a partnership policy.

The effectiveness of partnership programs was unclear at the time this course was being written. A 2007 study conducted by the Government Accountability Office looked at enrollments in the four original partnership programs and questioned whether the programs would ultimately result in savings for Medicaid. The goal of partnership programs has always been to encourage more purchases of long-term care insurance, but the study estimated that roughly 80 percent of partnership policies were bought by people who probably would've purchased long-term care insurance anyway. Although the remaining 20 percent were unlikely to have purchased a non-partnership policy, it was unclear whether those 20 percent would've mainly paid out of pocket for long-term care without a partnership policy or whether they would have been relying on Medicaid.

The U.S. Department of Health and Human Services has been more optimistic about partnership plans and has hypothesized that the plans might make Medicaid applicants less inclined to hide assets and engage in the kind of Medicaid planning that allows wealthier people to qualify for the need-based program.

Tax Treatment of LTC Insurance

Many instances of government support for long-term care insurance have been indicated by changes in tax law. For example, in 1996, the federal government made it possible for long-term care insurance policyholders to deduct a portion of their premiums from their taxable income. Be aware that there might be limits to this tax deduction depending on the policyholder's age and the size of the premiums. Also, this deduction for long-term care insurance premiums is only available to taxpayers who itemize on their returns rather than taking the standard income-tax deduction.

Regardless of the deductibility of premiums, the benefits received from long-term care insurance are usually tax-free to the recipient and are, therefore, not treated as income. This general rule applies to reimbursement policies, which only provide benefits based on the actual cost of care received by the insured. By contrast, an indemnity policy might pay a flat amount to the policyholder regardless of whether the cost of long-term care has met or exceeded the flat amount. Insurance benefits that exceed the actual cost of care are likely to be treated as taxable income to the recipient.

The tax benefits mentioned in this section are generally reserved for "tax-qualified" policies. These policies must include certain provisions and limits set by federal law. Although nearly all long-term care insurance policies in today's market are tax-qualified, some older policies that don't satisfy these requirements are still in force.

Tax-Qualified vs. Non-Tax-Qualified

In exchange for the positive tax features mentioned in the previous section, owners of tax-qualified long-term care insurance policies might face stricter rules for benefit eligibility than owners of the few remaining non-tax-qualified policies. Differences between tax-qualified policies and non-tax-qualified policies are summarized below:

- Tax-qualified policies cannot provide any long-term care benefits unless the insured is either cognitively impaired or unable to perform at least two activities of daily living (eating, bathing, continence, transferring, dressing or toileting). By

contrast, non-tax-qualified policies might allow benefits to begin if someone is incapable of performing just one activity of daily living. Non-tax-qualified policies might also allow the insured to receive benefits upon not being able to cook, balance a checkbook, make phone calls, or perform other activities not mentioned here.

- Tax-qualified policies can't provide any long-term care benefits unless a licensed physician has certified that the insured is likely to need care for at least 90 days. Once this initial certification has been obtained, a licensed physician must repeat this certification process at least once each year. Non-tax qualified policies might not require this certification or might at least require it on a less frequent basis.

The tax status of a long-term care insurance policy (tax-qualified or non-tax-qualified) should be disclosed to an applicant before coverage is purchased. In fact, many states require that this disclosure be made via a special form for all long-term care insurance sales.

Conclusion

Despite the many positives of long-term care insurance, the product hasn't been nearly as popular as many people initially expected. The retirement of the large Baby Boomer generation suggested that the market for long-term care insurance would be very competitive, but several factors have combined to have a negative impact on sales.

When talk about long-term care insurance started heating up in the 1990s, the carriers that chose to sell the product had to make assumptions about "lapse rates." Lapse rates are statistics that represent the number of people who purchase insurance but end up cancelling their coverage before receiving any benefits. By properly calculating its lapse rates, insurance companies can estimate the amount of money they will be able to actually keep and the amount that will ultimately be needed to pay benefits to their policyholders.

Since early long-term care insurers didn't have much historical data to guide their initial estimates, they had to make some less-than-educated guesses. Those guesses turned out to be incorrect, with lapse rates for long-term care insurance being significantly lower than expected. In general, people who had purchased early forms of long-term care insurance tended to keep their coverage in place for a long time and ended up filing more claims for benefits than insurers had anticipated.

The misjudged lapse rates meant that insurers had to be a bit more careful when investing consumers' premiums. If more money was likely to be needed to honor policyholders' claims, premiums couldn't be put into higher-risk, higher-reward financial vehicles and still satisfy the solvency rules set by state insurance departments.

Meanwhile, the United States began experiencing major economic problems. Those broader economic troubles led to even lower investment returns for individuals and businesses (including insurers) that needed to keep their money in low-risk portfolios.

These various factors caused the market for long-term care insurance to shrink dramatically. Many companies that had been selling the product in the 1990s had exited the market by the late 2000s. Those companies that remained in the market often had to impose major rate increases that didn't please existing policyholders or attract new buyers. Unfortunately, consumers who are interested in long-term care insurance are still being impacted by this instability and are often rightly concerned about present and future costs.

The good news for insurance professionals is that the problems with lapse rates, investment returns and rate increases haven't changed the public's need for long-term

care planning. People will continue to grow older and will continue to worry about how they or their loved ones will be able to access nursing and other long-term care services. With more time and more help from the many smart people in the industry, insurers should be able to adjust their business models in order to meet this important need.

CHAPTER 4: THE VIATICAL AND LIFE SETTLEMENT MARKET

Introduction

It may be easy to view the secondary market for life insurance as a purely American creation; just one extreme example of what a modern market economy can produce. Yet the practice of selling one's life insurance to strangers has its origins across the ocean in England, where economically poor individuals who suffered from serious illnesses could auction off their life insurance policies to the highest bidder at least as early as the 19th century. U.S. authorities who knew about these auctions and considered them despicable aimed to keep them out of our country by promoting non-forfeiture laws on a state level beginning in the 1860s.

Between that time and the 1980s, Americans with life insurance to their name were left in an odd position. As policy owners, they technically had the right to renounce policy benefits and put them in another person's hands. But beyond offering their policy as collateral to a creditor or surrendering it to the insurance company, they lacked formal ways of selling their policy for necessary cash.

When they look back on the state of life insurance as it was 30 years ago, multiple industry experts note that a person who wanted to sell an in-force yet unwanted policy usually had to deal with a "monopsony;" an environment in which people who market their goods and services can only do business with one buyer. That lone potential purchaser in those days was effectively the same company that issued the policy, and the "take it or leave it" offer from that buyer was never greater than the policy's cash surrender value.

Although the option of canceling a policy for its cash surrender value was certainly better than having no options at all, it was often far from a financial life saver for someone with a need to create immediate income from a policy. Then, as now, the cash surrender value often amounted to a very small amount if the owner had not yet paid significant premiums on the policy. At that time, insurance companies made no changes to surrender values for clients who had developed life-threatening illnesses.

Of course, the needy policyholder with a permanent life insurance policy also had the ability to receive a speedy delivery of dollars from the insurer by requesting a loan against the contract's cash value. But the amount available to the individual via a loan was sometimes very small compared to the policy's death benefit.

Meanwhile, critically ill people with term coverage could neither apply for a policy loan nor surrender their policies for cash. They received nothing positive from their insurance, other than the guarantee that a named beneficiary would receive some money when they passed away.

None of this boded well for people who were dying of AIDS during the late 1980s. As the disease attacked their immune system and made them too sick to remain in the workforce, many AIDS patients lost their income and employer-sponsored health insurance and struggled to pay for medical treatment that could have prolonged their lives. Those who were fortunate enough to hang onto their health coverage often found that their medical plans would not pay for the latest experimental drugs and therapies that scientists were developing to combat the new health crisis. Rather than being able to concentrate on enjoying their last days as much as possible, the terminally ill often spent their time

worrying about how they were going to pay for medical attention and still have enough money for such essentials as housing, food and utilities.

Typical AIDS patients—young and unmarried men—sometimes owned inexpensive term life insurance policies that had been made available years earlier through an employer. But with death catching up to them and no dependent spouses or children to think about, they began to question the practical value of such coverage and had no way of receiving any personal benefits from what, in some cases, was the largest item in their estate.

