COVERING YOUR ASSETS WITH LONG TERM CARE INSURANCE

I. Introduction.

A. A critical issue facing many elder clients concerns financing the potential costs of long term care.

1. Changes in public funding (particularly through the Medicaid program) have created pressures for alternative financing options.

2. The expansion of attention to such techniques as viatical settlements, accelerated death benefit insurance products, and reverse mortgages, are indicative of this process.

B. The insurance alternative is a financing option that has seen significant growth.

1. There have been significant changes in the structure, feasibility and quality of long term care insurance products.

2. The tax favored enhancements brought about by recent changes in the tax law have precipitated a significant increase in the marketing of long term care insurance.

II. Long Term Care Insurance helps preserve an estate.

A. Long term care policies insure that clients will be able to pay for needed care while preserving their assets for their beneficiaries.

1. To create an effective estate plan, there must be an estate to plan.

2. The average cost of a year's care in a long term care facility in Indiana is $41,000. Consequently, even a substantial estate can be depleted over a number of years of required long term care, particularly if both spouses require long term care.

B. There is increasing awareness among the public that the enormous cost of long term care demands serious planning measures.

1. However, many estate planners and their clients have misconceptions about the range and enormity of the problem.

2. Some believe, quite mistakenly, that Medicare is a comprehensive or significant source of funding for long term care needs.

C. Threshold issues.

1. Not every person is a suitable purchaser of long term care insurance.

(a) Age is a factor; most policies will not issue past age 84.

(b) Medical status is an issue; some people are too sick, and long term care policies usually require medical underwriting.

(c) Financial status is a factor; some individuals have income which is too limited, or resources which are too limited, and simply cannot afford long term care insurance. This may include individuals who have fairly significant assets, but which are illiquid, unless means are utilized to tap in to the illiquid equity.

2. Reliance on Medicaid planning; with proper planning, and taking advantage of the Medicaid spousal impoverishment protective provisions, some individuals are able either to satisfy the asset requirements for Medicaid or can meet those requirements by a short period of private payment or by making transfers that give rise to a period of ineligibility that ends before the expected time that long term care will be needed.

D. Policy choices.

1. Prior to the adoption of the Health Insurance Portability and Accountability Act, long term care policies were likely to be available in a confusing panorama of permutations.

2. Now, long term care insurance policies have become more standardized, particularly if the point of reference is a qualified long term care contract under the HIPAA.

3. "Tailoring" the benefit can affect the cost of the policy.

(a) The more risk the purchaser is willing to assume, the lower the premium will be.

(b) If long term care insurance is treated as "catastrophic" insurance rather than "first dollar" coverage, then the premium will be reduced because the purchaser is assuming the risk to pay the cost of the short nursing home stay or the early part of a longer stay, relying on insurance for the balance of the stay.

(c) The benefit duration will affect the policy premium.

(d) The "elimination period" will likewise affect the policy premium.

(e) Finally, the size of the benefit (that is, whether the entire cost of care is to be covered or only a portion of the probable charges) will have a significant impact on the cost of a long term care insurance policy.

(f) Whether or not a cost of living factor is included will also affect the premium. Generally speaking, the younger the applicant, the more important it is to include a cost of living factor in the policy (called "inflation protection").

III. Long Term Care Insurance under the Health Insurance Portability and Accountability Act of 1996.

A. Deductibility.

1. General medical expense deductibility.

(a) Under the HIPAA, the cost of qualified long term care services [IRC Section 213(d)(1)(C)] and qualified long term care insurance premiums [IRC Section 213(d)(1)(D)] are included in the definition of deductible medical care expenses.

(b) Payments for qualified long term care services provided to an individual do not qualify as paid for medical care if the services are provided by (i) the spouse of the individual or by a relative (directly or through a partnership, corporation or other entity) unless the service provider is a licensed professional with respect to the service, or (ii) a corporation or partnership which is related [within the meaning of IRC Section 267(b) or Code Section 707(b)] to the individual.

(c) For the purpose of the rule that treats payments for an insurance contract that covers both medical care and other items as not being a payment for medical insurance unless the charge for medical insurance is separately stated, qualified long term care services are treated as medical care.

