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Introduction

America's retirement financing structure has undergone profound changes over the past several years. Of these changes, four point to an ever-widening retirement income gap:

- the decline of defined pension plans that guarantee a predetermined retirement income stream
- the ever-lower income replacement rates provided by Social Security
- increasing life expectancies
- the passage of the baby boom generation—76 million strong—into their retirement years

The convergence of these trends has produced a new retirement reality: millions of Americans are now responsible for generating their own adequate—and sustainable—retirement income. Gone are the days when Social Security and an employer-provided pension plan could ensure a comfortable, secure retirement. Today, consumers must shoulder much of the responsibility for managing their own financial futures. They need self-directed options and self-directed ways to accumulate funds for their futures and to safely and efficiently distribute those funds during their retirement. For these purposes, the insurance industry offers a unique vehicle: the annuity.

Course Objectives

The purpose of this course is to offer a thorough orientation to annuities and their application for long-term asset accumulation and income distribution. We will focus on the design and function of these products as well as their benefits, costs, and limitations. We will examine how these products are funded and how they grow. The course explores the use of annuities for retirement income distribution and examines how these products are taxed. Finally, we will take a look at the suitability requirements that attend to the sale and placement of annuities and will explore the needs for which they are and are not appropriate.

Upon completion of this course, you should be able to:

- demonstrate an understanding of the purpose and application of annuities
- describe the basic types of annuity products
- explain the operation and function of fixed, indexed, and variable annuities
- articulate how an annuity's product features can support and advance various client objectives
- demonstrate an understanding of how annuities are taxed
- cite the suitability requirements that apply to the recommendation and sale of annuities
- outline the needs that annuities support and the applications they serve

This course covers the fundamentals of annuities and explains how these products can generally be applied and used. However, the precise terms and provisions of any annuity product will be unique to the product, and the guidelines or specifications for its placement are determined by the issuing insurance company and state law. Producers are encouraged to supplement this general study on annuities with additional training and education on the specific products they represent.

Chapter 1
Overview of Annuities

Overview

We begin the study of annuities by looking at these products in general: their purpose, function, features, and benefits. Annuities are unique financial planning vehicles, suitable for accumulating funds for the future and creating an income stream that cannot be outlived.

Upon conclusion of this chapter, you should be able to:

- describe the basic purpose and application of annuities
- identify the parties associated with annuity contracts
- explain the fundamental distinctions between immediate and deferred annuities and fixed and variable annuities
- cite basic features and characteristics that are common to all annuities
- explain the role of annuities for long-term financial planning

What Is an Annuity?

Annuities are unique financial instruments. They provide a way to accumulate funds for the future and then systematically distribute those funds over a given period. Annuities are financial contracts issued by insurance companies. Annuity buyers deposit money into the contract in the form of premiums. The insurer invests these premium dollars, which are then credited with a certain rate of interest earnings or grow in value in relation to the performance of the investments in which they are deposited. Funds accumulate in an annuity on a tax-deferred basis, which enhances the product's ability to grow: funds compound at a greater rate because none of the earnings are taxed away.

At a certain point in the contract's life, the insurance company—at the owner's direction—will convert all or a portion of the contract's funds into a series of periodic income payments. These payments are calculated actuarially to extend for a certain number of years or for the owner's lifetime. This is the process of **annuitization**—applying capital to purchase income. By design, annuities can serve as both asset accumulation vehicles and asset distribution vehicles.

For this reason, annuities are well suited for retirement planning.

Parties Associated with an Annuity

As noted, annuities are financial contracts issued by insurance companies. The contract specifies the details of the annuity product and each contracting party's obligations or responsibilities. In addition to the insurer that issues the contract, there are three parties associated with an annuity:

- the owner
- the annuitant
- the beneficiary

Owner

The **owner** of an annuity contract is the person who has all rights under the contract before the scheduled annuitization date. Typically, the owner is the party who purchases the contract and makes the premium deposits. An annuity owner receives all rights and privileges under the contract and assumes all financial responsibilities. For example, the owner:

- applies for and signs the annuity application, accepting the contract and its provisions
- designates the annuitant and the beneficiary
- receives the benefit of tax deferral
- specifies the contract's annuitization date and period. The owner decides when annuity payments will begin and selects the contract's payout option, which determines how long the payments will last.
- determines how the contract's funds will be invested and allocated among the insurer's investment options, if the contract is a variable annuity
- can make contract withdrawals
- can choose to liquidate or surrender the contract before the annuitization date

- can authorize changes to the contract. For instance, the owner can change the beneficiary (if the original beneficiary had not been named irrevocably); can adjust or change the investment allocation of a variable annuity; and can change the scheduled annuity start date.
- can assign the contract or even designate a new owner
- assumes liability for taxes owed on withdrawals and payouts

A number of insurance companies allow their annuity contracts to be purchased jointly and issued to two owners. Such arrangements, however, are usually limited to spouses. Both joint owners must sign the application. Each joint owner is authorized to make changes within the contract, but typically both must consent to the changes.

Once annuitization begins, the contract is in a liquidation mode and typically, the owner's rights end.

Annuitant

The **annuitant** is the person on whose life the annuity income payments are based and to whom the payments will be made. Quite frequently, the owner and the annuitant are the same person. Annuities often have joint annuitants—two individuals, such as a husband and wife—and the annuity income is structured so that payments are made for as long as either lives.

Beneficiary

The **beneficiary** is the person named who will receive the contract's death benefit proceeds, should the owner or annuitant die before the contract's values have been annuitized or before the contract's starting date (the date the contract is scheduled to annuitize). All annuity contracts provide for a death benefit but vary on whose death triggers this benefit: the owner or the annuitant. Annuity contracts that are **owner-driven (OD)** pay the death benefit when the owner dies. Contracts that are **annuitant-driven (AD)** pay the death benefit when the annuitant dies.

The beneficiary of an annuity has no rights in the contract before the owner or annuitant dies.

Annuity Issue Ages

Annuities are routinely issued to consumers of all ages, though insurers typically establish maximum age limits. Depending on the insurer, the type of contract, and the laws of the state in which the contract is issued, the minimum issue age may be 0; the maximum issue age may be as high as 80, 85, or even 90. Some companies distinguish between contract owners and contract annuitants and apply different issue ages (minimum and maximum) to each. Specific riders that can be added to an annuity contract may carry different issue age limits than those that apply to the base contract.

Types of Annuities

Annuities come in many forms. The primary distinctions among these forms and what separates one type of annuity from another are based on two fundamental factors:

- when the contract is scheduled to convert its funds into a series of income payments. This is the distinction between *immediate* annuities and *deferred* annuities.
- how the contract's funds are invested, how the funds grow, and how the funds are paid out upon annuitization. These are the distinctions between *fixed*, *indexed*, and *variable* annuities.

Let's take a closer look at these distinctions.

Immediate Annuities

An **immediate annuity** serves exclusively as an income distribution vehicle; its purpose is to generate an ongoing, systematic stream of income. Within a very short time after the contract is purchased—typically, within one month—the funds the owner deposited are annuitized and converted into a guaranteed stream of periodic income payments. These payments are configured to last as long as the owner wishes: for a set number of years, for the annuitant's lifetime, or for the joint lifetimes of two annuitants, such as the owner and his or her spouse.

An immediate annuity requires the payment of a single lump-sum premium upon contract purchase. The contract is simply a mechanism for converting the lump sum into a series of periodic income payments. Immediate annuities are often referred to as **SPIAs**, or **single-premium immediate annuities.** SPIAs can generate income streams that are fixed and unchanging, or they can pay out variable income streams, which will increase or decrease according to the performance of underlying investments accounts. Fixed or variable, the duration of the immediate annuity income stream is guaranteed by the insurer.

Deferred Annuities

A **deferred annuity** is designed to accumulate funds for the long-term. Accordingly, it is characterized by an accumulation stage. The **accumulation stage** is the period during which funds are deposited into the contract and are credited with a certain rate of interest earnings or grow in relation to the performance of the investments in which they are deposited. Generally speaking, the accumulation period associated with a deferred annuity is typically eight to ten years or more. Contract owners may be assessed a penalty if they withdraw funds from their annuities earlier.

At the end of the accumulation stage, the owner has several options. He or she can:

- withdraw the funds in whole or in part
- leave the funds in the contract to continue accumulating
- annuitize the contract

Any interest or growth the contract earns during the accumulation stage is not taxed as long as those funds remain in the contract. This tax-deferred growth is a distinct advantage that an annuity offers over other investment products.

A deferred annuity can be funded with a single lump-sum premium deposit or with a series of premium deposits over time, as and when the owner wishes.

Deferred Income Annuities

A fairly new form of annuity is the **deferred income annuity**, or **DIA**. A deferred income annuity can be described as a "cousin" to an immediate annuity. Like an immediate annuity, the contract is intended solely to produce a guaranteed income stream. The money that purchases the contract will be annuitized and converted into a series of payments, guaranteed payable to the annuitant for as long as he or she wishes.

However, unlike immediate annuities, a deferred income annuity's payments do not begin immediately. There is a deferral period between the time the contract is purchased and the time the income stream will begin. This period must be at least 13 months; more typically, it is much longer, such as five, eight, or ten years. There is no interest crediting during this deferral period; simply, a DIA provides the means to convert a lump sum of money today into a guaranteed income stream that is payable at some point in the future.

Income or Accumulation?

Choosing the right type of annuity always begins with choosing an immediate or deferred design. This choice is based on the buyer's need. If the buyer wants to use an annuity to save and accumulate funds, the choice is the deferred annuity. If the individual is ready to turn his or her savings into income now, the choice is the immediate annuity. If the individual wants to lock in a future income stream today for a payout years into the future, the choice would be a deferred income annuity.

By far, the majority of annuities purchased today are deferred annuities. However, with the expanding retirement market and this market's need for guaranteed lifetime incomes, immediate annuities and deferred income annuities are expected to gain popularity. Recognizing the opportunity to meet changing consumer needs and expectations, annuity carriers continue to introduce new annuity product designs, which include innovative features and options.

Fixed vs. Indexed vs. Variable Annuities

Immediate or deferred, an annuity is also characterized by the way its funds are invested, how those funds grow, and how they're paid out during annuitization. To this end, an annuity can be *fixed, indexed*, or *variable*. Though the characteristics of fixed, indexed, and variable annuities are explained in detail in the next chapter, an overview is appropriate here.

Fixed Annuities

A **fixed annuity** provides for:

- fixed levels of interest to be credited to the contract by the insurer during the accumulation stage
- a fixed, unchanging level of income to be paid upon the contract's annuitization

The rate of interest credited to a fixed deferred annuity during the accumulation stage is declared by the insurer, subject to periodic change, and is backed by a minimum guaranteed rate of return. For example, a fixed annuity could provide for an initial 6 percent declared rate of return for the first two years after contract issue and a minimum guaranteed rate of 3 percent for the contract's term. After the first two years, the insurer declares another rate of return that is to be credited to the contract. This renewal rate can be higher or lower than the initial 6 percent, but the owner is guaranteed that it will be no lower than 3 percent.

A contract that is annuitized on a fixed basis will pay the same income payment for the entire annuitization period. If, for instance, 60-year-old Charlie decided to annuitize his $200,000 annuity contract and selected a fixed monthly lifetime payout option, he would receive payments of about $1,000 every month for the rest of his life. Those payments will not increase or decrease and are guaranteed by the insurer.

Traditional fixed annuity products are conservative investment vehicles, appropriate for those who are risk averse and who seek safety of principal, conservative returns, and minimum guarantees. Most require a holding period of a number of years before the owner can access the contract's values without charge or penalty. Depending on the insurer and the product, this period may be as short as two or three years or as long as 15 years.

Indexed Annuities

Indexed annuities are a form of fixed annuity; however, the level of interest the insurer credits to the contract is not declared outright by the insurer but is instead based on the performance of a market index. Most indexed annuities are tied to a stock market index, such as the S&P 500 or the Russell 1000. For this reason, these products are also called **equity indexed annuities**.