The AIDS community's financial dilemmas caught the attention of a few insurance veterans, financial planners and entrepreneurs who had watched well-insured close friends or family members die of AIDS or cancer with little or no money left in their pockets. Searching for ways to turn life insurance into a greater financial asset for the terminally ill, these businesspersons developed a secondary market for life insurance in the United States by promoting what have become known as "viatical settlements."

The word "viatical" comes from the Latin term "viaticum," which was used first to describe a bundle of provisions given to Roman officers as they headed out on long, dangerous missions and was later associated with the religious sacrament of last rites administered to dying Catholics. In theory, viatical settlements and the companies that provide them take that old terminology and apply it to modern circumstances.

In exchange for receiving the eventual death benefits created through a terminally ill person's life insurance policy, a viatical organization pays a major portion of the policy's face value to the dying individual, thereby giving the terminally ill policyholder money to help with medical bills or other needs.

For the purpose of a hypothetical example, suppose a person with a $100,000 life insurance policy has been diagnosed with terminal cancer and is expected to die in roughly one year. By selling the policy to a viatical company—effectively making the company the beneficiary of death benefits—,the person might receive a lump-sum payment of $80,000 from the organization.

During his or her remaining lifetime, the terminally ill person would be able to spend the $80,000 as he or she sees fit. After the insured dies, the viatical organization would file a claim with the life insurance company for the full $100,000 death benefit and would expect to earn a $20,000 profit from its investment.

The first major viatical company in this country was started in Albuquerque, New Mexico, in 1988. After spreading to portions of the South and Midwest, the young industry made its way to such metropolitan areas as New York City and San Francisco, where a high prevalence of AIDS cases suggested there might be a favorable market for viatical settlements.

By the 1990s, the viatical business was growing and trying to find a place within mainstream America. Despite still being linked to the AIDS epidemic, viaticals were increasingly targeted at people with other serious illnesses, and funding for the settlements was coming from individual and institutional investors in big cities and small towns.

At least for a brief period, some advocates for the terminally ill praised viatical companies for creating financial opportunities for the sick. Meanwhile, many investors were won over by marketers who claimed that giving money to a viatical company was practically a charitable act; a good deed that would help the less fortunate among us enjoy their last days and pass away with an enhanced sense of dignity.

The promised yields on investments probably didn't hurt either. Many companies sold the idea of these transactions as an allegedly safe way for people to make at least 15 percent on their principal investment. That advertised yield greatly outpaced interest rates on certificates of deposit, and the basically nonexistent relationship between viaticals and the economy appealed to risk-averse investors who were fearful of market fluctuations.

In time, demand for viatical settlements and similar services helped transform the secondary life insurance market from a million-dollar industry in the early 1990s into a billion-dollar industry near the beginning of the new millennium.

How Do Viatical Settlements Work?

If you consider that viatical settlements involve such delicate matters as dollars and death, you will hardly be surprised to learn that these transactions are extremely complex and often packed with safeguards that protect the original policy owner, the ill person's loved ones and the viatical investor.

The viatical process involves a front end (in which ownership of a policy is transferred from the original policyholder to a viatical company) and a back end (in which the viatical company usually resells all or a portion of the purchased policy to a third-party investor).

At this point in our course, we will study the viatical transaction in a roughly chronological fashion, beginning with front-end activity.

The Front-End Viatical Process

A policy owner who seeks out a viatical settlement is known as a "viator." In most cases, the viator and the person covered by the life insurance contract are the same person. However, as long as proper permission is obtained from the insured individual, a policy owner can "viaticate" (or sell) an insurance contract that covers someone else's life. Such leniency makes it possible for trusts and corporations to qualify as potential viators.

A viator can sell nearly any kind of individual or group life insurance policy, including but not limited to a whole life, universal life, variable life or term life contract. Even federal employees with group life insurance have been known to viaticate their coverage.

Still, some life insurance products are easier to viaticate than others. Among the more challenging types are term life insurance and group life insurance.

Term Life Insurance

Term life insurance is probably the simplest kind of life insurance. This classic product is sometimes called "pure insurance" because, unlike other life insurance policies, it lacks investment options and has no cash value. Instead, term life customers pay premiums only so that beneficiaries can potentially receive the policy's "face value."

The face value is clear to the insurer and the policyholder when the policy is issued, and it generally does not change as long as premiums are paid. The face value is not dependent on the economy or the insurer's financial performance. If a person who is insured through a $100,000 term life policy dies, the insurance company pays $100,000 to beneficiaries, barring any unusual circumstances.

As their name suggests, term life policies remain in effect for a contractually agreed-upon time and then expire. People who opt for a term life policy instead of a permanent life policy tend to have short-term needs and view beneficiaries' welfare as their top life insurance concern. A father, for example, might purchase a term life policy in order to

ensure that his young children will have some financial support if he were to die before they reach adulthood.

When a policy's term concludes, the insured individual can reapply for another term insurance policy. However, premiums for the new term policy are likely to be higher than premiums under the old policy. This is because the person's susceptibility to mortality risks will have increased with age.

If policyholders have no interest in renewing a term life policy, they can sometimes exchange it for one of the several kinds of permanent life insurance policies.

Term life insurance creates problems in a viatical transaction because the coverage is temporary and could run its course before the terminally ill person dies. Suppose a viatical company purchases a term life policy from a terminally ill man who is expected to die within two years and has five years of coverage left on his contract. If the man dies within the remaining five years of the policy, the viatical company will still be able to collect a death benefit from the insurer. But if the company's estimate of the man's life expectancy is wrong and the man lives for another six years, the company might never receive any death benefits from the insurance company.

Viatical companies will usually only purchase term life policies if the policies can be converted to permanent coverage. In general, insurance companies will allow their term life customers to convert to a whole life or universal life policy at least until insured persons turn 65.

Group Life Insurance

Group life insurance is most commonly used to insure several people who work for the same employer. Premiums for group coverage usually depend on the collective age of the group participants and help pay for limited death benefits in the neighborhood of one or two times an insured person's annual salary.

Group life insurance involves very little underwriting and, therefore, can allow an ill or older individual to obtain some coverage at a low price. Some employers even offer limited group life benefits at no cost to their workers. The typical employer-funded group plan will pay at least enough death benefits to offset funeral and burial expenses and perhaps some debts.

When the policy that is up for sale involves group coverage, the viatical company will want a guarantee that the group's administrator will not cancel the coverage for any reason. As protection against this risk, the viatical company might force the viator to leave the group plan and convert the coverage to an individual policy.

Along with these cancellation concerns, viatical companies will be interested in the group insurer's attitude toward beneficiaries. In order for any settlement to be feasible, the viatical company must have the ability to become the insured's irrevocable beneficiary. Yet some group contracts do not grant irrevocable beneficiary status to any party, do not allow for transfer of ownership and do not even permit a corporation to be listed as a revocable beneficiary.

It is worth noting, however, that these obstacles are not necessarily insurmountable. Human resource professionals have noted that group life insurers are occasionally sympathetic and flexible when they learn that an insured wishes to sell his or her coverage to a viatical company.

Brokerage Companies and Settlement Companies

Before potential viators start actively shopping their life insurance policies around the secondary market, they must understand the differences between "viatical brokerage companies" and "viatical settlement companies." These two kinds of organizations perform separate duties and ultimately serve separate audiences.

A viatical brokerage company should operate with the viator's best interests in mind. Brokerage employees usually help viators fill out applications for settlements, collect and deliver paperwork, solicit bids for viators' life insurance policies from settlement companies and analyze the pros and cons of any offers that are received.

A viatical settlement company, to a certain degree, operates with its own or its investors' best interests in mind. Settlement companies evaluate the life insurance policies that are up for sale in the secondary market, use underwriting techniques to estimate insured persons' remaining life expectancies, make settlement offers to desirable clients and either gather or directly provide the money that is used to purchase a viator's policy.

Viatical Brokers

Viators have the option of either using a broker to handle a viatical transaction or contacting settlement companies on their own. Many viators choose to utilize brokerage services, not only to avoid the work of negotiating with settlement companies but also because an experienced broker will at least have a general idea of which settlement companies might be most likely to show an interest in purchasing a particular policy. Note that working as a viatical settlement broker is likely to require a special license or certification. Merely having a life insurance license is not enough to serve in this role in most states.