2. Long term care insurance deductibility.

(a) The cost of eligible long term care insurance premiums are included in the definition of deductible medical care [IRC Section 213(d)(1)(D)].

(b) Eligible long term care insurance premiums are amounts paid during a tax year for any qualified long term care insurance products up to the specified limits (depending on the age of the individual):

Retained Age by Year End	Annual Limit on Premium Deduction
- 40 or less	$ 200.00
- more than 40 but under 51	375.00
- more than 50 but under 61	750.00
- more than 60 but under 71	2,000.00
- over 70	2,500.00

(c) For tax years beginning after 1997, the dollar amounts shown above will be increased by an adjustment to reflect inflation.

(d) Note that the limits on the deductibility of long term care insurance premiums are per individual, and not per return. If the husband and wife, each over 70 years of age, have both paid eligible long term care premiums, then up to $5,000 would qualify as deductible medical expenses on a joint return.

(e) To the extent that the cost of long term care services and premiums qualify as medical services, they are nevertheless still subject to the overall floor of 7.5% of adjusted gross income on the deduction of medical expenses.

(1) Despite the marketing bonanza, the deductibility of premiums is illusory for most potential purchasers.

(2) Many seniors, if not most, do not itemize deductions; others that do itemize may nevertheless be unable to exceed the 7.5% of AGI floor.

(f) The rule for deductibility in the case of a self-employed person is different, and as a result, a portion of the premium can be deductible even if the 7.5% of AGI floor is not exceeded.

B. Tax treatment of benefits.

1. Exclusion from taxation of benefits under qualified contracts.

(a) Under HIPAA, a "Qualified Long Term Care Insurance Contract" is treated as an accident and health insurance contract.

(b) Accordingly, amounts received under a Qualified Long Term Care Insurance Contract are treated as amounts received for personal injury or sickness and as reimbursement for expenses actually incurred for medical care.

2. The per diem limitation.

(a) The per diem limitation for any period is the excess (if any) of the greater of (i) $175 per day or the equivalent amount when payments are made on another periodic basis, or (ii) the costs incurred for Qualified Long Term Care Services provided for the insured during the period **over** the aggregate payments received as reimbursements (through insurance or otherwise) for qualified long term care services provided for the insured during the period.

(b) In short, if payments exceed the dollar cap, the excess is excludeable only to the extent of actual costs incurred for long term care services. Any amounts in excess of the dollar cap, with respect to which no actual costs are incurred for long term care services, are fully includeable in income without regard to the basis recovery rules of IRC Section 72.

(c) After 1997, the per diem limitation amount of $175 will be increased to reflect inflation at the same time and in the same manner as the adjustment for the annual limitation on deductible premiums.

C. Applicable Definitions.

1. Qualified Long Term Care Services.

(a) These are necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services, and maintenance or personal services;

(b) These expenses, however, must: (i) be required by a Chronically Ill Individual; and (ii) be provided under a plan of care prescribed by a Licensed Health Care Practitioner [IRC Section 7702B(c)(1) as added by the Health Reform Act, Section 321].

2. Chronically Ill Individual.

(a) A chronically ill individual is one who has been certified within the previous 12 months by a Licensed Health Care Practitioner as (i) being unable to perform (without substantial assistance from another individual) at least two activities of daily living for at least 90 days due to a loss of functional capacity, (ii) having a similar level of disability as determined the Internal Revenue Service in consultation with the Department of Health and Human Services, or (iii) requiring substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment.

(b) The 90 day period referred to is not a waiting period; an individual can be certified as chronically ill if the licensed health care practitioner certifies that the individual will be unable to perform at least two activities of daily living for at least 90 days.

(c) Refer to the guidelines in IRS Notice 97-31.

3. Severe Cognitive Impairment.

(a) This is a deterioration or loss in intellectual capacity that is measured by clinical evidence and standardized tests which reliably measure impairment in (i) short or long-term memory, (ii) orientation to people, place or times; and (iii) deductive or abstract reasoning.

(b) The deterioration or loss must place the individual in jeopardy of harming himself or others and thereby require **substantial** supervision by another individual.

(c) An individual who is physically able but has a cognitive impairment such as Alzheimer's disease or another form of irreversible loss of mental capacity is treated similarly to an individual who is unable to

perform without substantial assistance at least two activities of daily living.