The basis for the interest credited to an indexed annuity is the performance of the market index to which it is tied. If the index rises during the contract's interest crediting period—for example, increasing 10 percent from a starting value of 1000 to an ending value of 1100—that 10 percent increase will be the basis for the interest that will be credited to the contract for that crediting period. In this way, indexed annuities allow some measure of participation in market-based returns: the increase (or decrease) in the index reflects the aggregate characteristics of the index's underlying securities, and that increase (or decrease) is the basis for the amount of interest that will be credited to the annuity.

Indexed annuities also provide for a minimum guaranteed interest rate, which protects the values in the contract against market downturns. At the end of each interest crediting term, the greater of the indexed interest or the minimum guaranteed rate will be credited to the contract. In this way, an indexed annuity buyer's principal is protected from loss.

Variable Annuities

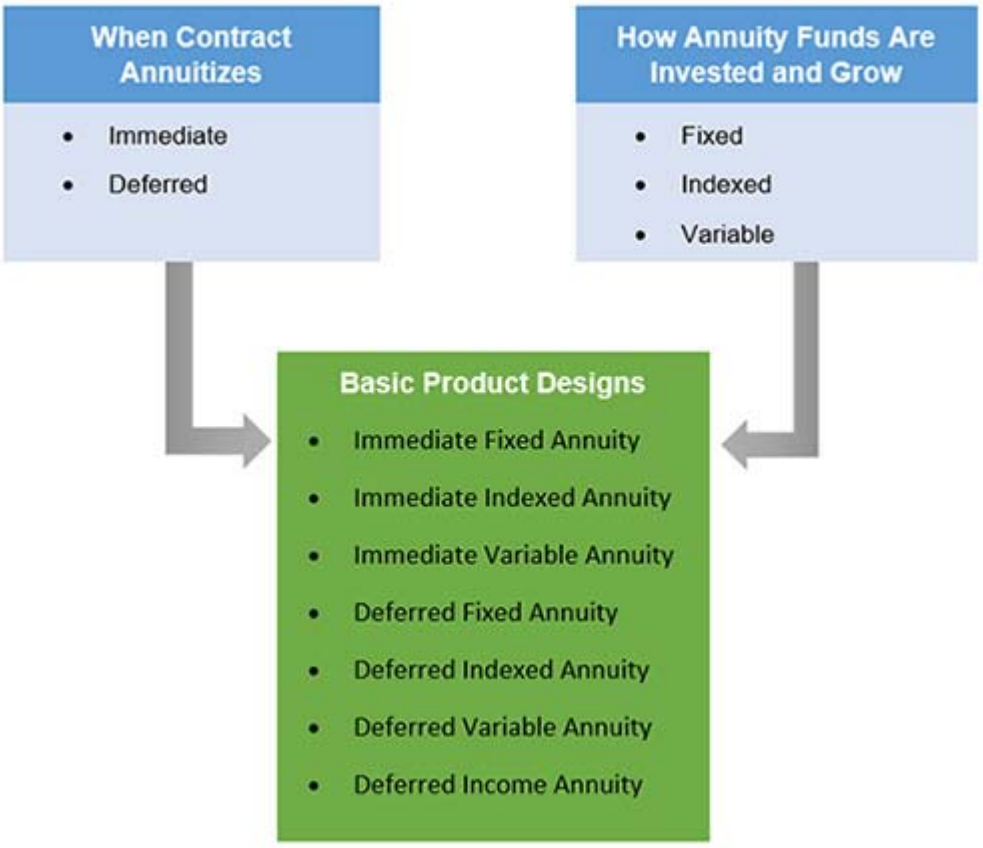
In contrast to fixed and indexed annuities that provide for some level of minimum guaranteed returns are **variable annuities (VAs)**. The funds a variable annuity owner deposits into his or her contract are directed into nonguaranteed investment portfolios maintained by the insurer. These separate account portfolios consist of a variety of stock, bond, and money market accounts and are similar to mutual funds. The performance of a variable annuity's underlying investments determines the growth of the variable annuity: if the underlying investments perform well, the contract's values increase; if the underlying investments perform poorly, the contract's values may decrease.

Unlike traditional fixed or indexed annuities, there are generally no guarantees associated with the values or the growth of a variable annuity. If the investments in which the contract's funds are deposited decline, the value of the contract will also decline; the insurer does not guarantee any minimum rate of return. For this reason, the variable annuity owner bears the investment risk for the contract's performance. With a variable annuity, the attraction is with the *potential* for growth that is associated with the contract's underlying investments—a potential that is generally greater than what can be obtained with fixed annuities or other conservative investments, such as certificates of deposit or government bonds.

Over the past several years, insurers have designed a number of **guaranteed living benefit riders** for their variable annuities. These riders—which are available for an additional cost—provide some level of guarantee of the variable annuity's values, to be used for accumulation, withdrawals, or annuitization. These riders have proven to be very popular in the VA market; however, they can be costly and very complex.

Due to the nature of their investment feature and the risks they pose, variable annuities are considered *securities* as well as insurance products. Accordingly, these products and those who sell them are subject to federal and state securities regulation as well as state insurance laws. Variable annuities must be sold with a prospectus, and all sales and marketing activity must conform to the standards and requirements of all associated regulatory bodies. Producers who sell variable annuities must be securities licensed as well as life licensed.

How Annuities Are Distinguished



Annuity Features: Pro and Con

In addition to providing a means to accumulate and/or distribute funds, annuities are characterized by a variety of features that make them unique financial planning vehicles. Full discussions of these features are reserved for later chapters, but a brief overview is provided here. Generally speaking, all types of annuities provide the following:

- tax deferral
- death benefits
- flexible funding
- variety of annuitized payout options
- no limits on contributions
- probate avoidance

- lifetime income options through annuitization
- income options other than annuitization
- contract fee waivers for “crisis” situations

Annuities offer a way for those of moderate means to save and accumulate funds for their later years. Higher income earners are often drawn to these products because of their tax-deferred treatment. The fact that interest earned on annuity funds is not taxed until it is withdrawn or distributed has always been a strong motivation for purchasing these products. According to a Gallup Organization Report, 70 percent of (nonqualified) annuity owners stated that they have set aside more money for retirement than they would have if the tax advantages of annuities were not available.[1]

Annuity Drawbacks

But for all their advantages, annuities also have a number of limitations. These limitations (which will be reviewed in detail throughout the course) could, for some buyers and in some circumstances, outweigh the advantages, which would make an annuity an unsuitable product for these buyers and these circumstances. Annuity drawbacks include:

- lack of liquidity
- contract surrender charges
- tax penalties for early withdrawals
- fees and charges that may be higher than those associated with other investments
- no capital gains treatment of distributed funds
- no step-up in basis for beneficiaries
- complex design

Again, these benefits and drawbacks will be discussed throughout the course. Producers and planners must be thoroughly aware of all of the annuity’s aspects, good and bad. They must be prepared to help their clients measure and weigh all of an annuity’s features—pros and cons—before they recommend or sell any such product.

The Purpose of Annuities

Annuities contain a number of features, benefits, and drawbacks. They can be intricate products, often difficult for consumers to understand. But their fundamental purpose and application can be easily summarized:

- to accumulate funds on a tax-deferred basis for the long term
- to provide a source of income, guaranteed payable for life or for a specified period

To these two fundamentals the following can be added to further define the purpose and application of annuities:

- Deferred annuities are long-term products designed to provide benefits for a time later in life, typically retirement. They are not intended nor are they appropriate for short-term needs.
- Deferred annuities are primarily savings and investment products. They are designed foremost to provide for the tax-deferred accumulation of funds for use during an individual's life and secondarily to provide benefits at death. To this end, the buyer can select a product design that matches his or her investment profile and investment objectives: fixed annuities and, to a large extent, indexed annuities are conservative vehicles, appropriate for "safe money" needs; variable annuities offer the potential for market-based growth and market-based returns, neither of which is guaranteed.
- Both deferred and immediate annuities can provide a means to produce and deliver an ongoing income stream that will last as long as the owner desires.

The application of an annuity and the suitability of the product for any given client should embrace the preceding functions in one way or another. If the purpose and application of the product match the needs of the client, then the foundation for an appropriate product placement is firm.

Qualified and Nonqualified Annuities

Annuities can be used to informally accumulate assets for the long term or they can be used as the funding vehicle for a qualified plan, such as an IRA, SEP, or 403(b) plan. The former are **nonqualified annuities**; the latter are called **qualified annuities**. Qualified annuities provide the same features and benefits as nonqualified annuities; however, the rules under which each operates are different.

For example, an individual who purchases a nonqualified annuity cannot deduct the premium deposits. By contrast, an individual who purchases an annuity to fund a traditional IRA might be able to deduct the premium payments depending on income level and whether he or she is participating in an employer-provided plan. The individual who owns a nonqualified annuity may make premium deposits in any amount he or she wishes, while an individual who owns a qualified annuity is limited in the amount of premium deposit based on the contribution limits that apply to the qualified plan the contract supports. Any type of annuity can be used to fund a qualified plan; when used for this purpose, the annuity is then subject to the same rules that apply to the qualified plan, whether individual or employer-sponsored.

Should Annuities Be Used to Fund a Qualified Plan?

Using annuities to fund qualified plans is controversial. Critics correctly point out that the annuity's tax-deferral benefit in these instances is redundant, because qualified plans, by definition, provide for tax deferral. For this feature, an annuity offers no additional benefit over other funding instruments, such as mutual funds. In addition, annuities impose charges and fees that other investment products do not. Why, then, should investors put one tax-deferred instrument—an annuity— into another—a qualified plan—especially when the instrument may cost more than others?

The reason is that annuities offer unique benefits other than tax deferral. These include a guaranteed death benefit, a means to generate a guaranteed lifelong income stream, and a variety of options for paying out the income stream. If the product is a fixed annuity, the owner's principal is secure and is guaranteed by the insurer; if the product is a variable annuity, the owner is able to direct his or her premium deposits into a variety of investment subaccount options and achieve diversification. Many of today's VAs offer innovative options that can guarantee certain accumulation amounts or certain minimum income payments (which will be discussed later in this course).

For those who do not need or want these additional benefits, using an annuity to fund a qualified plan would not be appropriate. Furthermore, those who can participate in a 401(k) plan or SIMPLE plan that provides for matching employer contributions should maximize contributions to such a plan before contributing to any individual qualified annuity. Roth IRAs, funded with appropriate investments, should also be considered, because the earnings on these vehicles are not subject to taxation at all as long as the owner maintains the account for the required number of years.

For others, the additional benefits annuities offer could fit their situations, and these products could be suitable funding instruments for a qualified plan. It depends on the individual's objectives and needs. Like any savings or investment product, an annuity's features, benefits, costs, and limitations must align with the needs of the purchaser.

Summary

- Annuities are unique products, primarily intended as long-term savings and investment vehicles.
- Annuities are designed to hold the owner's funds for a certain time and to then convert those funds into a stream of income that can extend as long as the owner desires. This process is called annuitization.
- Annuities are defined in terms of when they are scheduled to annuitize (immediate or deferred) and how the products' funds are invested and how they grow (fixed, indexed, or variable).
- As they have evolved over the years, today's annuity products have become sophisticated retirement planning products that can be used for long-term asset accumulation and lifelong asset distribution.