A broker is entitled to a commission when a viatical settlement has been finalized. This commission can reduce the amount of money the viator would otherwise receive from a settlement company. Commissions for viatical brokers are paid by settlement companies and typically run as high as 6 percent of the sold policy's death benefit. In rarer instances, the broker may receive a commission equal to a portion of the settlement amount, usually no more than 30 percent of the total given to the viator.

Doctors, lawyers and financial advisers have been known to occasionally receive finders' fees from brokerage and settlement organizations when they refer people to viatical companies, but public concerns over conflicts of interest have caused some states to prohibit these fees.

Verifying Information and Obtaining Consent

Whether the viator utilizes a broker or opts to handle the sale of a policy alone, he or she must grant and obtain various types of consent and provide various bits of personal information to settlement companies in order for the bidding process to begin.

To protect themselves from litigation, viatical companies will not purchase a life insurance policy in the secondary market unless the policy owner agrees to a settlement. This means, for example, that a terminally ill individual who has transferred policy ownership to a trust cannot enter into a viatical settlement without the trustee's signed permission.

A viatical company will also usually refuse to buy a policy if the person covered by the insurance contract fails to give written consent. Therefore, a business that owns a life insurance policy on a terminally ill employee generally cannot viaticate the ill person's coverage without obtaining permission from the sick individual.

This consent requirement serves legal, ethical and practical purposes. It ensures that insured persons will not unknowingly end up in a situation in which a complete stranger has a financial interest in their death. It also helps settlement companies obtain the kind of private medical information that is essential to proper underwriting in the viatical industry.

In some states, terminally ill persons cannot enter into a viatical agreement unless they acknowledge they are doing so through their own free will and unless an attending physician concludes that they are in a sound state of mind.

Because viatical settlement companies ultimately become irrevocable beneficiaries on the policies they purchase, any pre-existing irrevocable beneficiaries must actively renounce their policy rights in order for a settlement to be valid. Many companies will also refuse to bid on policies unless revocable beneficiaries consent to a potential sale. This practice exists as a deterrent to possible legal action that might otherwise be brought by an insured's angry family members or other interested parties.

As obvious as it may sound, a settlement company must be able to verify that a policy being shopped in the secondary market actually exists and is configured as advertised by a broker or viator. When applying for a viatical settlement, the viator will likely need to disclose the policy's face value, list the policy number and provide copies of the insurance contract and the policy application form.

The viatical company will need permission to contact the insurer that issued the policy so that it can confirm this information and investigate any possible barriers to a smooth transfer of ownership. Although the insurance company might charge a fee for verifying this information, the National Association of Insurance Commissioners (NAIC) has proposed standard legislation that would forbid insurance companies from charging higher verification fees to viatical companies than to other parties who request this information.

A basic questionnaire submitted by the viatical company to the insurer will likely address the following issues:

- The policy's face value.
- The identity of all current policy owners.
- The identity of any revocable or irrevocable beneficiaries.
- The existence of any outstanding loans on the policy.
- The existence of any liens a creditor might have on a policy.
- The applicability of any contestability periods or suicide clauses.
- The amount of premiums required to keep the coverage in force.

The importance of life expectancy to proper viatical underwriting makes medical analysis an essential part of the transaction process. No matter a life insurance policy's face amount, the viator or other covered individual will usually not need to submit to a medical examination in order to qualify for a viatical settlement. But applicants are not exempt from having to fill out health-related questionnaires and will usually need to give settlement companies access to their medical history over the past two years.

The forms used by viatical companies to access an applicant's medical records are similar to those given to life insurance applicants and should comply with standards set forth in the Health Insurance Portability and Accountability Act (HIPAA).

Upon becoming authorized to view an applicant's medical records, the settlement company will put its own underwriting team to work in order to come up with a settlement offer. Alternatively, it may outsource the job to experts who specialize in underwriting for viaticals.

Determining the Size of Settlements

Once the settlement company receives and analyzes the insured's medical records and verifies coverage with the insurance company, the viator may receive a settlement offer for the life insurance policy. Competition in the viatical industry and differing investment objectives among settlement companies make it unlikely that a viator will receive exactly the same offer from multiple viatical organizations. But there are several variables that nearly all viatical companies take into account before they make any offer to a viator.

Life Expectancies

The main consideration among these variables is the insured person's remaining life expectancy. As morbid as it may seem, neither settlement companies nor their investors are keen on working with applicants who have several years left to live. Long life expectancies diminish investment returns for settlement companies and their investors because the people who fund the viatical settlement need to pay a longer stream of premiums to the insurer to keep the policy active. Overly healthy applicants might also tie up investors' money for an unacceptably long time, since no one in the viatical business gets a return on an investment until insured people die.

As a general rule, viatical settlements are made available to terminally ill individuals who have a remaining life expectancy of two years or less. All else being equal, applicants with longer life expectancies can anticipate receiving a smaller percentage of their policy's death benefit than applicants with shorter life expectancies. Someone with an estimated two years left to live might only be offered 50 percent or less of a policy's death benefit from a settlement company. Someone who is expected to live for just a few months might be able to sell a life insurance policy for as much as 90 percent of the death benefit.

The responsibility for careful underwriting for life expectancies rests with the settlement company and its underwriters. The viator will suffer no penalty if the insured lives longer than expected.

Policy Premiums

As a previous paragraph briefly pointed out, policy premiums influence the size of a viatical settlement. Applicants who own inexpensive policies (relative to the death benefit) or who have a waiver of premium clause in their policies can expect to receive higher settlement offers than the average viator.

When the viatical industry began, some settlement companies required the viator to pay premiums on a viaticated life insurance policy for at least one year after the settlement date. However, it is now standard industry practice for settlement companies and their investors to handle payment of all premiums until the insured person dies.

Health of the Insurer

Like any savvy insurance customer, a viatical settlement company wants to ensure that the life insurer that issued a policy will be financially strong enough to honor eventual claims. Devastating occurrences, such as natural disasters and terrorist attacks (not to mention poor business planning), have been known to place some insurers into insolvency, thereby preventing policyholders from receiving benefits in full and in a timely manner. State guaranty funds may help a failed insurer's clients receive some policy

benefits, but these funds usually cap the amount available to policy owners at $100,000 or so.

Many settlement companies are hesitant to buy policies issued by life insurance companies that have not received decent marks from insurance rating organizations, such as Standard & Poor's, A.M. Best and Weiss Ratings. If an applicant wants to viaticate a policy that was purchased from a lowly rated insurer, the settlement company may make a lower offer to the viator. Drafts of the NAIC's Viatical Settlement Model Regulation have suggested that settlement companies be allowed to reduce a viator's payout if the viaticated policy comes from a company that has not received one of the four highest ratings from A.M. Best or a similarly high grade from another rating organization.

Age of the Policy

At times, the age of the life insurance policy can mean the difference between receiving a high offer from a settlement company, a low offer from a settlement company, or no offer at all. Life insurance policies typically contain suicide clauses and contestability clauses that allow the issuing company to void coverage within two years of the purchase date if the insured takes his or her own life or if the insurer discovers that an applicant obtained insurance through fraudulent means. Successful cancellation by the insurer would leave the settlement company and its investors empty-handed at claim time, and even unsuccessful attempts by the insurer to cancel a viaticated policy could cost the settlement company thousands of dollars in legal fees.

Most companies in the secondary market will not purchase a policy that is less than two years old or that is still subject to any type of contestability period. Among the companies that do not boycott these young policies, settlement offers for contestable coverage are usually very tiny. It is not uncommon for a viator with a contestable policy to receive less than 10 percent of the contract's death benefit.

Policy Loans

Potential viators should not forget about any outstanding loans they have on their life insurance policy.

Several reasons exist for people to take advantage of a life insurance policy's loan provisions. For example, prospective borrowers are unlikely to be turned down by their insurance company as long as their policies serve as adequate collateral for a loan. Along with this privilege come fewer questions on a loan application and greater overall privacy than a person would receive from a traditional lending institution, such as a bank.

Though the federal government has tightened tax laws pertaining to life insurance loans over the past several decades, borrowing from a life insurance policy is still likely to incorporate fewer tax issues than borrowing from a person's 401(k) or other retirement account. Also, unlike other credit situations, a loan from a life insurance company usually comes with a low-pressure obligation to pay off the debt. If a person dies or cancels a policy without paying off a loan, the company can simply take money out of the policy's cash value or death benefit.