4. Activities of Daily Living.

   (a) Eating - the ability to move food to mouth after food has been provided;

   (b) Toileting - the ability to get to the bathroom, to get on and off the commode, to perform needed functions, and to clean oneself afterwards;

   (c) Transferring - the ability to move body weight such as from bed to chair;

   (d) Bathing - the ability to wash body in a shower or bathtub including getting in and getting out;

   (e) Dressing - the ability to put on and take off daily clothing;

   (f) Continence - the ability to voluntarily control bowel and bladder functions or to maintain personal hygiene with the aid of equipment; and

   (g) A long term care insurance contract need not take into account all of the specified activities of daily living; however, it must take into account at least five activities. For example, a contract can require that an individual be unable to perform two out of five activities, but a contract is not qualified if it requires that an individual be unable to perform two out of any four of the activities.

5. Maintenance or Personal Care Services.

   (a) Any care the primary purpose of which is to provide needed assistance with any of the disabilities as a result of which the individual is chronically ill (including protection from threats to health and safety due to severe cognitive impairment).

   (b) IRC Section 7702B(c)(3).

6. Licensed Health Care Practitioner.

   (a) A physician [as defined in Section 81861(r)(1) of the Social Security Act], Registered Professional Nurse, licensed Social Worker, or other individual who meets requirements that may be prescribed by the Internal Revenue Service.

   (b) IRC Section 7702B(c)(4).

7. Qualified Long Term Care Insurance.

(a) Provides insurance coverage only for long term care services;
(b) Does not pay or reimburse expenses to the extent that expenses are reimbursable under Medicare (or would be reimbursable but for a deductible or a co-insurance amount); this requirement does not apply to expenses which are reimbursable under social security only as a secondary payor;

(c) Is guaranteed renewable;

(d) Does not provide for a cash surrender value or other money that can be paid, assigned or pledged as collateral for a loan or borrowed;

(e) Provides that all refunds of premiums (other than refunds on the death of the insured or on a complete surrender or cancellation of the contract, which cannot exceed the aggregate premium paid under the contract) and policy holder dividends are to be applied as a reduction of future premiums or to increase future benefits;

(f) In addition to the above-described requirements, a qualified long term care insurance contract must further meet certain consumer protection requirements of the Long Term Care Insurance Model Regulations and the Long-Term Care Insurance Model Act, each promulgated by the National Association of Insurance Commissioners; and

(g) In addition, a qualified contract must meet the disclosure requirements of IRC Section 4980C(d).

D. The benefit differences under the new plans.

1. Removal of medical necessity as a trigger.

(a) In order to be a qualified contract, the contract must provide for benefit eligibility to be determined by meeting the ADL trigger (i.e., inability to perform two out of six or two out of five ADL's due to loss of function or capacity).

(b) Prior to this change, many policies used "medical necessity" as a trigger or as an alternative trigger.

(c) When medical necessity was used as the eligibility trigger, companies would deny claims alleging that the need for care was not "medically necessary" due to an illness or an injury, and the physician certification was challenged on the basis that the institutionalization was not due to an illness, accident or injury requiring medical care, but rather a chronic medical condition requiring only custodial assistance.

2. Need for "Substantial Assistance".

(a) A major consideration in determining the advisability of a non-qualified contract over a qualified contract is how much assistance will be needed.

(b) One of the "gate-keepers" in pre-1997 policies was the amount of assistance that would be required. Total human assistance every time an ADL is performed is far more restrictive than "supervisory" or "directional" assistance. Advocates have been concerned whether "substantial assistance" would put all contracts into the more restrictive mode.

(c) A secondary concern is the issue of cognitive impairments. Qualified contracts are required to cover substantial supervision to protect an individual from threats to health and safety due to *severe* cognitive impairment. At what stage and under what circumstances would an Alzheimer's patient's cognitive impairment be considered "severe?"