Chapter 1 Review Questions

1. Which annuity design is appropriate for a consumer who seeks a way to grow and accumulate funds for the future?
    A. immediate annuity
    B. deferred annuity
    C. both a and b
    D. neither a nor b
2. "Using capital to purchase income" defines which of the following?
    A. annuitization
    B. asset allocation
    C. tax deferral
    D. market timing
3. A fixed annuity can be used to fund a qualified plan; a variable annuity cannot.
    A. True
    B. False
4. The primary reason a consumer should purchase an annuity is to provide a death benefit to his or her heirs.
    A. True
    B. False
5. The basis for the interest credited to Angela's annuity is the growth of the S&P 500. What kind of annuity does Angela own?
    A. an indexed annuity
    B. a traditional fixed annuity
    C. a variable annuity
    D. a value-adjusted annuity
6. What is the primary difference between fixed and variable annuities?
    A. the frequency of the product's premium payments
    B. the option for annuitization
    C. the ways in which their funds are invested for growth
    D. provisions for death benefits

Answers to Chapter 1 Review Questions

1. B. Deferred annuities offer a way to grow and accumulate funds for the future. Immediate annuities are designed to produce an income stream for a guaranteed period.
2. A. The concept of annuitization is applying capital to purchase income-changing a principal amount of money into a series of ongoing, periodic income payments.
3. B. Any type of annuity can be used to fund a qualified plan. Doing so is appropriate as long as the owner seeks benefits other than tax deferral.
4. B. Annuities are intended foremost to provide living benefits for the owner or annuitant: accumulation, income, or both. Providing a death benefit should not be the primary need.
5. A. Indexed annuities are tied to a market index, such as the S&P 500 or the Russell 1000. The interest that is credited to an indexed annuity is based on the performance of the market index to which it is tied.
6. C. The primary distinction between fixed and variable annuities is how their funds are invested and how the funds grow.

Chapter 2
Basic Annuity Designs

Overview

Annuities are classified as immediate or deferred, referring to when the contract is scheduled to annuitize. They are also classified as *fixed*, *indexed*, or *variable*. The primary distinction between fixed, indexed, and variable annuities is the way in which the product's funds are invested and how they accumulate. In this chapter, we will take a closer look at the basic designs of fixed, indexed, and variable annuities: how these contracts are structured, how premiums are invested, and how the products' values are determined.

Upon completion of this chapter, you should:

- understand the characteristics of fixed, indexed, and variable annuities
- know how each product type grows and accumulates and how its funds are invested
- understand how each product design's values are determined
- be able to explain how an annuity's investment and accumulation features can be matched to individual buyer needs and objectives

Traditional Fixed Annuities

With **traditional fixed annuity** products, the insurer directs contract premiums into its **general account**, an undivided investment account that supports the contractual obligations of the company's guaranteed products. These funds are invested by the insurer in generally safe, secure investments—primarily long-term quality bonds.[2] The company can then project the earnings it will receive on these investments and, accordingly, guarantee a certain rate of return that it will credit to its fixed annuity contracts. This is the **spread**—the difference between what the insurer earns on its invested assets and the interest rate it then credits to its fixed annuity products. If, for example, the insurer projects it will earn a return of 7.5 percent on its invested general account assets, it might determine that it will credit a rate of 4.5 percent to its fixed annuities. The 3 percent difference covers the insurer's expenses and generates profits.

Initial vs. Renewal vs. Guaranteed Minimum Interest Crediting Rates

Typically, a fixed deferred annuity is issued with a rate of interest that will be paid for a set number of years (one, two, or three, for example). At the end of that initial crediting period, the insurer declares a new interest rate that will be credited to the contract for a specified period (often one year). This is the **renewal rate**. Upon each new crediting period, the insurer declares another renewal rate that will be credited to the contract and guaranteed for that period. These **declared interest rates** reflect the investment returns the insurer projects it will earn on its general account invested assets. These rates also reflect current economic conditions, the insurer's actual investment, mortality and expense results, and its reserve requirements.

Underlying a fixed annuity contract for its life is a **guaranteed minimum rate of return**, such as 1.5 or 3 percent. The owner of a traditional fixed annuity can be assured that his or her premiums are protected and that the contract will grow steadily (if conservatively) at a rate of return no less than the minimum. The guaranteed minimum rate is specified in the annuity contract.

Portfolio-Based Crediting vs. New Money-Based Crediting

Generally speaking, insurers use two methods to determine and credit declared interest rates to their clients' fixed annuities: portfolio-based crediting and new money-based crediting.

Portfolio-Based Interest Crediting

An insurer using a **portfolio-based** interest rate method allocates all annuity premiums to one large investment portfolio. Based on the investment performance of the entire portfolio, the insurer declares the applicable interest rate for all contract owners purchasing the annuity contract. When the annuity contracts renew, the insurer establishes a renewal interest rate based on the performance of the entire portfolio. The portfolio-based interest rate method applies to annuity contracts regardless of the specific interest rate environment that existed on their issue date.

New Money-Based Interest Crediting

Under a **new money-based** interest rate method, insurers establish the declared interest rate specifically to reflect the interest rate environment at the time premiums are received rather than as a reflection of the performance of the overall portfolio. In managing new money interest crediting, the insurer assigns annuity premiums received during a particular interest rate cycle into a distinct segment or "bucket." Premiums continue to be assigned to that bucket and credited with that bucket's interest rate for as long as the interest rate remains relatively stable. When the interest rate environment changes, the insurer creates a new bucket and directs new premium payments to the new bucket. Each new premium deposit is credited with the rate that is associated with its bucket and guaranteed for a specified period (such as one year). Renewal rates are declared at the end of the interest crediting period and will generally vary for each premium deposit.

Regardless of whether an insurer uses a portfolio-based crediting method or a new money-based crediting method, the interest rates credited to a fixed annuity will never be lower than the guaranteed minimum rate.

How Fixed Annuities Accumulate

To better understand how fixed annuities accumulate values, consider the following example. Assume that 52-year-old Leon purchased a fixed deferred annuity with a single premium deposit of $50,000. The declared interest rate on Leon's annuity when it was issued was 5 percent, with an underlying guaranteed minimum rate of 2.5 percent. The initial declared rate was payable for two years. Therefore, at the end of the first contract year, $2,500 in interest earnings was credited to Leon's contract ($50,000 × .05 = $2,500) and at the end of the second contract year the contract was credited with $2,625 ([$50,000 + $2,500 = $52,500] × .05 = $2,625). The renewal interest rate for the third contract year and later may be higher or lower than 5 percent; however, Leon can be assured that it will never be less than 2.5 percent. Thus, his invested principal and credited earnings are secure.

Year 1	Year 2
$50,000 × .05 = $2,500	$52,500 × .05 = $2,625
$50,000 + $2,500 = $52,500	$52,500 + $2,625 = $55,125

Factors That Influence Declared Interest Rates

Declared interest rates are a function of many factors:

- the insurer's mortality and expense results
- the insurer's reserve requirements
- competitive market influences
- prevailing interest rates and investment returns

Prevailing interest rates and the investment returns the insurer projects it will earn on its general account-invested assets play a very significant role. During periods of generally stable or rising interest rates, insurers can be more confident that the assets they invest in will be less likely to be "called" by the issuer and that their cash flows will remain stable; the opposite occurs during periods of declining interest rates. As insurers' returns increase and decrease, so do their declared annuity interest crediting rates.

For these reasons, the rates that are declared and credited to traditional fixed annuity products are subject to change over the contract's term. Producers who sell fixed annuities must make sure that their clients understand what *guaranteed declared rate* means and for how long it applies. A fixed annuity issued with declared rate of 5 percent for the first two years, for example, may not be credited with that same rate in year three. Consumers who purchase this annuity because the producer stated that it "guarantees a 5 percent interest rate" should not be left wondering what happened when, at the beginning of the third contract year, they receive notice from the insurer that their annuity contract will be credited with a 4 percent rate for that year.

Two-Tiered Fixed Annuities

A variation on the traditional fixed annuity is the **two-tiered annuity**. A two-tiered annuity provides for the crediting of two different interest rate schedules depending on when and how the contract owner accesses the contract's values. As long as the owner does not surrender the contract or take contract withdrawals during the contract's accumulation period, a specified rate of interest will be credited to the contract, and the contract will generate a higher value for annuitization. However, if the owner surrenders the contract early or decides to access the funds through withdrawals instead of annuitizing, a different and much lower interest rate will be credited, applying retroactively from the contract's inception. Thus, a two-tiered annuity provides for two tiers of interest credits: a higher tier of interest if the contract is maintained and annuitized and a much lower tier of interest if the contract is not annuitized.

Fixed Annuities: Safety of Principal and Guaranteed Rates of Return

Insurance companies guarantee their fixed annuity credited rates. No matter what the insurer earns on the investment of its general account funds, it is contractually obligated to pay the declared interest rate on its fixed annuity products, which is guaranteed to be no less than the minimum rate. For this reason, fixed annuity owners do not bear any investment risk: their principal is secure, and they are guaranteed a minimum rate of return on their invested premiums. "Safety" is one of the most common reasons why annuity owners purchase their contracts.[3]

Guarantees Based on Insurer's Financial Strength

It is important to understand that any guarantees associated with any annuity product are based on the financial strength and claims-paying ability of the issuing company. Though consumers are protected to some degree by a state's guaranty association (which covers claims and contract values up to certain limits in the event an insurer becomes insolvent), this in no way reduces the need for consumers—and producers—to research insurers and work only with those that are financially stable and well managed. States do not want consumers to rely on guaranty associations; in fact, state laws prohibit insurance companies and producers from mentioning or referring to a state's guaranty association in their advertising or communications with the public, or using it as an inducement to purchase any kind of insurance. Instead, producers whose clients are interested in fixed annuities should help them evaluate the following:

- the investment holdings of the insurer's general account and the kinds of investments that support the insurer's annuity rates
- the insurer's historical renewal rates
- the insurer's financial strength rating and how long the insurer has been in the annuity business

Indexed Annuities

Indexed annuities are a form of fixed annuity. However, the interest credited to the contract is not declared in advance by the insurer; instead, it is based on the performance of an independent market index, such as the S&P 500.

The basis for the interest credited to an indexed annuity is the performance of the index to which it is tied. If, for example, the index was at 1000 when the contract's interest crediting period began and reached 1100 when the crediting period ended, the index increased by 10 percent [(1100 – 1000 = 100) ÷ 1000]. Consequently, the basis for the interest that will be credited to the indexed annuity for that period is 10 percent. In this way, indexed annuities allow some measure of participation in market-based returns: the increase (or decrease) in the index to which the product is tied is the basis for the amount of interest that will be credited.

Indexed annuities also provide for a minimum guaranteed interest rate, which protects the values in the contract against market downturns. At the end of each interest crediting term, the indexed interest or the minimum guaranteed rate, *whichever is greater*, will be credited to the contract. In this way, an indexed annuity buyer's principal is protected from loss. However, the guaranteed minimum rate for an indexed annuity may be lower than the guaranteed minimum rate that applies to a traditional fixed annuity, and it is common for indexed annuity insurers to apply the guaranteed minimum rate to only a portion of invested premiums, such as 90 percent.

Features of Indexed Annuities

As a result of the way in which interest is credited to equity indexed annuities, these products are characterized by a number of unique features. For example, most include some provision that limits the amount of indexed interest that will be credited to the contract. These limits take the form of *participation rates, spreads (*or *margin rates),* and *caps.*

Participation Rate

The **participation rate** is the amount or level of the index increase that will be credited to the contract. For example, if the participation rate is 80 percent and the index to which the contract is tied increased by 11 percent over the crediting period, then the contract will be credited with 8.8 percent interest (.80 × .11 = .088). If the participation rate is 70 percent and the index to which the contract is tied increased by 11 percent over the crediting period, then the contract will be credited with 7.7 percent interest (.70 × .11 = .077). Indexed annuity participation rates vary widely from insurer to insurer and from product to product. Some may be as low as 50 percent; others may be as high as 90 percent or 100 percent. Products with lower participation rates may feature additional benefits that are not included on products that apply higher participation rates. Conversely, products that have longer terms may carry higher participation rates than those with shorter terms.