Policy loan provisions are an important and attractive feature of permanent life insurance, but the insurer's ability to subtract the amount of outstanding loans from the death benefit makes them an undesirable element in a viatical transaction.

Because interest on policy loans can further decrease the death benefit if the loan is left unpaid, a settlement company will want to satisfy the terms of any existing lending agreement between the insurer and the insured immediately after buying someone's

coverage. When bidding for a policy with an unpaid loan attached to it, the company might look at all other underwriting factors first, come up with a specific settlement amount, deduct the unpaid balance on the loan from that settlement amount, and offer the result to the viator.

Economic Influences

Despite their distance from major market risks, viatical settlements can be influenced by the national economy in subtle ways. This is demonstrated, in some cases, by the bids settlement companies make on people's policies. If a settlement company wants to purchase a policy in the secondary market and needs to borrow money to fund the settlement, current interest rates will factor into the amount of money that will be offered to the viator.

The Settlement Contract

If a viator wants to accept a settlement company's bid, he or she must sign the settlement contract. The settlement contract is a legal document that spells out the rights of the viator and the settlement company. If a settlement company does not live up to the terms and conditions of the contract, it risks losing its license.

The settlement contract will contain the following pieces of important information:

- The exact amount of money the viator is due to receive from the settlement company.
- When and how the money will be delivered to the viator.
- How the settlement company may remain in contact with the insured individual.
- Under what conditions the viator may terminate the settlement agreement.

Before the contract becomes a binding agreement, the viatical settlement company and the viatical broker must typically make several important disclosures to the viator and remind the seller of various important facts. Many of the disclosures that typically must be made by either the settlement company or the broker are listed below:

- A reminder that beneficiaries will lose their right to death benefits in the event of a settlement.
- Disclosure of the fact that the settlement might jeopardize the viator's ability to qualify for another life insurance policy.
- Disclosure of the fact that the viatical broker represents the viator and does not represent the insurance company.
- Disclosure of the fact that the viator can cancel the transaction and retain ownership of the insurance policy within 30 days after a contract has been finalized or 15 days after money has been transferred to the viator, whichever date is earlier.
- Disclosure of the fact that the viator will be entitled to receive the agreed-upon settlement amount within three days after the settlement company obtains ownership of the insurance policy.
- Disclosure of the fact that viaticating the policy could cause a viator to lose important policy rights and privileges, including conversion rights or any waiver of premium.

- Disclosure of the fact that the settlement company can periodically contact the viator after the settlement in order to confirm relevant information, such as the insured's health status.
- Disclosure of the fact that the settlement will result in someone having a financial interest in the insured's death.
- A reminder that a viator with a group life insurance policy should contact the insurer to see if there are any conditions related to viaticating the coverage.
- Disclosure of the fact that a settlement could have a negative effect on the viator's eligibility for Medicaid and other need-based government programs. (With a few exceptions, a person cannot receive full Medicaid benefits if their personal assets are worth more than a few thousand dollars.)
- Disclosure of the fact that settlement proceeds may be accessible to a viator's creditors.
- A reminder that there are other opportunities for financial relief (including but not limited to accelerated death benefits from a life insurance company) besides viatical settlements.
- Disclosure of the fact that, under some circumstances, settlement proceeds may be taxed by federal and state governments.
- Disclosure of the fact that sharing of the insured's personal, medical and financial information is possible.

Prior to engaging in a viatical transaction, you should review any specific disclosure requirements in your state.

Transfer-of-Ownership Forms and Escrow Agreements

Along with the settlement contract, the viator often receives important supplementary documents, including transfer-of-ownership forms and a copy of an escrow agreement.

Transfer-of-ownership forms and change-of-beneficiary forms must be completed by the viator and submitted to an escrow agent. Though viatical companies generally prefer to become owners of the policies they buy, insurable interest laws in some states may prohibit a transfer of ownership between an individual and a viatical organization. When faced with this potential legal hurdle, the viatical company might still be able to gain the right to a policy's full death benefit as an irrevocable beneficiary.

The escrow agent is responsible for sending the viator's completed forms to the settlement company. The settlement company usually picks the escrow agent, but it must limit its choice to a properly licensed entity that has nothing to gain from the sale of the viator's policy.

When the transfer-of-ownership forms are returned by the viator to the escrow agent, the settlement company moves all money intended for the viator into an escrow account. This account should be insured by the Federal Deposit Insurance Corporation.

Assuming the insurer approves the transfer of ownership from the viator to the settlement company, the escrow agent releases the settlement amount to the viator through a wire transfer or check.

Receiving Payments

Some viators have the option of receiving settlement proceeds in a few periodic installments or in long-term pieces, as if the settlement were a modified kind of annuity. But many people who have monitored the viatical industry since its inception have warned potential viators that agreeing to anything other than a lump-sum settlement could lead to problems if a settlement company ever closes its doors. Some states' insurance and securities laws require that all viatical settlements in the area involve lump-sum payments to sellers.

Though the viator's federal tax obligations may depend on the manner in which the settlement proceeds are spent, viators are not required to use their settlement money to fund any medical care.

Rescission Clauses

If viators develop strong second thoughts about having sold their life insurance policy to a viatical company, they may be able to cancel the transaction in accordance with the settlement contract's "regret provision" or "rescission clause." A regret provision or rescission clause is similar to the free-look provision found in life insurance policies and allows the viator to void the settlement agreement and retain policy ownership for any reason.

A common rescission period lets a viator cancel a viatical settlement within 30 days of signing a settlement contract or within 15 days of receiving settlement proceeds, whichever date is earlier. In unregulated parts of the country, the length of the rescission period will differ among settlement companies.

If the viator has already received money from the viatical company as part of a settlement, the amount must be paid back in full for the agreement to be canceled. Likewise, a viator who wants to utilize a regret provision must reimburse the settlement company for any money it used to eradicate outstanding loans on the policy.

Contact With Viators

The relationship between the viator and the settlement company will continue, in some way, for as long as the insured individual remains alive. While finalizing the details of a viatical settlement, the viator must give his or her contact information to the settlement company.

After the settlement has been legally completed, the company uses this contact information to periodically check up on the insured individual. In an arguably gruesome yet true reality of the viatical business, these regularly scheduled peeks into the insured's life essentially involve the settlement company asking if the person is either dead or at least close to death.

In the early days of viatical settlements, insureds complained of being harassed by antsy settlement investors who could barely wait to gain access to a policy's death benefits. In response to insureds' concerns about potential invasions of privacy, the NAIC has proposed (and many states have implemented) limits on the amount of contact a settlement company can have with a viator.

For reasons of privacy or convenience, a viator can decline to serve as the main point of contact for the settlement company during this stage of the viatical process. Instead, the viator can bestow this role upon another person, such as a physician, family member or friend, who is at least 18 years old.

The responsibility for keeping an eye on the insured belongs to the settlement company rather than to a settlement company's investors. The settlement company can employ its own staff to conduct these checkups, or it can hire an independent third party.

The company or the third party may conduct these periodic inquiries through the mail, over the telephone or over the internet. In addition to or in place of these inquiries, many established companies use Social Security databases to confirm an insured person's death.

Upon being able to verify that the insured has died, the settlement company is responsible for filing a timely death claim with the insurance company and distributing proper shares of the resulting death benefits to investors.

The Back-End Process

Much of what occurs on the back end of a viatical transaction is probably more relevant to financial planners and investment strategists than to insurance producers. But we cannot adequately understand the successes, failures and controversies within the secondary market for life insurance unless we know at least some general information about how settlement companies deal with investors.

A few settlement companies have significant financial backing and purchase unwanted life insurance policies in the secondary market for their own portfolios. However, most settlement companies repackage viaticated insurance policies in some way and market them to third-party investors.

The young viatical market featured a lot of individual investors who funded all or part of a single viator's settlement. A retiree from Florida, for example, might have chosen to give $100,000 to a viatical company in order to fund a settlement designed for an unnamed male across the country with AIDS and a remaining life expectancy of nine months.

Over time, many of these individual investors lost money in the secondary insurance market, either because a viatical company had engaged in unethical business practices or because the people insured by the viaticated contracts were simply living much longer than expected. Meanwhile, critics of viatical companies continued pointing out that giving individual investors a stake in another person's life insurance policy could create some uncomfortable—let alone dangerous—situations for the sick.