(d) These concerns have been addressed to a certain extent by the Treasury Department in Notice 97-31 which provides:

> In applying the ADL trigger to its post-1996 contracts, insurance companies are permitted to use the same standards that it uses to determine whether an individual is unable to perform an ADL for the purposes of eligibility for benefit payments under its pre-1997 contracts ("pre-1997 ADL Standards"). If the insurance company makes determinations regarding an individual's inability to perform an ADL under a post-1996 contract using its pre-1997 ADL standards, the contract will be deemed to satisfy the requirement under the ADL trigger that an individual is unable to perform (without substantial assistance from another person) that ADL due to loss of functional capacity.

E. Miscellaneous.

1. Coverage as part of life insurance contract.

(a) Long term care insurance coverage can be provided by rider on or as a part of a life insurance policy.

(b) In that case, the requirements for the long term care insurance contract are applied as if the portion of the contract providing such coverage is a separate contract [IRC Section 7702B(e)(1)].

2. State maintained plans.

(a) If an individual receives coverage for qualified long term care services under a state long term care plan and the terms of the plan (if the plan was an insurance contract) would qualify based on the

requirements for a long term care insurance contract, the plan is treated as a long term care insurance contract.

(b) IRC Section 7702D(f)(1).

3. Cafeteria plans or flexible spending arrangements.

(a) Qualified plans under a cafeteria plan do not include any product that is advertised, marketed or offered as long term care insurance.

(b) IRC Section 125(f) as amended by the Health Reform Act, Section 321(c).

(c) An employee **must** include in gross income employer provided coverage for long term care services to the extent that such coverage is provided through a flexible spending or similar arrangement.

4. COBRA continuation rules.

(a) The COBRA health care continuation rules do not apply to coverage for qualified long term care services.

(b) IRC Section 4980B(g)(2) as amended by the Health Reform Act, Section 321(d).

F. Effective date and grandfathered policies.

1. The new law is generally effective for contracts issued after 1996; however, any contract issued before 1997 that met the long term care insurance requirements of the state at the time it was issued is treated as a qualified long term care insurance contract.

2. Services provided under or reimbursed by such a pre-1997 contract are treated as qualified long term care services.

3. No gain or loss is recognized if a contract providing for long term care insurance is exchanged solely for a qualified long term care insurance contract (or the former is cancelled and the proceeds are reinvested in the latter within sixty days) after the date of enactment of the Health Reform Act and before 1998; however, if in addition to a qualified long term care insurance contract, money or other property is received in the exchange, taxable gain is recognized to the extent of the money or other property received.

4. IRS Notice 97-31 clarifies what is meant by "long term care insurance requirements of the state..." for grandfathering purposes:

(a) According to the guidelines, the phrase means the "state laws (including statutory and administrative laws) that are intended to regulate insurance coverage that constitutes long term care insurance as defined in Section 4 of the NAIC LTC Model Act."

(b) As a result, all pre-1997 policies that were approved by the insurance laws of the state and which covered long term care services are considered qualified under the HIPAA.

IV. Group Coverage.

A. Approximately 1,000 companies are offering employees (and usually their spouses, parents and in-laws) group long term care policies.

1. The number is rising rapidly.

2. These policies aren't always as good a deal as they seem.

3. Premiums are almost always paid by the employees with no employer contribution.

4. Coverage for active employees, and possibly spouses, may be guaranteed, but under some plans insurers apply underwriting standards to each employee and coverage is not a sure thing.

5. For example, if you have controlled hypertension, you may be automatically rejected, even though you may qualify for an individual policy.

6. You may stand a better chance of getting coverage, and at lower rates, if you shop for a policy on your own.

B. Many group buyers are younger, and are attracted by premiums that may be only a few hundred dollars a year.

1. Often, an individual policy can be found which costs less and which offers a longer list of benefits, including coverage for assisted living facilities, which is often omitted from group policies.

2. Less stringent conditions may also be attached to an individual policy in order to qualify for benefits.

3. Buying group insurance in your 40's when you may not need it until your 80's can be risky. With a health care delivery system that is changing very rapidly, if a company doesn't upgrade its policy, by the time a person is older the person may need a new policy in any event.

V. Summary of Insurance Company Ratings By Five Major Ratings Services.

A. Different ratings services and analysis.

1. There are no uniform or industry-wide systems of assigning ratings; each service has different standards and gives different meanings to its ratings.