Margin

As an alternative to—or in addition to—a participation rate, some indexed annuity issuers use a **margin** (or **spread**) to determine the interest rate that will be credited to their contracts. A margin is a stated percentage deducted from the percentage change in the index level before that percentage is applied as an interest rate to the annuity funds. Thus, a margin is subtracted from the index yield, and the remainder is the credited interest rate. For example, if the index to which the contract is tied increased by 8 percent and the margin is set at 5 percent, the interest rate that will be applied to the annuity for that specific crediting period will be 3 percent (.08 – .05 = .03).

Cap

In addition to a participation rate or margin, indexed annuities usually impose a **cap**, which is the maximum amount of interest that will be credited during any one interest crediting period. A 14 percent cap, for instance, limits the amount of interest credited to the contract in any interest crediting period to 14 percent regardless of the performance of the underlying index and regardless of the participation or margin rates.

Floor

Most indexed annuities contain provisions that prevent any negative index return from affecting the contract's previously credited values. This is known as the **floor**—the minimum amount of indexed-linked interest that is to be credited to a contract during any crediting period. With most indexed annuities, the floor is zero. In other words, if the index to which an annuity is tied were to decrease over the crediting period, the amount of indexed interest that would be credited to the contract would be zero—no indexed interest would be credited. As a result, a decline in the index would *not* equate to negative interest crediting.

For example, assume that an indexed annuity provides for annual interest crediting, an 80 percent participation rate, and a zero percent floor. During the first two contract years, the index to which the annuity is tied yields a positive return; the third year, the index return is negative; in years four and five, the returns are again positive. The following illustrates the amount of interest that would be credited to the contract in each of these five years:

	Contract Year 1	Contract Year 2	Contract Year 3	Contract Year 4	Contract Year 5
Index return	12%	9%	–4%	3%	7%
Interest credited to annuity contract (80% of index return)	9.6%	7.2%	0%	2.4%	5.6%

The negative index return in Year 3 does not generate negative interest crediting; instead, the zero percent floor results in no index interest credited in Year 3, and the annuity's value does not decline.

The negative index return in Year 3 does not generate negative interest crediting; instead, the zero percent floor results in no index interest credited in Year 3, and the annuity's value does not decline.

An indexed annuity's floor should not be confused with the product's minimum guaranteed rate of return. The floor represents the minimum rate of indexed interest that will be credited to the contract during any crediting period; the minimum guaranteed rate of return is the rate that will be applied to the contract at the end of the contract's crediting term if the index interest accumulations are less than the minimum guaranteed.

Index Crediting Methods

Indexed annuities employ a variety of **interest crediting methods**. These methods define the period or term over which the index returns will be measured and how those returns will be calculated and applied to the contract.

Common index crediting methods include the following:

- **point-to-point**—This method credits an interest rate based on the increase in the index value from one defined point of time to another. Often these points are the date of contract inception and the date the interest crediting period ends.

  Example: Assume Indexed Annuity A uses a three-year point-to-point interest crediting method, a 90 percent participation rate, and no cap. The index to which the contract is tied was at 1000 when James purchased Indexed Annuity A with a $10,000 premium deposit. This is the first "point." Three years later, at the end of the contract's crediting term, the index is at 1150. This is the second "point." The difference in the index between these two points represents a 15 percent gain ([1150 – 1000] ÷ 1000 = .15). At a 90 percent participation rate, this means that a rate of 13.5 percent will apply to James's contract for that three-year term, resulting in $1,350 of credited interest. This example uses a three-year crediting term. Other point-to-point methods may use a longer term, such as five years. Because the crediting methods in both cases apply to terms that extend beyond a single year, they are considered long-term point-to-point methods.

- **high water mark**—This method looks at the index value at various points during the interest crediting period, such as contract anniversary dates. The highest of the index on these dates is compared to the index level at the start of the period, and the difference between these two points is the basis for the interest to be credited.

  Example: Assume Indexed Annuity B uses a five-year high water mark interest crediting method, a 100 percent participation rate, and a 15 percent cap. The index to which the contract is tied was at 1000 when Lydia purchased the contract with a $20,000 premium payment. As marked by the anniversary dates of the contract over the five-year term, the index values during the product's crediting term were as follows:

	Year 1	Year 2	Year 3	Year 4	Year 5
Index value, as of contract anniversary dates	1000	1070	1110	990	1010

  The high point for the index over the five-year crediting period came in year 3, when the index was 1110. This represents an 11 percent gain over the index level at the start of the five-year period ([1110 – 1000] ÷ 1000 = .11). Because the crediting method provides 100 percent participation and the cap is 15 percent, the full 11 percent of the index gain is the interest that will be credited to Lydia's contract for that period. Therefore, for this five-year term, $2,200 will be credited to the contract.

- **annual ratchet or annual reset**—This method credits an amount of interest based on the performance of the associated index over a single year. The index gain or loss each year is measured and interest is credited accordingly. The index level at the end of every year is the starting point for measuring the index return for the following year. (This method is also known as an **annual point-to-point**.)

  Example: Assume that Indexed Annuity C uses an annual ratchet indexing method, with an 85 percent participation rate, a zero percent floor, and a 14 percent cap. Chris purchased this annuity with a $50,000 premium payment. The contract's initial term (i.e., its crediting period) is five years. Assuming the index to which Annuity C is tied performs as shown below, Chris's annuity would be credited with $2,125, $0, $3,545, and $5,255 respectively in the second through the fifth year:

	Contract Year 1	Contract Year 2	Contract Year 3	Contract Year 4	Contract Year 5
Index level at beginning of year	1000	1050	1000	1080	1200
Index return for contract year	--	5%	–4.7%	8%	11.1%
85 percent participation rate applied	--	4.25%	0%	6.8%	9.44%
Amount of interest credited*	--	$2,125	$0	$3,545	$5,255
** Assumes that interest credited to the contract is compounded from year to year.*					

- **monthly average**—This method credits an amount of interest based on the average of the associated index's monthly returns over a single year or other term.

  Example: Assume that Indexed Annuity D uses a monthly average indexing method, with an 80 percent participation rate and a 15 percent cap. Jamison purchased this annuity with a $20,000 premium payment. The associated index was at 1000 when the contract was purchased, and over the next 12 months, the index levels were as follows:

Month 1	Month 2	Month 3	Month 4	Month 5	Month 6
1010	1095	1120	1125	1280	1295

Month 7	Month 8	Month 9	Month 10	Month 11	Month 12
1270	1220	1200	1150	1015	1110

  The average index level over the 12-month period was 1157.5. Consequently, using this average, the index gain from the start of the term is calculated to be 15.75 ([1157.5 – 1000] ÷ 1000). Applying the 80 percent participation rate, Jamison's annuity would be credited with 12.6 percent for this year.

Variety of Indexed Crediting Methods

The index crediting methods just discussed are but a few of the many that are used with today's indexed annuities. Some methods will combine these approaches, and additional design features unique to a given product may also apply. For example, a given indexed methodology may provide for either simple or compound interest crediting.

Depending on the insurer and the product, the choice of the index crediting method may be up to the client, or the client may be allowed to select a new index crediting method at certain points during the contract's term. In these cases, it is imperative that the client is made to understand how the selected method works and its associated advantages and disadvantages.

How Insurers Invest for Index Crediting

As with traditional fixed annuity contracts, insurers provide for guarantees on their indexed products. For example, the insurer guarantees that:

- No less than the contract's guaranteed minimum rate will be credited to the contract.
- A specified percentage of gain in the associated index will be credited if that amount is greater than the guaranteed minimum rate.

Therefore, insurers must invest carefully to ensure that they can meet their contract guarantees. The premiums that an insurer receives for its indexed annuities are applied to cover four things:

- the contract's underlying guaranteed minimum rate of return, which is typically covered by the purchase of bonds and bond-like instruments
- contract expenses (including administrative and sales expenses)

- the insurer's profit
- the interest crediting that is associated with the indexed strategy. This is usually covered by the purchase of index call options. By purchasing call options, the insurer is guaranteed that it will have the necessary funds to credit indexed interest greater than the minimum rate guaranteed in the contract. Purchasing an index call option gives the insurer the right to demand and receive a specified amount of cash from the index writer.

Index Call Option Budget

When premiums are allocated to an indexed strategy, the insurer must determine how much of that premium is available to purchase index call options—in short, the insurer must figure an index call option "budget." To determine this budget, the insurer deducts from those aggregate premiums the costs associated with the other aspects of the contract, namely the cost of the required bonds, the expenses for administration and sales, and profits. The balance of premiums remaining is the index call option budget. If the insurer is able to effectively manage the other costs and aspects of the contract, it will have a larger amount with which to purchase index call options.

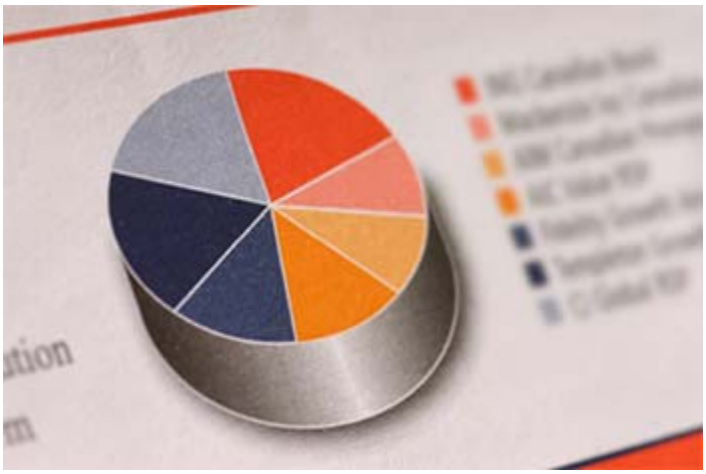
The most significant deduction from premiums to arrive at the index call option budget is the cost of the investments needed to credit guaranteed interest. For that reason, indexed annuities generally have lower interest rate guarantees than similar guarantees found in traditional declared rate annuities.

Complexity of Indexed Annuities

Indexed annuities have become very popular investment vehicles. However, whether their popularity is due to informed consumer enthusiasm or to aggressive marketing tactics by insurers and producers is in question. While indexed annuities may generate returns that are higher than traditional fixed annuities or other guaranteed investments (such as certificates of deposit), and while they do provide for some guaranteed minimum level of return, they cannot be presented as a no-risk market investment, nor can they be likened to a market investment. An indexed annuity is *not* a direct investment in the stock market, and it will *not* be credited with any dividends on the stocks that compose the index. Furthermore, due to participation rates and caps, an indexed annuity's returns will rarely match those of the index to which it is tied.

Indexed annuities are also very complex products, difficult for the average consumer to fully comprehend. These products are characterized by many different design options and unique features. It is imperative that producers thoroughly understand the indexed annuities they represent and be able to explain all of the products' features and restrictions to prospective buyers. One of the principles of a suitable financial product recommendation is that buyers understand the product and how it will meet their needs in a manner consistent with their risk profile and objectives. If the consumer does not understand how the product functions or how his or her funds will be invested, the product is not suitable.