That occasionally perilous investment environment evolved for the better into the secondary market we have today, in which reputable foreign and domestic institutional investors (such as banks and insurance companies) purchase interests in a diverse collection of viaticated policies in order to minimize their investment risk. Each settlement company might have a small group of institutional investors, all of whom have their own idea of what kind of policies the company ought to buy.

Viatical investors, be they individuals or financial institutions, need to collectively contribute more than the settlement amount offered to a viator. They must help the settlement company pay the remaining life insurance premiums, fund commissions for brokers and cover general operating expenses.

More often than not, these investors technically do not become the owners of a viaticated policy, but they do earn themselves a piece of the policy's death benefit when the insured person passes away. Barring some grossly inadequate underwriting by the settlement company, they receive a return of principal plus interest.

It is important to note here that, unlike many traditional investment vehicles, viatical investments offer simple, total interest rather than compounded, annual interest. It should

also be noted that this simple, total interest is almost never guaranteed. Returns on viatical investments will depend almost entirely on the insured's date of death, with yields getting smaller and smaller the longer the person lives.

Are Viaticals Ethical?

Since arriving in the United States a few decades ago, viatical settlements have continued to be one of the most divisive issues in the insurance and financial worlds. Regardless of the potentially positive monetary opportunities for investors in the secondary market, many critics have always viewed the term "viatical settlement" as a euphemism for something that threatens and sometimes takes advantage of sick people during a time when they are arguably at their most vulnerable. A quick inquiry on a popular search engine at the time of this writing revealed there were more than 800 items on the Web that linked viaticals to the word "ghoulish."

Insurable Interest Concerns

People's occasionally queasy feelings toward the viatical industry are understandable, if not entirely warranted. After all, viatical companies and investors do not make any money until an insured person dies, and they make more money if the person dies sooner than expected. Investors might indeed hope that viators experience some dignity and some relief from financial stress as a result of a settlement, but one has to wonder how those investors would react if medical professionals developed a cure for a terminal disease. Would their humanity cause them to be happy for affected viators and rejoice over the fact that the viators, their friends and their family would be spared from the grief that is associated with death? Or would their first instinct lead them to worry primarily about the substantial sum of money they will end up losing as a result of the cure? With many investors having locked their retirement savings in viaticals, some critics believe the latter is the more likely response and that the industry is merely a corporate-built arena in which investors can gather and root for people's deaths.

For some observers, their objection to viaticals relates as much to safety as to ethical principles. Back when viatical investment opportunities were being marketed to individuals rather than to financial institutions, naysayers were worried that a viaticated policy would wind up in the wrong hands and that the terminally ill would answer their doors someday and be greeted by an assassin who might take matters into his own hands if he believed the insured was living too long.

These worries were probably not reduced when it was revealed that a viatical businessman in Texas had served prison time for hiring a hit man to kill people for insurance money. It was perhaps just a matter of time before the seedy potential in viaticals captured the attention of fiction writers, including author Richard Dooling, who incorporated viatical settlements into the fraud-focused plot of his 2002 novel "Bet Your Life."

The ethical issues involved with viatical settlements tend to relate to the way these transactions treat a highly valued concept known as "insurable interest." In order for applicants to secure any kind of insurance policy, they must demonstrate that they have an insurable interest in the person or thing that is to be covered by the contract. This means the owner of the policy must have an economic or emotional reason for wanting the insured individual or item to remain unharmed.

Life insurers have consistently recognized that an individual most likely wants to remain unharmed and have therefore allowed a person to own a life insurance policy on his or her own life. Insurers have also recognized that a person's spouse, parents, employers

and business partners often have financial and emotional reasons for wanting him or her to remain unharmed. Therefore, the parties in a familial or business relationship are often permitted to own insurance policies on one another's lives.

Viatical settlements involve a viator and at least one party who lacks an insurable interest in the person covered by a life insurance policy. Yet viatical settlements are permissible in spite of an absence of insurable interest because many insurers' internal operating policies, as well as many states' laws, only require that insurable interest exist at the time the policy is issued.

Requirements pertaining to insurable interest often do not apply to transfers of policy ownership because the person insured by the policy either is the one actively pursuing the transfer or has the right to reject a transfer of ownership between the original owner and a third party. In other words, viatical settlements are permitted because the settlements usually require the insured's consent.

In a few cases from the viatical settlement's early days, the worries over seemingly elastic definitions of insurable interest involved more than the relationship between insureds and investors. Finders' fees, now illegal in various forms in some states, caused some people to be additionally concerned when they contemplated the consequences of these settlements.

Of particular concern were those fees payable to legal professionals, financial consultants and physicians. A few consumer advocates feared that the terminally ill, in a desperate search for advice, would pursue any plan proposed by their trusted advisers, even if that plan involved venturing out into the relatively fresh and untested waters of viatical settlements, and even if those trusted advisers had a financial interest in seeing sick people rush to a particular viatical company.

Even more disturbing to some were cases in which doctors received money for referring their patients to viatical companies and instances in which AIDS clinics were paid to advertise the services of specific settlement providers. Though the AIDS clinics in particular claimed that introducing their patients to the idea of viatical settlements was merely yet another opportunity to help the sick, some people seemed to imply that any individual or organization that was in the business of providing medical treatment and counseling to the terminally ill should have had no links to an industry that made its money from death benefits.

Legislation proposed by the NAIC would make it illegal for viatical companies to knowingly pursue funding for a settlement from anyone who is in any way responsible for the insured's health.

Privacy Concerns

Beyond the issues of insurable interest and the potential for foul play, a few people who claim to be looking out for the interests of viators have suggested that the viatical industry might jeopardize its clients' privacy, particularly in regard to health.

When viatical companies first arrived in the United States, AIDS was considered a problem of potentially epidemic-level proportions and was still a disease that had several social stigmas attached to it. Out of fear of professional or social backlash, several patients felt it necessary to keep their condition hidden, even from family and close friends.

Of course, those social stigmas still exist today to a degree, but the ethical issue of privacy in the secondary market has arguably become less specific as settlement companies have broadened their target market to include people other than AIDS patients. Rather than

being concerned about insureds being identified as people with specific terminal illnesses, privacy advocates seem to have shifted their efforts to a general argument that basically says, "No matter if you are dying of cancer, feeling pain in your lower back or experiencing absolutely no ill health at all, your medical history should only be shared with people on a need-to-know basis."

Like a life insurance company, settlement companies must have access to pertinent medical records in order to underwrite an applicant properly. But the line between necessary and unnecessary sharing of personal information sometimes gets blurry when a company engages in back-end activity. Any sale of the policy from one viatical company to another increases the number of people who have knowledge of the insured's condition.

Settlement companies that sell interests in policies to investors have sometimes divulged more information to prospective financial clients than viators may have expected. One of the industry's pioneering companies was criticized in the early 1990s for allowing investors to pick their own viator and for making investors aware of the viator's initials, the viator's life expectancy, the viaticated policy's cash value and the insurer's rating.

As much as this assortment of information may have helped investors make sound financial decisions, it was feared that a little detective work could have pulled the curtain away from viators and made their identities visible to the very people whose financial prosperity was dependent upon their deaths.

For obvious reasons, those states that specifically regulate viatical settlements have usually included prohibitions on sharing viators' medical information in their laws and rules.

Payment Concerns

Another criticism of viaticals involves the size of settlements. Some people wonder if, in spite of their professed mission to help insureds get fair market value for their unwanted policies, viatical companies might try to exploit the terminally ill by betting that a sick person will accept any offer from a settlement company, no matter how small the amount might be. Early media reports on the viatical industry suggested that a few companies were threatening to take settlement offers off the table if the viator did not agree to terms within a few days.

Standard pricing for viatical settlements was one of the first issues tackled by the NAIC when it began crafting its Viatical Settlements Model Act in the 1990s. Mirroring industry practice, the association's recommendations linked the size of a fair viatical settlement to the insured's life expectancy, with sicker people set to receive more money than healthier applicants.

A 2007 version of the model law called for viators to receive no less than the following portions of a life insurance policy's death benefit, unless a low-rated insurer or policy loans factor into the settlement:

- If the insured's remaining life expectancy is less than six months, the viator should receive a settlement equal to no less than 80 percent of the policy's death benefit.
- If the insured's remaining life expectancy is at least six months but less than one year, the viator should receive a settlement equal to no less than 70 percent of the policy's death benefit.
- If the insured's remaining life expectancy is at least one year but less than 18 months, the viator should receive a settlement equal to no less than 65 percent of the policy's death benefit.