2. Before relying on a rating for a particular company, it is imperative to ascertain which rating service assigned the rating and what meaning that service has attached to its rating.

(a) For example, a Moody's rating of "B" means something very different from a "B" rating from Weiss.

(b) The best way to get an idea of a company's stability is to get ratings from several different ratings services and to understand what the service took into account when it assigned the rating score.

(c) Ratings can be categorized as "comprehensive" (which means they are based on data beyond what is publicly available), some of which may be subjective.

(d) Some ratings may be "statistical", meaning they are objectively based on calculations performed from data which is published in annual statements.

B. Comprehensive ratings.

1. Moody's Investors Service.

2. Standard & Poor's Claims Paying Ability Ratings.

3. Duff & Phelps.

4. A.M. Best.

C. Statistical Ratings.

1. Weiss Ratings.

2. Standard and Poor's Qualified Solvency Ratings.

VI. Long Term Care and the Indiana Long Term Care Program.

A. Introduction.

1. Since May of 1993, Hoosiers have been able to choose between a traditional long term care insurance policy or an Indiana "Partnership" policy.

2. Through February of 1999, approximately 3,400 people have chosen to purchase Indiana Partnership policies.

(a) Both types of policies are purchased through private insurance agents.

(b) The Indiana Long Term Care Program ("ILTCP"), better known as the "Indiana Partnership Program", pairs the office of Medicaid Policy and Planning in the Indiana Department of Insurance with private long term care insurance companies and their agents.

(c) Together the "partners" have created a high quality long term care insurance product which contains consumer protective features as well as a unique state-added benefit.

3. Indiana is one of only four states to have developed such a program (the other states are California, Connecticut and New York).

4. The Indiana plan is one of the so-called "public-private initiatives", developed under a grant from the Robert Wood Johnson Foundation.

   (a) These public-private initiatives were intended to create a link between private insurance and Medicaid by making affordable policies available for the protection of assets.

   (b) The theory is that people who do their part by maintaining adequate long term care insurance should be permitted to collect Medicaid benefits without being forced to deplete their assets.

B. Medicaid Asset Protection.

1. A person is able to protect assets (which are disregarded in the Medicaid eligibility process should they need Medicaid assistance after exhausting their policy benefits) by purchasing and using an Indiana Partnership policy.

2. In addition, there is no asset recovery under the Medicaid rules as a means of recovering protected assets from the person's estate once a person dies.

   (a) Please note that only assets are protected, not income.

   (b) The asset protection will depend on the amount of coverage purchased and then later used.

C. Total Asset Protection.

1. As of March 12, 1998, an Indiana Partnership policy with minimum coverage at least equal to the state-set dollar amount, who then exhausts the policy benefits and applies for Medicaid, will receive total asset protection (referred to as "asset disregard").

2. This means that a person with $250,000 worth of assets could protect all of those assets by buying and owning a partnership policy with initial minimum coverage of $140,000 in 1998 ($147,000 in 1999).

3. The following shows the state-set dollar amounts through the year 2002.

Year	State-Set Dollar Amount
1998	$ 140,000
1999	147,000
2000	154,350
2001	162,068
2002	170,171

The state-set dollar amount increases by 5% compounded annually beginning January 1, 1999.

4. The state-set dollar amount affects only the Partnership policies purchased and effective during each calendar year.

5. For both spouses to receive total asset protection, each spouse must purchase his and her own Indiana Partnership policies with coverages which equal or exceed the state-set dollar amount, with the option of being able to share their maximum benefit with each other.

   (a) Policies are available allowing both spouses to purchase one policy and share the maximum benefit, or each spouse may purchase an individual policy with a rider which allows them to share their maximum benefits with each other.

   (b) In these instances, the possibility exists that one spouse (the remaining spouse) may not receive total asset protection due to the amount of benefits remaining for him or her to use.

   (c) It is important to understand that the Medicaid asset protection stays with the individual who uses the benefits; it is not transferrable between spouses.

D. Dollar For Dollar Asset Protection.

1. Individuals who purchase an Indiana Partnership policy with initial coverage which is less than the state-set dollar amount for that year will receive dollar-for-dollar asset protection.