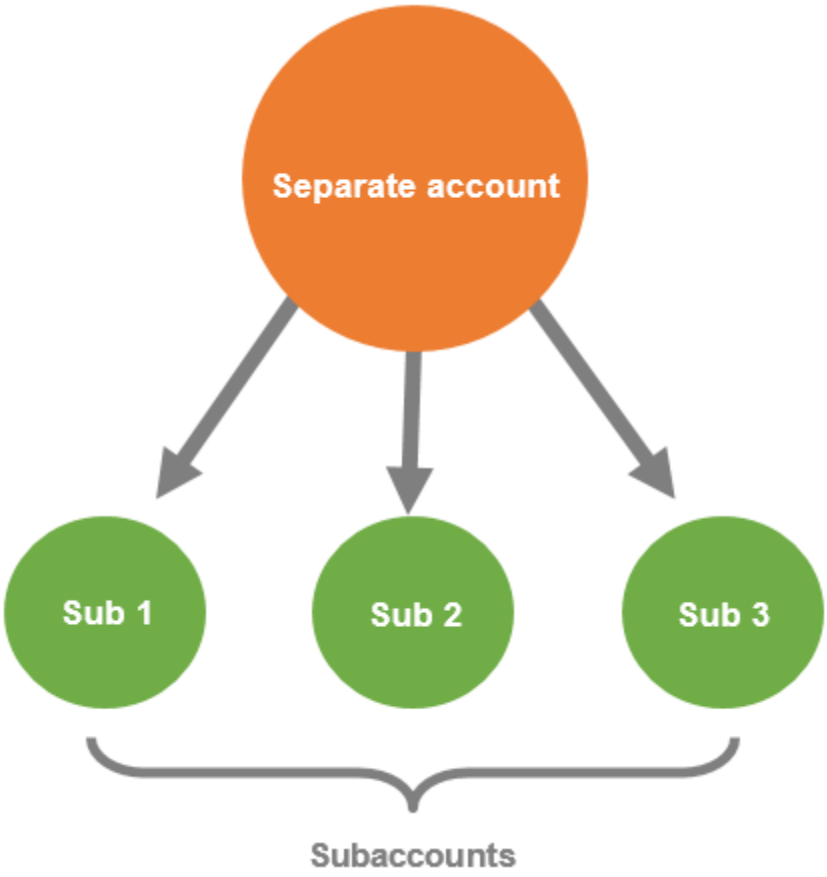
Variable Annuities



In contrast to fixed and indexed annuities that provide for some level of minimum guaranteed returns are **variable annuities (VAs)**. The funds a variable annuity owner deposits into his or her contract are directed into investment portfolios maintained by the insurer. These **separate account** portfolios consist of a variety of stock, bond, and money market accounts and are similar to mutual funds. The performance of a variable annuity's underlying investments determines the growth of the variable annuity: if the underlying investments perform well, the contract's values increase; if the underlying investments perform poorly, the contract's values may decrease.

Unlike traditional fixed or indexed annuities, variable annuities do not carry any mandated minimum interest crediting rate and, as a general rule, there are no guarantees associated with the values or the growth of a variable annuity. If the investments in which the contract's funds are deposited decline, the value of the contract will also decline; the insurer does not guarantee any minimum rate of return. For this reason, the variable annuity owner bears the investment risk for the contract's performance. With a variable annuity, the attraction is with the *potential* for growth that is associated with the contract's underlying investments—a potential that is generally greater than what can be obtained with fixed annuities or other conservative investments, such as certificates of deposit or government bonds.

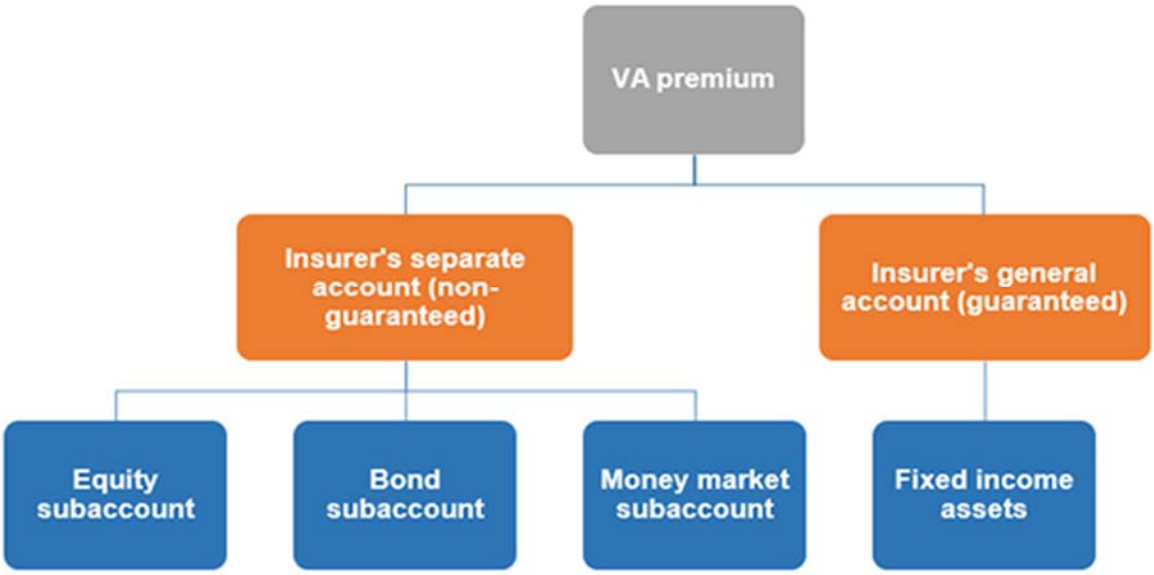
VA Separate Accounts



The investment options for the allocation of variable annuity premiums and contract values are many and diverse. They can include equity, bond, money market, international, and sector accounts. Each separate account includes many diverse investment options; these are the **subaccounts**. For example, an insurer's separate equity account could include subaccount offerings for large cap, mid-cap, and small cap investments, or subaccount offerings based on investment style, such as value, blended, or growth. Within an insurer's separate bond account, subaccount investments might include corporate and government bonds, short-term, medium-term, and long-term. It's not uncommon to find 30, 40, or even more separate subaccounts available for a single variable annuity.

Assets held in the separate account are distinct and segregated from assets held in the insurer's general account. Income, gains, and losses associated with the separate account and its portfolio of subaccounts are credited to or charged against the separate accounts; income, gains, and losses associated with other aspects of the insurer's business do not affect the separate account. The investment performance of the separate account—and the products that are supported by the separate account—are entirely dependent on the investment performance of its underlying subaccounts.

Subaccount funds are typically made available to insurance companies by investment advisory companies which, in turn, employ portfolio managers and analysts to manage these funds. Each fund has a distinct objective that drives its approach to how it is managed and how its funds are invested. As an investment option, most variable annuities also offer a **fixed account fund**. With this option, a VA owner can direct a portion of the contract's premiums into an account that pays a fixed and guaranteed rate of return in a way similar to fixed annuity interest crediting. To the extent that a variable annuity's values are invested in a fixed account, this segment of the contract's principal is secure, and earnings are guaranteed by the insurer. Fixed account values are supported by the insurer's general account.



Each subaccount in a VA is documented by a **prospectus**. The prospectus provides detailed information about the fund, its management, investment objectives, and risks, fees, and other associated disclosures. Fees charged by the investment advisory company for managing its fund are assessed against the assets held in the fund.

VA Accumulation Units

When a variable annuity contract owner deposits premiums into the contract's subaccounts, he or she purchases **accumulation units** in the subaccounts. These units represent a proportional share of the net assets in the subaccount. Because the value of the subaccount fund is subject to fluctuation, the value of the fund's accumulation units is subject to fluctuation as well. When the value of the fund rises, the value of an accumulation unit rises; when the value of the fund falls, the value of an accumulation unit falls. Insurers regularly revalue the units in their subaccounts, typically daily.

Example

To better understand the concept of accumulation units, let's consider an example. Grayson purchased a deferred variable annuity and selected two subaccounts, A and B, for the allocation of his $10,000 premium deposit. He directed $5,000 into Subaccount A and $5,000 into Subaccount B. At the time of his purchase, the value of a Subaccount A unit was $10; the value of a Subaccount B unit was $5. Therefore, Grayson purchased:

500 units of Subaccount A	($5,000 ÷ $10)
1,000 units of Subaccount B	($5,000 ÷ $5)

One month after the initial purchase, the value of an accumulation unit in Subaccount A had risen to $12 and the value of an accumulation unit in Subaccount B had dropped to $4.50. At that point, the value of Grayson's contract would be:

500 units of Subaccount A × $12	=	$6,000
1,000 units of Subaccount B × $4.50	=	+ $4,500
		$10,500

If Grayson were to make another premium deposit into his variable annuity and direct any monies into either of these subaccounts, the funds would purchase additional accumulation units at their then current value (after deductions for expenses and fees). At any given time, the value of Grayson's investment in his variable annuity would be the total of the value of all accumulation units associated with each subaccount in which his funds are invested, plus any values that are invested in the fixed account fund.

Fluctuations in unit values will not change the number of units credited to any subaccount. That number remains constant unless and until additional premium dollars are invested. As the value of the accumulation units in a variable annuity rises and falls, so too does the value of the contract.

Variable Annuity Investment Options

The many investment options within a variable annuity are key to the product's appeal and are a primary reason the product is purchased. Owners can also take advantage of a host of investment strategies and techniques that insurers now commonly offer their VA contract holders. These include the following:

- **automatic asset allocation programs**—With these programs, the insurer designs allocation models that align with specific investment profiles, such as conservative, moderate, moderately aggressive, and aggressive. Owners select a specific model that matches their investment profile, and their premium deposits are then automatically allocated according to the subaccounts that comprise the model. If an asset allocation model is changed, the values in an owner's contract (and any subsequent premium payments) will automatically be reallocated in accordance with the change. Insurers typically offer their asset allocation programs at no charge. Contract owners simply select the allocation model that best matches their investment profile, and their premium deposits will be allocated accordingly.

- **cost-free fund transfers**—Variable annuities offer their owners the option to transfer funds from one subaccount to another, at any time the owner wishes. Insurers might impose some limit on the number of transfers—for example, 25 per year. Owners can transfer funds without incurring any fee or tax. The ability to transfer funds tax free from one subaccount to another enables the VA owner to take advantage of long-term market trends and to match the contract's investment allocation to his or her changing needs and risk tolerance.
- **automatic portfolio rebalancing**—This feature works to maintain the contract owner's original subaccount allocation mix as it was first created. Over time, the original configuration of the allocation of funds within a VA's subaccounts will change due to the performance of the funds. Consequently, as a contract's investment mix changes, it may move out of alignment with the owner's goals and risk tolerance. Automatic portfolio rebalancing brings the mix back in line. Automatic portfolio rebalancing is available to owners who do not participate in the insurer's automatic asset allocation program but who want to maintain a certain percentage balance among the values of their subaccount investments.
- **interest sweeps**—With this option, the interest earned on amounts invested in the fixed account or in a money market subaccount is periodically transferred or "swept" into any one or more subaccounts. This "sweep" occurs regularly on an ongoing basis: monthly, quarterly, semiannually, or annually. Interest sweeps allow the contract owner to maintain the principal amount invested in the fixed account or the money market account while putting its earnings to work in the subaccounts, where potentially higher gains are possible.
- **dollar cost averaging**—Dollar cost averaging is a common investment technique and is available with many variable annuity contracts for no additional charge. Using dollar cost averaging, or DCA, an investor acquires securities in a series of regular purchases instead of in a single purchase. This process enables the investor to average the purchase price of the securities over time, "smoothing out" peaks and valleys in purchase prices. As it applies to variable annuities, DCA is used to purchase additional accumulation units in the contract. These purchases are made by regularly withdrawing a set amount of money from one subaccount fund and depositing it into one or more of the contract's other subaccounts. These withdrawals and purchases occur regardless of the price of accumulation units. Therefore, more units are purchased when prices are low, and fewer units are purchased when prices are high. Over an extended period, DCA tends to reduce the average cost per accumulation unit because, as a general rule, investments increase in value over long periods.

How Annuities Are Funded

Annuities are funded through a single lump-sum premium payment or through a series of premium payments, as and when the owner desires.

Obviously, all immediate annuities require the payment of a single lump sum, which is used to fund the annuitized income stream. For their (nonqualified) deferred annuities, insurers establish the amount that a buyer must pay to purchase the contract, such as $1,000 $5,000, $10,000, or $25,000. Owners can make additional premium deposits at any time, though the insurer might specify a minimum amount for subsequent deposits, such as $25, $50, or $100.