- If the insured's remaining life expectancy is at least 18 months but less than 25 months, the viator should receive a settlement equal to no less than 60 percent of the policy's death benefit.
- If the insured's remaining life expectancy is greater than or equal to 25 months, the viator should receive a settlement that is at least the greater of the policy's cash surrender value and any applicable accelerated death benefits that would be available from the insurance company.

It should be stressed that the contents of the NAIC's model regulation and model law, as summarized in parts of this material, are merely guidelines that lay the basic framework for the viatical laws in the individual states. Each state is free to adopt all or none of the NAIC's models. Local governments have been especially hesitant to include the NAIC's minimum settlement amounts in their insurance codes.

Broker Compensation Concerns

In recent years, the secondary market has faced some tough questions about the manner in which viatical brokers receive their share of settlements. With many brokers' commissions coming out of the viaticated policy's death benefit rather than out of the settlement amount, some people wonder if there is a big enough incentive for brokers to shop policies aggressively and bring back the highest possible offers to their clients. In 2006, New York's attorney general accused some companies in the secondary market of paying "co-brokering" fees to brokers in an attempt to keep competitors' bids hidden from viators.

Depending on their state, brokers might have a legally imposed fiduciary duty to viators, meaning that they are required to pursue bids that are in the viator's best interest. They should also be aware that they may need to disclose the size and source of their commissions to their clients.

Defending Viatical Settlements

At this point, it is perhaps worth stressing that, in spite of the somewhat negative tone the reader might have detected in the previous paragraphs, many people who have criticized the viatical industry have not been viators themselves. Documented feedback from the terminally ill has often been positive, with viators telling reporters how a settlement helped them pay off debts, fund a dream vacation, treat their loved ones to extravagant gifts or spend their last days in a state of reduced stress.

When the U.S. House of Representatives Committee on Financial Services conducted a day-long hearing on alleged fraud in the viatical industry, hardly any of the attention was focused on the plights of wronged viators. Rep. Sue Kelly even said, "The industry began, in large measure, as a noble means of allowing AIDS patients to pay their steep medical bills before death," and Ohio Director of Insurance Lee Covington said, "While the nature of viatical transactions is dependent on the death of the viator, the social benefit of viaticals are extremely valuable for some terminally ill persons and some senior citizens."

Before turning his attention to frauds committed against investors, Rep. Michael Oxley conceded that, "A properly conducted viatical settlement can benefit all parties involved."

Only Rep. Luis Gutierrez talked at length about the alleged mistreatment of viators, saying, "(Viators) are so desperate for this cash that they act quickly—without information, without guidance … As a result, viators often settle for unreasonably low offers."

Tax Breaks, Fraud and Life Settlements

The Health Insurance Portability and Accountability Act

The viatical industry appeared ready to break out into the mainstream in 1996 when Congress passed the Health Insurance Portability and Accountability Act (HIPAA). Until that point, a viatical settlement's tax treatment was extremely uncertain, with some alleged experts insisting that the Internal Revenue Service viewed settlement proceeds as taxable income, others claiming the transactions were subject to capital gains taxes, and a third group professing that one portion of a settlement was taxable income and another portion was a capital gain.

A few viatical companies did nothing to ease all this confusion. Some of them made it a point to tell prospective viators that settlement proceeds would not need to be reported on a specific tax form, such as a 1099, and perhaps led their clients to believe that they could get away with paying no taxes on their settlements at all.

HIPAA made it possible for many viatical settlements (excluding those involving a business relationship between the viator and the insured) to be treated like the tax-free death benefit paid to a life insurance beneficiary. However, in order for the viator to receive settlement proceeds without needing to pay capital gains or income tax on the money, several conditions must be met.

In order for any of its viators to receive the federal tax breaks made possible through HIPAA, the settlement company must be properly licensed in the state where the viator resides. If the settlement is executed in a state with no licensing requirements for viatical companies, the tax breaks are available to the viator only if the company adheres to various sections of the NAIC's Viatical Settlement Model Act and the Viatical Settlement Model Regulation.

Assuming the company offering the settlement meets those requirements, viators can receive a tax-free viatical settlement if the person insured by the viaticated policy is a "terminally ill individual." For tax purposes, the federal government 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." As clarification, the government defines the term "physician" as "a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he performs such function or action."

HIPAA does not provide full tax breaks to viators when the person insured by a viaticated life insurance policy is expected to live longer than two years, but the legislation does not completely ignore those people either. A limited tax break is available to viators if the insured qualifies as a "chronically ill individual." According to Title 26 of the U.S. Code, a "chronically ill individual" is defined as follows:

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.

Within the above excerpt, you probably noticed the term "activities of daily living." These activities come from the long-term care (LTC) insurance industry. An insured's inability to perform multiple activities of daily living is a standard benefit trigger for LTC policies.

Most LTC insurers in the United States incorporate at least the following six activities of daily living into their benefit triggers:

Bathing: Including the ability to move in or out of a shower or tub, clean oneself and dry oneself.

- **Dressing:** Including putting on clothing and any medical accessories, such as leg braces.
- **Eating:** Including chewing, swallowing and using utensils.
- **Transferring:** Including moving in and out of beds, cars and chairs.
- **Toileting:** Including being able to get to a restroom facility and perform related, basic personal hygiene.
- **Continence:** Including controlling the bladder and bowels and performing related, basic personal hygiene.

When the insured person in a viatical settlement is deemed a chronically ill individual, the viator only avoids tax obligations on the portions of the proceeds that are considered a return of premium and on the portions of the proceeds that are used to pay for "qualified long-term care services." The U.S. Code defines these services in the following manner:

The term "qualified long-term care services" means necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services, and maintenance or personal care services, which—

(A) are required by a chronically ill individual, and

(B) are provided pursuant to a plan of care prescribed by a licensed health care practitioner.

Factors such as the policy's cash surrender value and the amount of premiums paid will determine whether the rest of a settlement for a non-terminally ill person will be taxed as income or as a capital gain. If the cash surrender value is less than the premiums paid, the remainder of the settlement will be taxed as a capital gain. If the cash surrender value is greater than the premiums paid, the IRS treats the difference between the cash surrender value and the premiums paid as taxable income. Then, the difference between the settlement amount and the cash surrender value would be taxed as a capital gain.

Taxation of a settlement can be difficult to understand, and, of course, tax laws can change over time or be interpreted differently by the IRS depending on a viator's situation. For these reasons, brokers should consult with an expert before providing specific tax-related information to clients

Problems for the Viatical Industry

To many viatical companies and legislators, the federal tax breaks available as a result of HIPAA seemed destined to breed positive results for businesses and government. In an ideal world, formerly hesitant policyholders were expected to hear about HIPAA's effect on viaticals, determine that this new and somewhat mysterious industry was legitimate and sell their unwanted insurance contracts for the kind of cash that would significantly reduce people's dependence on such cash-strapped social programs as Medicaid. But several developments combined to dash those high hopes.

A few factors were perhaps beyond most of the industry's control and revealed some of the weaknesses in the general concept of viaticals. Others were attributable to a few discouraging companies that were less than truthful with their investors.

Throughout the first few years of the viatical business, settlement companies and their financial associates had little reason to be concerned about their decision to target AIDS patients as potential viators. In the absence of a small medical miracle, people who had progressed from being HIV-positive to having AIDS were expected to live no longer than a few more years. Even when viatical companies underestimated an AIDS patient's remaining life expectancy, the miscalculation was not likely to cause tremendous liquidity problems for investors or cause the settlement company to pay too many unforeseen premiums.

That changed when, in 1995, the Food and Drug Administration started approving the use of "protease inhibitors," drugs that have proven to be effective in slowing or preventing the spread of the AIDS virus in the body. Though hardly a cure for the disease, protease inhibitors, along with other medicines, have made it possible for someone who contracts the AIDS virus today to live an additional 20 years or more. In a relatively quick fashion, these drugs managed to turn a terminal condition into a potentially chronic one.