2. They will earn one dollar of asset protection for every one dollar of benefits paid out by the policy.

E. Win-Win-Win.

1. Medicaid Asset Protection is said to be Indiana's way of saying "thanks" for using a high quality long term care insurance product before turning to Medicaid for assistance.

2. The State of Indiana's policy is that everyone wins by having high quality private insurance with Medicaid asset protection: the companies by the sale of the product; the policyholder by having high quality insurance with Medicaid asset protection; and the state by avoiding Medicaid claims through the use of high quality long term care insurance.

F. Other Policy Features.

1. An Indiana Partnership Policy may be sold only to Indiana residents.

   (a) However, the insurance policy benefits will be paid regardless of the state where the policyholder is receiving care.

(b) The exception will be the Medicaid asset protection feature, since only Indiana's Medicaid program (because of the federal approval in regard to the disregard) will honor the asset protection feature.

2. Consequently, once a person has exhausted his or her policy benefits, he or she would need to return to live in Indiana in order to receive assistance from Indiana's Medicaid program.

3. There are two policy types of partnership policies.

(a) All participating insurance companies must offer a "comprehensive" policy containing both home and community based benefits.

(b) Insurance companies may choose to offer a "long term care facility" policy which provides coverage primarily for only institutional care.

(c) There are tax qualified versions of both policy types available.

4. All Indiana Partnership policies contain an inflation protection feature (based on a 5% compounded rate).

5. All Indiana Partnership policies use the same benefit triggers, as compared to traditional policies in regard to which the insurance companies may choose the benefit triggers as well as the definitions relating to the trigger.

6. An Indiana Partnership policy is identified on the policy application, the outline of coverage, and on the front page of the policy.

G. Indiana Partnership Companies and Agents.

1. Any insurance company can participate as long as the company has obtained approval for the policy which meets the state standards.

2. All participating companies offer both traditional long term care policies and Indiana Partnership policies.

3. Insurance agents who sell Indiana Partnership policies must complete a seven hour continuing education course on the Indiana partnership.

VII. Viatical Settlements (Sometimes Referred to as a "Viatication").

A. The HIPAA enables people with "terminal" or "chronic" illnesses to receive the proceeds of a "viatical settlement" free of any federal tax.

1. A viatical settlement is comprised of the sale of a life insurance policy to a viatical settlement company for the purpose of providing the policyholder and his or her family with one or more cash payments.

2. Being "terminally ill" is defined in the law as having been certified by a physician to be suffering from an illness likely to result in death within

twenty-four months of certification, while "chronically ill" is defined generally as being permanently or severely disabled by an illness.

3. Some viatical settlement companies now also provide cash to those seventy-five and older, subject to certain underwriting criteria. Even those with life expectancies of up to ten years may be eligible.

4. A viatical settlement is a means of dealing with the problems of people with limited life expectancies who often face significant financial difficulties brought on by rising medical costs and a loss of income.

5. Viatical settlements enable them to sell their life insurance policy and use the proceeds to preserve their financial security.

6. A viatical settlement company pays the individual a percentage of the policy's face value, maintains the policy payments, and becomes the policy's beneficiary.

B. In a qualified viatical settlement, a life insurance policy is exchanged for cash on a tax-free basis. The cash may be used for any purpose:

1. To pay off accumulated medical bills and other immediate needs brought on by the loss of income.

2. To provide funds for gifts and transfer planning.

3. To remove the policy from the estate and avoid the "three year" rule.

4. Cash can be used for "spend-down" requirements or "conversion" of assets.

5. Any person who owns the policy, not just the insured, can "viaticate" an insurance policy, such as a trustee of an irrevocable trust.

6. Provides an opportunity to structure transactions so as to take advantage of discounts due to lack of marketability or minority interest.

VIII. Lifetime Insurance Settlements.

A. Sale of a life insurance policy to a third policy.

1. Similar to a viatical settlement, but different in many respects and with different tax consequences.

2. Candidates would include business-owned policies previously used to fund split-dollar arrangements and trust-owned policies which have outgrown their intended estate planning purpose.

B. Virtually any type of policy, from any insurer, may qualify for a lifetime settlement.

1. The result would be an immediate lump sum payment and relief from future premiums.

2. A lifetime settlement should probably not be used unless the individual is contemplating the disposal of a policy or if a viatical settlement would not be available.