No Limit on Annuity Contributions

One of the benefits of the (nonqualified) annuity is that generally, there is no limit on the amount the owner can contribute to his or her contract. This feature, in conjunction with tax deferral, can make annuities very appealing retirement accumulation products.

For example, consider Alfred and Lorraine, a married couple in their early fifties. For a number of reasons, the couple is behind on saving for their retirement; their primary focus for the past several years has been purchasing a new home and putting their two children through college. Now that these milestones are behind them, the couple is committed to saving seriously for retirement. They're concerned that even with contributions of the maximum annual amount to Alfred's 401(k) plan, they may not be able to accumulate the sum they estimate they'll need for their planned retirement in 12 years. The purchase of a deferred annuity would enable the couple to make additional contributions to their retirement savings goal in any amount they wish, at any time they wish, and those invested dollars will grow, as does their 401(k) plan, on a tax-deferred basis.

Any limit an insurer imposes on deposits into its nonqualified deferred annuity contracts is usually very high, such as $1 million. This restriction applies to any single contribution or to contributions that would bring the contract's total accumulated values to the specified limit.

Annuities that are used to fund qualified plans, such as IRAs, must limit the amount of premium than can be deposited in accordance with the rules that govern the qualified plan.

Summary

- Annuities are classified as immediate or deferred, referring to when the contract is scheduled to annuitize. They are also classified as fixed, indexed, or variable, referring to how the contract's funds are invested, how the funds grow, and whether the insurer guarantees the funds.
- Fixed and indexed annuities provide for guaranteed minimum rates of return and for current interest crediting, which is either declared in advance by the insurer (fixed annuities) or tied to an independent market index (indexed annuities).
- Variable annuities are distinguished by the manner in which their premium funds are invested and the many investment options that are available to the owner within a single contract.
- In contrast to fixed and indexed annuities, which are conservative accumulation and savings vehicles, variable annuities are purchased for their investment aspect and growth potential.
- Premiums deposited into the contract are directed into subaccount funds and are applied to purchase accumulation units. As the value of the investments within the subaccounts changes, so does the value of the accumulation units.
- Owners of (nonqualified) annuities can invest as much or as little into their contracts as they want.
- In addition to their accumulation properties, annuities include many features and benefits that set them apart from other investment options. We will examine these unique features in the next chapter.

Chapter 2 Review Questions

1. What are fixed annuity premium deposits invested in?
    A. the insurer's separate account
    B. the insurer's general account
    C. a stock market index
    D. the state's insurance guaranty fund
2. Felipe owns an annuity that credits a rate of interest that is based on annual percentage changes in the S&P 500. If the index change is positive, the insurer will credit 90 percent of the percentage change to his contract for that year; if the index change is negative, the insurer will credit zero percent to the contract for that year. What kind of annuity does Felipe own?
    A. a traditional fixed deferred annuity
    B. an indexed deferred annuity
    C. a variable deferred annuity
    D. an immediate fixed annuity
3. What are premium deposits in a variable annuity's subaccounts applied to purchase?
    A. shares
    B. annuity units
    C. accumulation units
    D. rights
4. When Geneva purchased her variable annuity, she directed $500 of her initial premium into the product's Subaccount A. The unit value at the time of her purchase was $10. How many Subaccount A units did Geneva acquire?
    A. 5
    B. 50
    C. 500
    D. 5,000
5. Which of the following is a distinguishing feature between fixed and variable annuities?
    A. Fixed annuities can only be funded with the payment of a single premium.
    B. Only variable annuities provide for annuitization.
    C. Fixed annuities allow owners to direct their premium payments into stock and bond accounts.
    D. Variable annuity principal and earnings are not guaranteed by the insurer.

6. When are annuity owners limited as to the amount of premium they can contribute to their contracts?

    A. when any portion of the premiums is allocated to the insurer's separate account

    B. when the contract is the funding vehicle for a qualified plan

    C. when the owner is also the annuitant

    D. at no time, because annuities never impose limits on contributions

Answers to Chapter 2 Review Questions

1. B. Fixed annuity premiums are directed into the insurer's general account. This is an undivided investment account that supports the contractual obligations of the company's guaranteed products. Funds in the general account are invested by the insurer in generally safe, secure investments-primarily long-term quality bonds.
2. B. Because the interest credited to the contract is based on changes in the S&P 500 stock index, Felipe owns a deferred indexed annuity.
3. C. Premium deposits in a variable annuity contract purchase accumulation units in the selected subaccounts.
4. B. The number of subaccount units purchased is determined by dividing the premium deposit by the value of an accumulation unit. In this case, Geneva's premium deposit of $500 purchased 50 accumulation units: $500 ÷ $10 = 50.
5. D. One of the primary differences between fixed and variable annuities is how each product's premiums are invested and how the funds grow. Both product types provide for funding with single or flexible premium payments; both product types provide for annuitization. Fixed annuities guarantee a minimum rate of interest will be credited to the contract, thus securing the owner's principal. Variable annuities provide for the investment of the owner's premiums into nonguaranteed investment subaccounts.
6. B. Annuity contracts that fund a qualified plan, such as an IRA, impose the same limit on contributions that apply to the qualified plan.

Chapter 3
Annuity Features and Characteristics

Overview

We have learned the basics of the different types of annuity products—traditional fixed, indexed, and variable—and how each is designed to accumulate funds. But there are many savings and investment options available to today's consumers for their long-term needs. Why should they choose an annuity? What sets the annuity apart? Conversely, what are the product's drawbacks and limitations? In this chapter, we will examine the fundamental features and characteristics of annuities. Upon conclusion of this chapter, you should:

- understand the annuity's tax-deferred nature
- know the death benefit options that are commonly available with these products
- be able to explain basic annuitization options
- understand annuity charges and expenses and why they are imposed
- know how and when an annuity owner can access the contract's values

Tax-Deferred Accumulation

Annuities come in many different forms and are purchased for many different reasons. However, one thing they all have in common—and one of the most significant benefits they offer—is **tax deferral**. That is, the interest and growth on an annuity's funds accumulate on a tax-deferred basis. As long as these values remain in the contract, they are not subject to tax. Only when earnings are withdrawn or distributed are they taxable. The annuity remains one of the few individual investments a consumer can make outside of a qualified plan that is given this favorable tax treatment.

Tax Deferral + Compounding = Enhanced Gain

Tax deferral greatly enhances an investment's ability to build assets for the long term. Compounding and tax deferral are a powerful team. To illustrate, let's assume that two individuals each have $25,000 to invest. Each is in the 28 percent tax bracket. Larry chooses a taxable investment, one subject to ordinary income taxation; Mary selects a tax-deferred fixed annuity. Assuming that each investment earns a constant 7 percent return over 20 years, the following shows how their $25,000 investments will grow:

Value Over 20 Years, Taxable vs. Tax Deferred				
	5 Years	**10 Years**	**15 Years**	**20 Years**
Larry—28% ordinary tax treatment	$31,968	$40,878	$52,271	$66,840
Mary—tax deferred	$35,064	$49,179	$68,976	$96,742

As you can see, Mary's investment in the tax-deferred annuity—with its earnings compounded and untaxed—readily outpaces the taxable investment. When withdrawn, the earnings on Mary's fixed annuity—$71,742—will be subject to ordinary tax treatment. If Mary is still in the 28 percent tax bracket and she withdraws those earnings all at once, her tax would amount to $20,088, still ahead of Larry's investment in the taxable vehicle. However, if Mary is in a lower tax bracket when she withdraws her funds, say 25 percent, her total tax would be $17,935. In this case, her net investment, after taxes, would amount to $78,807.

Death Benefit

Another feature of the annuity—and another advantage these products offer—is the payment of a **death benefit** in the event the owner or the annuitant dies before the contract has annuitized. This feature provides assurance to contract owners that the values of their contracts will be available to their beneficiaries or heirs in the event of an early death.

The amount payable under an annuity's death benefit provision is usually defined as the greater of:

- the contract's accumulated value at the time of death
- the sum of all premiums paid, less any withdrawals

Because traditional fixed and indexed annuities provide for guarantees on the growth of contract funds, the death benefit associated with these contracts is normally the contract's accumulated value. Variable annuities, whose values rise and fall according to the investment performance of the underlying investment accounts, are subject to loss; however, payment of a death benefit is one aspect of these products that is almost always guaranteed. That amount will be the contract's value at death or the sum of premiums paid (less any prior withdrawals), whichever is greater.

Example

For example, say that Floyd purchased a variable annuity ten years ago when he was 52, with a premium deposit of $35,000. He made no additional deposits and took no withdrawals. At the age of 65, Floyd died. At that point, his contract was valued at $60,000. His beneficiary would receive a death benefit equal to $60,000. Had the market taken a downturn and had the value of Floyd's contract dropped below the $35,000 he had invested in it, the beneficiary would still receive a death benefit of $35,000. For additional charges and through the addition of a contract rider, variable annuities can provide for "enhanced" death benefits, such as a compounded amount or a lock-in of the contract's highest value on any anniversary date.

As mentioned previously, an annuity's death benefit is payable if death occurs *before* the contract has annuitized. If a spouse is the sole beneficiary of an annuity contract, he or she may be able to take ownership of the contract and maintain it (i.e., keep it in accumulation mode) in his or her own name.

Flexible Funding Options

As noted, an immediate annuity is purchased with a single lump-sum premium payment; a deferred annuity can be purchased and funded with a single premium payment or with any number of premium deposits, as and when the owner desires. Unless the product is the funding vehicle for a qualified plan such as an IRA, the amount and frequency of the premium deposits are up to the owner. Consequently, no annual contribution limits are imposed on a (nonqualified) deferred annuity, nor are there any ongoing premium deposit requirements.

An issuing insurer might stipulate a certain minimum premium deposit to purchase a deferred annuity contract; this amount varies. It could be as low as $1,000 or as high as $25,000. After purchase, any additional premium deposits the owner makes might have to be of a minimum amount, but these minimums are typically very low, such as $25 or $50.

Qualified Annuity Funding

The premium deposit rules are different for annuities used to fund qualified plans, such as IRAs. In these cases, premium deposits must conform to the contribution limits that apply to the qualified plan. For example, premium payments to an annuity that funds an IRA would be limited to the annual contribution maximums that apply to all IRAs, taking into account the owner's age. (Those who are 50 and older are allowed to make higher annual contributions to their IRAs, SEPs, 401(k)s, and 403(b)s than those who are younger than 50.)

Annuitization

In addition to tax-deferred accumulation, the payment of death benefits, and flexible funding options, annuities contain a provision for **annuitization** whereby the contract's accumulated values are converted into a stream of periodic income payments. These payments are guaranteed to be made for whatever length of time the owner wishes: for a specified term of years, for life, or for a combination of the two. For this reason, annuities are well suited to late-life retirement planning, when a consumer's priorities and needs typically shift from asset accumulation to income distribution.

Annuitization Date

Most annuity contracts specify a date on which annuitization is scheduled to begin. This date is called the **annuity date**, the **annuity start date**, or the **maturity date**.

With immediate annuities, this date is very soon after contract purchase: typically one month but no later than one year. Its timing mirrors the timing of the income payments. For instance, if the payments are to be received monthly, the start date is one month from contract purchase. If the payments are to be received quarterly, the start date is three months from purchase. If the payments are to be received annually, the start date is one year from purchase.

With traditional deferred annuities, the annuity start date is usually defined and fixed as the contract's tenth anniversary date or the anniversary date that falls in the year the annuitant reaches age 80 or 85, whichever date is later. Most deferred contracts give the owner the option to change the annuity date, enabling the contract to continue its accumulation period for some time after the original annuity date, or to annuitize before the scheduled date.

With deferred income annuities, the start date is selected by the owner, anywhere from 13 months to 40 years in the future. As a general rule, DIAs do not allow the funds to be annuitized before or after the selected start date, though some contracts provide some flexibility on this requirement. Most DIA contracts stipulate that the income start date cannot extend past a certain age, such as 85.