This was all good news for the AIDS community, of course, but was hardly a welcome medical advancement from the perspective of investors who had spent thousands of dollars on viaticated policies. Within a few years, the media were busy telling stories of people who were waiting twice as long for a return on their viatical investments. Handfuls of investors became incredulous when they received notices from viatical companies, informing them that the amount of money that had been set aside to pay premiums was running out and that, if they wanted to maintain their claim to any portion of eventual death benefits, they would need to reach into their wallets and pull out some additional cash. A few retirees wondered out loud if the ill people in whom they had invested their nest egg might actually outlive them.

It wasn't just the productive work of scientists and drug companies that was spoiling investors' chances of netting big yields from viaticals. In a somewhat ironic twist, some of the same safeguards that the industry had instituted in order to protect the privacy of viators ended up making it easier for unethical companies to abuse and defraud innocent investors. Without access to insureds' medical records, investors had no way of knowing how well the settlement companies were underwriting policies and estimating life expectancies. Without the insured's personal information, an investor could not even verify that an insured individual actually existed.

In numerous lawsuits, state regulators, the Securities and Exchange Commission (SEC) and individual investors accused viatical companies of various frauds. In some cases, money received from fresh investors was allegedly being used to pay off old investors, and no new policies were ever purchased. Sometimes, according to prosecutors,

settlement companies did in fact purchase viaticated policies, but they employed doctors who would purposely downgrade an insured's projected life expectancy in order to make the person's policy more attractive to investors.

In a practice known as "clean-sheeting," some viatical companies encouraged terminal patients to apply for several small life insurance policies from multiple providers, lie about their health and viaticate the policies in exchange for a small settlement. This brand of fraud either hurt insurers, who had to pay death benefits when the fraud went undetected, or hurt investors, who lost their principal when an insurer spotted a fraud and canceled a dishonestly obtained policy.

On occasion, individuals were duped by misleading advertisements that appeared in the pages of obscure trade magazines and major financial newspapers. Marketers sometimes stressed the alleged safety of investing in viaticals, saying viatical investments were on par with certificates of deposit but not bothering to mention that, unlike CDs, viatical investments have no firm maturity date and are not insured by the Federal Deposit Insurance Corporation. A few ads took people's public comments out of context and made it seem as though nationally recognized financial advisers and even members of the Supreme Court were endorsing viatical investment strategies.

This collection of dishonest deeds and outright frauds resulted in a lot of bad press for the industry and caused regulators in some states to warn residents about the risks involved with viatical settlements. State efforts were particularly strong in Florida, where, according to the SEC, one company had misrepresented or misjudged the life expectancy of 90 percent of its viators and where, in the summer of 1999, five of the state's eight licensed viatical settlement companies were being investigated by the local insurance department. In 2000, a Florida grand jury estimated that roughly half of viatical investments were linked to insurance fraud.

By 2002, the North American Securities Administrators Association had listed viaticals near the middle of the pack on its annual list of the top-ten investment scams in the continent, and multiple trade groups had removed the word "viatical" from their names, perhaps as a way of distancing themselves from the embarrassing scandals.

Legislative Responses to Fraud and Other Deceptive Practices

One common complaint about the regulation of viatical companies in this country has been that the laws enacted in various states, while giving adequate protection to viators, do not shield individual investors well enough from unethical opportunists. Drafts of NAIC model laws and regulations say investors should be made aware of the following things before their money can be used to fund a settlement:

- Returns will not be accessible until the insured person dies.
- Rates of return are not guaranteed and will depend on how long the insured person lives.
- Investors may lose money if the insurance company that is associated with the viaticated policy becomes insolvent.
- Premiums paid to keep the life insurance policy in force will have an effect on the rate of return.
- The investors may lose some or all of their money if the insurance company contests the validity of the insurance policy.

Not every state has adopted these various rules in their entirety or even at all. In 2007, more than 10 years after the NAIC approved its first edition of the Viatical Settlements Model Act, the trade publication Best's Review said some 12 states hadn't passed viatical-specific laws. In fact, a debate has raged for at least a decade as to whether viatical companies should be regulated by the individual states or the federal government.

Regulation of Viatical Settlements

Because few investors had enough money to fully fund a viatical settlement on their own, early members of the viatical community began letting people buy "fractional interests" in viaticated policies. With a fractional interest, an investor funds only a portion of a settlement and shares any death benefits with other investors. A person might have a fractional interest in a single life insurance policy or in several policies.

Upon hearing about the buying and selling of fractional interests, the federal government claimed settlement companies had ventured into the marketing of securities and should therefore be subjected to federal regulation by the SEC. For the most part, the viatical industry disagreed, saying the sale of life insurance policies in the secondary market—no matter the method—was comparable to selling a piece of real estate or other kind of personal property. The industry was not against all forms of regulation, but it generally believed designating viatical transactions as securities would overcomplicate matters for buyers, sellers and middlemen.

On an admittedly basic level, securities involve investment contracts, must be registered with federal authorities, may not be sold unless accompanied by prospectuses and may not be sold by anyone who lacks an appropriate securities license. Some viatical companies claimed the cost of satisfying many of those requirements would be too much for some brokerage and settlement companies to handle and that the licensing requirements would prevent a significant portion of front-end and back-end workers from conducting business.

The regulatory issue was confronted in court when the SEC charged Living Benefits, Inc. with marketing unregistered securities. A U.S. district court ruled in the government's favor, but an appeals court eventually overturned a portion of the ruling and concluded that the company was selling neither securities nor insurance contracts.

That court ruling against the SEC has made it important for viatical professionals to be aware of the unique laws and regulations in their respective states. The majority of states that regulate viatical companies have taken it upon themselves to classify interests in viaticated policies as securities, but this does not necessarily mean state securities departments have the final say in all viatical matters.

A state may give its insurance department full authority to regulate viatical transactions. Alternatively, it may divide regulatory responsibilities by letting the insurance department handle all issues related to dealings between viators and viatical companies and letting the securities department handle all issues related to dealings between viatical companies and investors.

Life Settlements

Faced with a souring public reputation and advances in AIDS treatment, the viatical companies of the late 1990s and early 21st century had to find a new way to survive. At first, a few companies merely stopped buying policies from AIDS patients and shifted their focus toward people with terminal cancer or other life-ending illnesses. But this strategy

equated to a temporary patch for the industry's problems instead of a permanent fix. A groundbreaking cancer drug would have sent the industry back to the drawing board.

Gradually, the industry took note of the growing number of senior citizens in this country and recognized that, like terminally ill policyholders, many older Americans had purchased life insurance that no longer served much of a purpose for them. Many seniors who had originally bought life insurance for their children's sake no longer needed to worry about their grown son or daughter's financial stability. Many who purchased a policy years ago in order to provide for a spouse had gotten divorced or had been widowed. Businesses that had bought key-person policies on the lives of valued employees were watching those workers retire and wondered if it was economically prudent to keep paying premiums for the coverage. Other individuals had initially bought life insurance as part of a tax-sensitive estate plan but had later learned that changes in the tax code had granted their estate a tax exemption.

Assuming that many of these seniors would be intrigued by the chance to get more from their unwanted life insurance policies than their cash surrender values, the secondary life insurance market left most of its viatical business behind and began fiercely promoting a similar kind of financial arrangement known as a "life settlement."

Life settlements work like viatical settlements with a few important exceptions. The biggest difference between the two is that life settlements do not involve viators who are terminally ill. Instead, the typical viator in a life settlement is 65 or older with a remaining life expectancy of 15 years or less. To qualify for this kind of settlement, the insured must have experienced some moderately significant health problems since applying for the coverage.

Unlike viatical settlements, which may apply to policies big and small, most life settlements must involve an unwanted policy with a minimum face amount, usually somewhere near $100,000 or $250,000.

For various reasons (including life expectancy and the generally higher cost of insuring the elderly), a viator in a life settlement transaction receives a much smaller settlement than a viator in a viatical transaction. Life settlement amounts can range from 10 percent to 40 percent or more of the death benefit. Some settlement companies advertise that their average viator receives at least the viaticated policy's cash surrender value multiplied by three.

As with a viatical settlement, money received as part of a life settlement may be used by the viator as he or she pleases. Portions of life settlements that are considered a return of premium are tax-free to the viator. Portions that are not considered a return of premium but are not greater than the policy's cash surrender value are taxed as income. All additional proceeds are taxed as capital gains.