C. The proceeds of a lifetime settlement are unrestricted and may be used for:

1. Making cash gifts or purchasing a minority interest in a closely held business.

2. To reduce estate taxes.

3. Facilitating the transfer of a business to the next generation or funding the purchase of permanent life insurance to cover estate taxes.

4. Funding the purchase of long term care insurance.

5. Making charitable gifts and funding planned giving techniques.

6. Purchasing a business.

7. Paying down debt.

8. Investing the proceeds.

IX. Accelerated Benefits.

A. Also known as "living benefits", accelerated benefits are the proceeds of life insurance policies that are paid to policyholders before they die.

1. These benefits are sometimes included in policies when they are sold.

2. Some life insurance companies offer accelerated benefits as riders or attachments to new or existing policies.

B. Accelerated benefits are paid to the insured upon the occurrence of specified events:

1. Diagnosis of a terminal illness.

2. The need for long term care.

3. The onset of any medically incapacitating condition.

C. Other Issues.

1. Usually added to permanent insurance policies, but are increasingly being offered with term life insurance policies.

2. Companies offer anywhere from 25% to close to 100% of their death benefit as early payment, varying from policy to policy.

3. Sometimes payments are made in monthly installments.

4. The accelerated benefits are generally received without being subject to income taxes.

5. Collecting accelerated benefits may affect eligibility for Medicaid or may facilitate the process of spend-down or asset conversion.

6. Accelerated benefits differ from a viatical settlement:

   (a) A "viatication" involves a third party "purchasing" the terminally or chronically ill policyholder's life insurance policy, paying generally between 55% to 80% of the death benefit.

   (b) The viatical settlement company becomes the policy beneficiary and receives the full death benefit at the insured person's death.

   (c) A viatical settlement company is not affiliated with or sanctioned by the life insurance industry although they are regulated by the insurance departments of the various states.

X. NAELA Public Policy Legislative Agenda Pertaining To Long Term Care Insurance.

A. Financing long term care and the system for delivering long term care.

1. NAELA remains vigilant of any possible erosion in long term care benefits and protections through legislation or regulation and will work vigorously to stop any such efforts.

2. NAELA supports exploration of possible strategies to make long term care insurance more accessible and more affordable to more people - for example, through strategies such as incentives or the adoption of an open-enrollment legislative mandate with minimum standards, analogous to federal law applicable to "Medigap" insurance.

3. NAELA will promote additional incentives under Medicare and Medicaid to experiment with flexible alternative care strategies for persons with long term care and end of life needs - for example, more flexible assisted living waivers, more flexible use of hospice-type services in the case of chronic care, and more consumer-directed options for personal assistance services.

B. Long Term Care Insurance Certification ("LTCIC").

1. During the board meeting held in May, 1998, the NAELA board agreed to enter into negotiations to develop a contract between NAELA and the Corporation For Long Term Care Certification, Inc. ("CLTCC").

2. This joint venture was formed for the purpose of CLTCC establishing and administering a certification program for insurance agents who offer for sale long term care insurance policies and for NAELA to provide information and education, by being directly involved in writing the review materials for the certification course, as well as teaching the course to the insurance agents and monitoring the examination.

3. At the July meeting, the LTCIC task force presented a draft of the final contract proposal which the board approved with some modifications.

XI. Attachments and Supplemental Information.

A. Long Term Care and the Indiana Long Term Care Program (by Mary Ann Hack, Director, Indiana Long Term Care Program).

B. Customer Information Bulletin ("Tax Breaks for Owners of Long Term Care Insurance").

C. Companies with Indiana Partnership Long Term Care Policies (12/98).

D. When is the Best Time to Buy Long Term Care Insurance?

E. Indiana Long Term Care Program - Statute.

F. Fact Sheet - Total Asset Protection Law (Indiana Long Term Care Program).

G. Title 760 Department of Insurance, Final Rule, LSA Document #98-160(F) - Digest.

H. Indiana Long Term Care Program Regulations.

I. The 1999 Self-Assessment Guide for Long Term Care Insurance.

J. Indiana Partnership Select Agent Directory.

K. Coventry Financial - Newsletter (1/99/B).

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