Annuitization Options

Among the available annuitization options, the owner is asked to select the type of income he or she wants, the frequency of payment, and the length of the annuitization period. Though a thorough explanation of annuitization is presented in the next chapter, let's briefly review these options here.

Payout: Fixed or Variable

As a general rule, annuitization of fixed and indexed annuities generates fixed, unchanging income payments for the duration of the annuity payout period. Annuitization of variable annuities produces a variable income stream that rises and falls in accordance with the performance of the product's underlying subaccount investments. However, most variable annuity carriers will offer their contract owners the option of choosing either a fixed payout or a variable payout.

Income Frequency

Annuity owners can determine the frequency of their income payments by selecting a monthly, quarterly, semiannual, or annual payout mode. The most common option is monthly.

Annuitization Length

Annuitizing an annuity's accumulated values also involves a choice of how long the income payments will be made to the annuitant. This choice is up to the owner and may be defined in terms of:

- a specified number of years
- the duration of the annuitant's life
- the joint lives of two annuitants
- a specified life or lives and a certain number of years

Alternatives to Annuitization

Annuitization is assumed with an immediate annuity; the need or desire for an ongoing income stream is the overriding reason an immediate annuity is purchased. Annuitizing a deferred annuity is an option; the owner does not have to convert the contract's funds into an income stream. At the annuitization date—or at any point before that date—a deferred annuity owner can cash in all or a portion of the contract and take the accumulated values. Almost all annuities provide for income or withdrawal options from their contracts in a way that does not require or involve annuitization.

Annuity Charges and Fees

Virtually all investment products include specific fees and charges; annuities are no different. These charges are often a source of criticism; they do, in fact, cut into the contract's performance or serve to reduce the product's liquidity by limiting access to its funds without penalty. However, it's important to understand that such costs are associated with a contract feature or benefit, or they support the guarantees the contract may offer. Consequently, an annuity's charges must be evaluated in light of the benefits they provide. The practitioner must take care to disclose all contract fees and expenses and discuss them in detail with his or her prospects and clients.

Fixed Annuity Fees and Charges

Many of the internal costs associated with fixed annuities are built into the interest rate the insurer credits to the contract. From the spread—the difference between what the insurer earns on its invested assets and the interest rate it credits to its fixed annuity and life insurance products—the insurer covers the commissions it pays to its producers and distributors, its operational costs and reserve requirements, and generates profits. For these costs, the contract owner is not assessed any additional fees. However, for other reasons, fixed annuity owners may be faced with distinct charges.

Surrender Charges

Common to deferred annuities are contract **surrender charges**, which are the fees the insurer assesses for early withdrawals or contract surrenders. Depending on the insurer, the charge may be labeled as a **withdrawal fee** if less than the full contract value is taken, while the term **surrender charge** is reserved for transactions involving the full surrender or termination of the contract. (For purposes of simplicity, the term *surrender charge* will be used to refer to any charge or fee imposed by the insurer for early contract withdrawals or terminations.) Surrender charges help ensure that an insurer can recoup the product's sales and placement costs in the event of early terminations. As a rule, an annuity's surrender charge applies for only a limited time after a contract is purchased—the first five, eight, or ten years, for example.

When purchasing an annuity that includes a surrender charge period, the owner is effectively committing to holding the contract for at least a certain time. If he or she cashes in the contract or takes a withdrawal before the end of that period, a surrender charge may be assessed. For this reason, deferred annuities are fairly illiquid during their early years. Consumers must be informed of any surrender charges their contracts impose. Before an annuity sale is made, the practitioner must determine to the best of his or her ability whether the buyer might need access to the contract's values before the surrender charge period expires.

Insurers use a number of approaches to determine the surrender charges. Two of the most common are the *account value method* and the *premium deposit method*.

Account Value Method

A surrender charge based on the **account value method** assesses a surrender charge equal to some percentage of the contract's accumulated value. For example, a contract might impose a flat 4 percent charge on the contract's accumulated value for the first six years after issue. Assuming a buyer purchased this contract with a $25,000 premium deposit and earned a constant 5 percent return, the following shows the potential charges he or she would face if the contract were fully surrendered during the surrender charge period:

Account Value Method				
Contract Year	**Premium Deposit**	**Account Value***	**Account Value Surrender Charge**	**Surrender Amount**
1	$25,000	$25,000	4%	$1,000
2	$0	$26,250	4%	$1,050
3	$0	$27,563	4%	$1,103
4	$0	$28,941	4%	$1,158
5	$0	$30,388	4%	$1,216
6	$0	$31,907	4%	$1,276
7	$0	$33,502	0%	$0
**Assumes a constant 5 percent net rate of return and no withdrawals.*				

Premium Deposit Method

A surrender charge based on the **premium deposit method** calculates the charge on the amount of the contract's invested premium, applying a percentage that usually declines annually over the surrender charge period. For instance, such a contract might assess a 7 percent charge in the first year, 6 percent in the second year, 5 percent in the third year, and so on. In the eighth contract year, the surrender charge period expires.

Premium Deposit Method				
Contract Year	**Premium Deposit**	**Account Value***	**Premium Deposit Surrender Charge**	**Surrender Amount**
1	$25,000	$25,000	7%	$1,750
2	$0	$26,250	6%	$1,500
3	$0	$27,563	5%	$1,250
4	$0	$28,941	4%	$1,000
5	$0	$30,388	3%	$750
6	$0	$31,907	2%	$500
7	$0	$33,502	1%	$250
8	$0	$35,178	0%	$0
**Assumes a constant 5 percent net rate of return and no withdrawals.*				

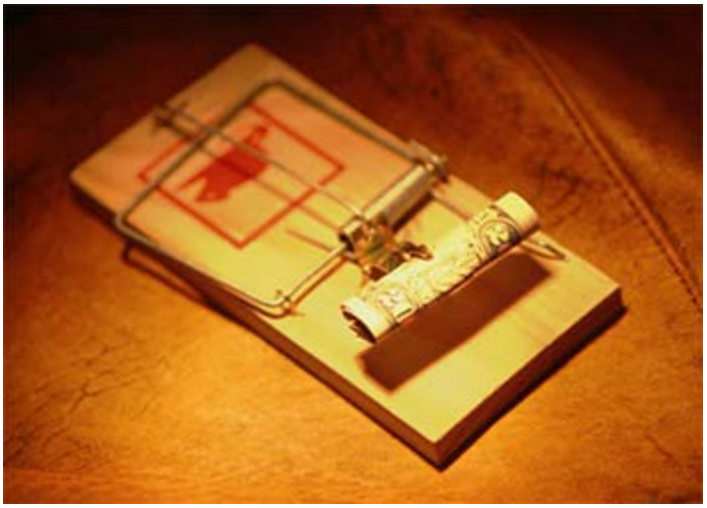
Market Value Adjustments

Some fixed annuities—traditional and indexed—are issued with a **market value adjustment (MVA)** provision, which applies if the contract is surrendered during the surrender charge period. The adjustment works to the detriment of the contract owner if interest rates increased since the contract was issued: an increase in interest rates will cause the insurer to reduce the value of the contract upon surrender to reflect the impact the difference in rates would have had if the contract had been held for its full term. On the other hand, an MVA adjustment can work to the benefit of the owner: the provision will increase the contract's values if, at the time of surrender, interest rates had decreased since contract issue. MVA annuities usually credit higher interest rates than those that do not contain this provision. In no case will an MVA adjustment serve to reduce the contract's value below the minimum guaranteed amount required by state insurance law.

Premium Tax

A number of states impose a tax on annuity premiums. The insurer typically pays the tax but ultimately will assess the tax back to the contract owner either by deducting it from the premium payment or from the contract's accumulated value when the contract is surrendered, annuitized, or pays out its death benefit.

Charges Associated with Variable Annuities



Because of the way in which their funds are invested and managed, variable annuities impose a number of unique charges and fees that fixed annuities do not. The most common fees associated with variable annuities include:

- mortality and expense (M&E) charge
- fund expense charge
- administrative service charge
- contract maintenance fee
- contingent deferred sales charge (CDSC)

Except for the fund expense charge, all VA fees are set forth in the contract. Fund expense charges vary according to which subaccount investments the owner selects; these charges are specified in the fund's prospectus.

Mortality and Expense (M&E) Charge

The cost of a variable annuity's death benefit and annuity charge plus related insurer costs (such as agent commissions and overhead) is called the **mortality and expense (M&E)** charge. This charge is assessed against the values of the separate subaccounts and is deducted before accumulation unit values are calculated. The M&E charge helps ensure that the insurer can meet its contractual obligations for annuitized income payments and a minimum death benefit. Almost all contracts guarantee that the M&E cost will remain the same and will not increase over the contract's life.

Of all the expenses associated with a variable annuity, the M&E charge is the most criticized. It cuts into the contract's overall performance and, over time, can amount to thousands of dollars. All other factors being equal, a variable annuity's investment returns would have to consistently exceed those of an alternate investment, such as a mutual fund, by an after-tax rate equal to the contract's M&E charge for the VA's returns to equal that of the alternate investment.

However, one must keep in mind what the M&E charge covers: the risk of death during the accumulation stage and the guarantee of a minimum annuity purchase rate when the contract is annuitized. If a variable annuity owner dies before annuitizing the contract, his or her beneficiary is guaranteed to receive the contract's accumulated values or the amount invested, whichever is greater, less any withdrawals. This benefit protects the financial interests of the beneficiary and, for this reason, can provide the owner with the incentive to remain invested in the contract: he or she knows that despite market fluctuation, a certain guaranteed amount will always be available to the beneficiary.

By the same token, a VA owner has the assurance that the contract's values can be converted into an income stream at some point in the future, guaranteed payable for as long as he or she specifies. The "price" of this benefit, built into the M&E expense, will not increase over the term of the contract.

Fund Expense Charge

A VA's **fund expense charge** is the cost imposed on the subaccounts for investment management and fund expenses: the charge for the investment company's managing the portfolio of securities within the subaccount, including the costs of buying and selling the securities. Depending on the complexity of the subaccount and the underlying nature of its fund and its investment objectives, this charge will vary. For example, the fee associated with managing a money market fund will be much less than the fee associated with managing an international fund.

Fund expense charges are assessed against the values in each of the subaccounts in which a contract's values are invested. This assessment is usually done daily at an annualized rate. For example, assume that the following three subaccount funds for Variable Annuity XYZ charge these annual expenses:

Large cap fund charge:	.92%
Short-term corporate bond fund charge:	.72%
Money market fund charge:	.57%

Now let's say that Dominick purchased this annuity with a $25,000 premium, allocating $10,000 to the large cap fund, $10,000 to the short-term corporate bond fund, and $5,000 to the money market fund. The fund expense charges she would incur this year would be $92, $72, and $28.50, respectively:

$10,000 × .0092	=	$92.00
$10,000 × .0072	=	$72.00
$5,000 × .0057	=	$28.50

Administrative Service Charge

A VA's **administrative service charge** covers administrative costs associated with servicing the annuity, including the cost of transferring funds, tracking premium deposits, issuing confirmations and statements, record keeping and customer service. On average, this charge amounts to .16 percent of the contract's assets.[4]

Contract Maintenance Fee

A variable annuity's **contract maintenance fee** is an annual fee imposed by the insurance company to cover the administrative costs of maintaining the contract. It typically ranges from $25 to $40 a year but is often waived for contracts whose account values exceed a specified amount (such as $50,000).

Contingent Deferred Sales Charge (CDSC)

Most variable annuities impose a **contingent deferred sales charge** or **CDSC**, which is the equivalent of a surrender charge—i.e., a fee for early contract surrenders. As with fixed annuities, CDSC charges tend to apply for only a limited time after a contract is purchased—the first five, eight, or ten years, for example. The ways in which CDSC charges are imposed on variable annuities are similar to the ways in which surrender charges are imposed on fixed annuities (i.e., account value or premium deposit methods).