The back end of the life settlement process is also very similar to a traditional viatical setup, with settlement companies either holding onto viaticated policies for their own portfolios or, more commonly, selling interests in several policies to groups of investors.

The young industry's reliance on institutional investors, rather than on individual investors, might be a major reason why some of the ethical concerns and instances of fraud that were prevalent in the viatical market have not been as problematic in the life settlement industry. At least on a privacy level, viators seem more comfortable with banks, insurance companies and other impersonal business entities having an interest in their life insurance policies than with unknown individuals having that same sort of interest.

Insurers' Reaction to the Secondary Market

You might be more than a little bit curious about how insurance companies have been affected by viatical and life settlement businesses and about how people working in the competing primary and secondary life insurance markets view one another.

At alternating points in time, the relationship between life insurance companies and viatical companies has been helpful or hostile on both sides. Viatical companies initially promoted themselves by criticizing life insurance companies for forcing unhappy policyholders to either hang onto their coverage or accept allegedly unfair settlements in the form of cash surrender values. Yet viatical companies have also admitted that life insurance agents are the average person's most likely source for information about potential opportunities in the secondary market.

For years, settlement companies have complained about insurers that refuse to employ people who have held jobs with viatical organizations and that allegedly do not let their agents discuss viatical-related options with clients. Some viatical companies have even claimed that insurance agents expose themselves to potential lawsuits when they know a client is interested in canceling a policy but do not mention the option of viaticating the coverage.

When pressed about this issue, insurance professionals sometimes say they lack enough personal expertise to advise clients in regard to the secondary market, or that they have legal or ethical reasons of their own for avoiding the subject. With viaticated contracts often occupying a gray area between insurance policies and securities, some agents and their employers have worried about mentioning viaticals and finding themselves in a licensing dispute with regulators. Other insurance workers have heard about the instances of fraud in the secondary market and claim they want to protect their clients from possible abuse.

In spite of insurers' stated reasons for avoiding mentions of viatical settlements in conversations with their clients, one can easily make the case that the main conflict between insurers and settlement companies boils down to dollars and cents. Once viaticals became an option for millions of Americans, industry observers predicted insurance companies would lose money as a result of falling "lapse rates."

Lapse rates represent the number of people who discontinue their coverage before their life insurance policy matures. These rates are significant indicators of expected profits for a life insurance company. When a policy lapses, an insurance company is no longer obligated to pay a death benefit to beneficiaries and often makes money on the policy as a result.

A healthy amount of lapses can reduce the insurer's reinsurance costs because the corresponding reinsurance company will need to back up fewer death claims. This reduction in cost might be passed down to new policyholders in the form of lower premiums. Conversely, when few policies lapse, the insurer makes less money, the reinsurance company tends to charge more for its services, and premiums are likely to rise.

Prior to the debut of viaticals and life settlement companies, it seemed nearly certain that a large percentage of terminally ill people and senior citizens would eventually let their policies lapse. But once settlement companies and their investors started stockpiling these policies with no intention of ever letting them lapse, insurance companies had to accept that more of their policies would end up reaching the claims stage.

The prospect of having to pay out more death benefits than originally planned did not sit well with insurers during the viatical era, and the secondary market's shift toward life settlements has done little to alter the displeasure.

It also should go without saying that the insurance community could not have been pleased by the instances of clean-sheeting in the viatical market. In some cases, as we have already noted, insurance companies spotted these frauds promptly and saved themselves from losing thousands of dollars in death benefits. In other cases, insurers recognized the scams too late and were forced to honor fraudulent claims.

Stranger-Originated Life Insurance (STOLI)

Insurers have also frowned upon the life settlement industry's involvement with "wet paper," "wet ink" or "stranger-originated life insurance" (STOLI) policies.

Similar to clean-sheeting, STOLI is life insurance that is bought by an individual at the suggestion of a life settlement company in exchange for money or gifts. When a policy becomes incontestable, the insured transfers ownership rights to the settlement company in accordance with a secret, pre-existing agreement.

To some insurers, STOLI presents a problem of principle by ignoring the insured's true need for life insurance and by turning a product designed for risk management into a clear investment vehicle. Even many settlement companies share this distaste for STOLI and sometimes worry that companies that promote it will give the federal government a good reason to eliminate the positive tax treatment of some viatical and life settlements.

STOLI was a major issue for members of the NAIC when they gathered to create updated versions of their viatical settlement model laws and regulations in 2006 and 2007. While insurers wanted to institute a waiting period between the time a policy is issued and the time a policy can be sold to a life settlement company, the secondary market cautioned that a rigidly enforced waiting period would penalize people who experience a major life change soon after acquiring their coverage.

In response to concerns about STOLI, many states have prohibited life insurance policies from being sold in the secondary market unless a policy is more than two years old. Those states typically allow for some exceptions, such as when the insured becomes terminally ill or is experiencing some kind of financial emergency.

All the public disharmony between insurers and their rivals in the secondary market tends to overshadow the fact that there is a considerable degree of peaceful and even mutually beneficial overlap within the two industries. Life insurance entities such as CNA Financial Group and BMI Financial Group have scooped up viatical and life settlement companies for themselves or have developed their own settlement businesses from scratch. After years of mystery, it was revealed that the insurance giant American International Group was the main financial force behind life settlement leader Coventry. In a clear and public sign that insurance professionals and viatical veterans can coexist in business, former Illinois Director of Insurance Nat Shapo became Coventry's chief compliance officer in 2005.

Accelerated Death Benefits

Competition from the early viatical companies helped push the insurance industry into offering "accelerated death benefits." These benefits entitle insureds to a portion of a policy's face value if they come down with a particular disease, are deemed terminally ill or require long-term care.

Accelerated death benefits work like a combination of traditional life insurance benefits and viatical settlements. When a person is diagnosed with a chronic illness that requires assistance with multiple activities of daily living or has less than a year to live, a policy with accelerated death benefits typically nets the individual up to 50 percent of the policy's face value. These benefits are treated like viatical settlements in the tax code, meaning that people with less than two years to live receive them tax-free, and that people who are chronically ill do not need to count the benefits as income when the money is used to pay for qualified long-term care services.

The portion of the policy's face value that is not given out to the client in the form of accelerated death benefits is earmarked for the policyholder's beneficiaries. Unlike a transaction in the secondary market, accelerated benefits have no effect on policy ownership or beneficiary status. Meanwhile, the policyholder remains responsible for paying premiums in full and on time.

The cost of accelerated death benefits and the manner in which an insurer charges for them vary among companies. A few companies charge the policyholder for these benefits for as long as the policy is in force. Others include these benefits in policies from the very beginning but only start charging for them when the insured becomes ill or needs care. These days, a consumer might even be able to secure a policy that includes these benefits at no additional cost.

There has been much debate regarding which financial option—a settlement in the secondary market or an accelerated death benefit from an insurer—is more valuable to unhealthy consumers. Where people stand on this issue will depend on what they want most out of their life insurance policy when they become seriously ill.

In most cases, ill policyholders receive a larger percentage of their policy's death benefit when they opt for viatical settlements over accelerated death benefits. Whereas an insurer's accelerated benefits might offer a client no more than 50 percent of a policy's death benefit for personal use, a viatical settlement company might be willing to buy the same policy for 80 percent of the death benefit or more.

Still, if we compare the amount of death benefits that ultimately go to policyholders and beneficiaries against the amount of money that goes to third parties in these two options, accelerated death benefits might be deemed the better deal. When a viator sells a policy for 80 percent of its face value, the remaining 20 percent of the policy's value becomes the property of a settlement company and its investors. But when a policyholder utilizes a 50 percent accelerated death benefit provision, almost all of the policy's remaining half will eventually belong to the person's chosen beneficiaries.

In many states, a viatical or life settlement company cannot purchase an unwanted life insurance policy unless the viator understands that accelerated death benefits may be available through the person's insurance company.

Conclusion

The story of viatical and life settlements is probably far from over. At the time this material was being written, the settlement industry was still influencing the way some insurance companies conducted business, and entrepreneurs were still experimenting with ways to make life settlements increasingly attractive to insureds and investors.

Whether we love, hate or have complicated feelings about viatical and life settlements, it is difficult to deny that the secondary market forces us to think seriously about what a life insurance policy ought to provide for its owner. Whereas life insurance can ensure that

survivors are taken care of, these settlements keep the attention on policyholders and have the potential to provide another kind of peace.

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