Low or No Surrender Contracts

In an effort to be more competitive in the marketplace, a number of insurers now offer variable annuity contracts with no surrender charge fees or surrender charge period. These **no-load** VAs are also known as **C share annuities**. However, no-load VAs rarely offer a fixed account investment option. Because of the way insurers invest for their fixed accounts, surrender charges are necessary to enable the insurer to guarantee the interest rates they credit to assets invested in these accounts. Therefore, contracts that do not impose surrender charges usually do not provide for any guaranteed interest rate investment option.

L share annuities are those with surrender charge periods that are much shorter than traditional VAs, such as two or three years. L share annuities typically charge higher M&E fees.

Free Withdrawal Provision

To provide for some measure of liquidity during the surrender charge period, most annuity contracts—fixed, indexed, and variable—include a provision that allows the owner to take withdrawals from his or her contract without a surrender charge. These **surrender-free withdrawals** are limited annually and are usually defined in terms of:

- a percentage of premium invested
- a percentage of accumulated values
- a percentage of earnings

The most common definition of a contract's free withdrawal allowance is 10 percent of the contract's accumulated value annually. In other words, a contract owner can withdraw up to 10 percent of his or her contract's total value each year without incurring a surrender charge.

For example, let's say Brandy invested $25,000 in a deferred annuity that has a seven-year surrender charge period. At the end of the fourth year, the contract had grown to $32,000. Assuming her contract included the typical 10 percent free withdrawal provision, Brandy could withdraw as much as $3,200 from her contract that year, free of a surrender charge.

Some contracts allow for cumulative withdrawals. Any free withdrawal amount that is not taken in any year "rolls over" to the next year.

Free withdrawals are usually available after the first contract year for the remainder of the surrender charge period. When the surrender charge period expires, so does the provision for free withdrawals because the owner can take any amount from the contract as and when he or she desires.

Free withdrawals are "free" only from the insurer's perspective; the IRS is not so generous. Free withdrawals are subject to income tax and, if taken before the owner's age 59½, a possible penalty.

Crisis Waivers

Annuities also commonly offer provisions for waiving the surrender charge in the event of certain "crises." These crises vary from contract to contract, but generally include:

- death
- disability
- unemployment
- entry into a nursing home
- terminal illness
- the distribution of required minimum distributions (if the annuity is the funding vehicle for a qualified plan or IRA)

If the owner experiences any of these events during the contract's surrender charge period, the surrender charge is waived and the owner (or beneficiary, in the event of death) may take withdrawals from the contract without charge. Again, "surrender-charge free" does not mean "income-tax free." The owner will still face income taxes on any withdrawals and, depending on the circumstance and his or her age, could also be assessed a tax penalty.

Depending on the insurer and the terms of the contract, an additional charge could apply for any of these crisis waivers. Before recommending an annuity contract for purchase, the practitioner should review the terms of any such waivers and, if the waiver has an associated fee, it should be disclosed and discussed with the client. The value the waiver provides must be weighed against the cost it might entail.

Bonus Credits

A number of insurers offer **bonus credits** for their annuity buyers. Those who purchase bonus credit annuities will be credited with an additional amount based on some specified percentage of the premium deposit.

For example, if an annuity offers a bonus credit equal to 3 percent of the contract's initial premium deposit, an individual who purchases this contract with a $25,000 premium deposit would be credited with an additional $750. Another individual who purchased this contract with a premium of $100,000 would be credited with an additional $3,000. Most bonus contracts limit the bonus to the contract's initial premium. A few provide bonuses with each premium payment or with each premium payment made during the first contract year.

Some insurers also make bonus credits available to owners who **annuitize** their contracts. Under this provision, the owner must fully annuitize the contract (or die while the contract is in force).

A **persistency bonus** is another means of encouraging annuities to be held for longer terms. Using a persistency bonus, at the end of a stated contract year—the seventh year, for example—the contract may be credited with additional interest of 1 percent of total premiums paid, less any previous withdrawals or outstanding loan balances. At the end of the eighth and subsequent years, the contract might be credited with additional interest equal to .25 percent of the total premiums paid, less any previous withdrawals or outstanding loan balances.

Cost of Bonus Credits

One might not think there could be any drawback to an insurer crediting an additional amount to its contracts. However, bonus credits have a downside: they always carry some kind of cost. This cost usually takes one of the following forms:

- higher surrender charges and/or longer surrender charge periods
- increased M&E and/or other charges
- lower commission rates for agents who sell the bonus contract

The disadvantage to higher surrender charges and longer surrender charge periods is obvious. Those who purchase bonus annuities under these conditions will be assessed higher charges for early withdrawals or will be locked into the contract for longer periods.

If the contract is a variable annuity and the cost of the bonus is covered by an increased M&E charge, the buyer should consider the effects of that charge over time. Even a slightly increased charge can add up dramatically over the years.

A number of insurers recoup the cost of their bonus credits by paying a lower commission on the sales of such contracts. In this way, the agent or broker pays for this benefit.

The terms of a bonus credit can vary. Some contracts specify that the bonus will be forfeited if the contract holder takes a withdrawal or if the death benefit is paid out during some specified period. Others provide that the bonus will vest over a certain period. Producers must take the time to explain to their clients the terms, conditions, and limitations of any bonus credit that might apply to products they represent.

Guaranteed Living Benefit Riders

Over the past few years, a number of innovative riders have been designed for variable annuity purchasers. These riders offer additional benefits intended for use during the owner's life that are guaranteed to be available regardless of market conditions and regardless of the contract's actual performance. Collectively called **guaranteed living benefits**, or **GLBs**, these riders guarantee that the owner's principal will be protected, and a minimum level of principal will be available for income, accumulation, or withdrawal.

Generally speaking, there are three types of GLB riders:

- **guaranteed minimum income benefit (GMIB)—**guarantees that a minimum level of income payments will be paid if the owner decides to annuitize his or her contract, regardless of the value of the contract upon annuitization
- **guaranteed minimum accumulation benefit (GMAB)—**guarantees that a contract's principal will be safeguarded and will not be drawn down by poor investment performance
- **guaranteed minimum withdrawal benefit (GMWB)—**guarantees that the full amount of the owner's invested principal will be available for systematic withdrawals over a specified number of years, regardless of the contract's actual values

GLB riders are added to a variable annuity for an additional fee. This fee varies widely from rider to rider and insurer to insurer, ranging from a low of about .5 percent to 1.25 percent or more of the contract's accumulated values, deducted annually.

Fixed Annuity Income Riders

Income riders are also available for fixed annuities, primarily indexed product designs. Such riders provide a way for the annuity owner to receive lifetime income payments while preserving the contract's accumulation aspect. In other words, the contract does not have to be annuitized for income payments to be made to the annuitant. Fixed annuity income riders create a separate income value—a hypothetical account—distinct from the contract's accumulated value. This income account is credited with a specified rate of return for a given period (the **growth rate**). At the end of that term, the owner is able to make annual withdrawals of a given percentage from the contract, such as 5 or 7 percent (the income rate). The owner is guaranteed to be able to make these withdrawals for life, even if the contract's actual values are depleted.

Long-Term Care Riders

A number of insurance companies now offer their deferred annuity buyers the option of adding a **long-term care (LTC) insurance rider** to their contracts. These riders are designed to provide cash benefit payments in the event the owner needs long-term care. The cost of the rider is deducted from the annuity's cash value.

If the contract owner never needs long-term care and makes no claims for long-term care benefits against the annuity, he or she can use the product's values as with any deferred annuity: the owner can let the contract accumulate, take contract withdrawals, surrender the contract, or annuitize the contract. If long-term care is needed, the rider will provide funds according to a specific LTC benefit design. Benefits paid under the contract for long-term care are not subject to taxation; thus, using the contract's values for LTC benefits avoids income taxation on the annuity's gain.

Currently, these so-called hybrid long-term care annuities are more common with fixed annuity designs rather than with variable annuities.

Term Insurance Riders

Term insurance riders are sometimes available on annuity contracts. These riders provide additional life insurance protection for a specified period on the lives of the contract owner, his or her children, or others. For coverage on children, coverage is typically limited to a nominal amount, such as $10,000. Other term insurance riders might be limited in amount to some multiple of the basic contract's death benefit, such as four times the amount.

Free-Look Provision

As is common with life insurance policies, annuities are issued with a free-look provision. The free-look provision allows the contract holder to return the contract within a specified period after its delivery and receive a refund of premiums. The free-look period is determined by state law; it is typically ten days. Some states have extended the free-look period to 30 days if the contract purchaser is 60 years old or older.

In most states, the refund of premium due is equal to the contract's accumulation value as of the date the insurer receives notice of the cancelation, plus any charges or fees that were assessed against the contract. Thus, the owner would be subject to risk during the free-look period: he or she would keep any investment gains that the contract experienced during this time and would absorb any losses. Other states specify that the contract holder must receive a full refund of any premiums he or she paid.

Probate Avoidance

Annuities are contracts. As such, they are not subject to probate or to estate administration when the owner dies. Annuity death benefits payable to a named beneficiary pass directly to the beneficiary. They are not part of the estate assets that must be validated and inventoried prior to distribution; therefore, they are not subject to delay or publicity. Upon receiving proof of death, the insurer pays the proceeds directly to the beneficiary.

Summary

- The annuity is a unique product with a variety of features and benefits. It is also a complex product.
- In addition to tax deferral, annuities offer a death benefit and the option for lifetime income through annuitization. Depending on the product design, the cost of these features is built into the interest crediting methodology the insurer uses (fixed product designs) or is deducted from the contract's values (variable annuities).
- Most annuities impose a surrender charge if withdrawals are taken or if the contract is terminated within a specified number of years after issue. For this reason, deferred annuities are fairly illiquid products for the first seven to ten years after purchase, though most contracts offer provisions for some free withdrawals during this period.

- Additional features have been added to annuities over the past few years that offer, through riders, ways to enhance and guarantee the product's values or to provide additional benefits, such as funds for long-term care.
- Annuity contracts are not subject to probate. Upon the owner's death, proceeds pass directly to the beneficiary.

Chapter 3 Review Questions

1. Mary purchased a variable annuity for $50,000. Upon her death ten years later, the contract was valued at $115,000. Assuming her contract provided for the standard death benefit, what amount does her beneficiary receive?

    A. $50,000

    B. $65,000

    C. $115,000

    D. $0

2. Deferred annuity interest earnings are never subject to income taxation, regardless of whether the earnings are withdrawn or kept within the contract.

    A. True

    B. False

3. When is a variable annuity CDSC charge imposed?

    A. when the contract is annuitized

    B. when the contract pays out its death benefit

    C. when the owner deposits funds into the contract

    D. when a withdrawal is made during the surrender charge period

4. Sal owns a fixed annuity that he purchased with a $28,000 premium payment. Three years into the contract, its values have grown to $32,000, and Sal wants to take a withdrawal. Assuming the contract has a standard free withdrawal provision, how much can Sal withdraw without incurring a surrender charge?

    A. $0

    B. $3,200

    C. $4,000

    D. $28,000

5. All of the following are common conditions for which an annuity's surrender charge is waived EXCEPT:

    A. financial hardship

    B. death

    C. entry into a nursing home

    D. disability

Answers to Chapter 3 Review Questions

1. C. The standard death benefit in an annuity is the greater of the contract's invested premiums or its accumulated value as of the date of death.
2. B. The interest earnings on annuity contracts are tax deferred, not tax free. Earnings are not subject to tax while accumulating within the contract; earnings are subject to tax when withdrawn. However, tax deferral enhances accumulation.
3. D. A CDSC, or contingent deferred sales charge, is assessed when a contract is surrendered or withdrawals are taken during the contract's surrender charge period. This period is typically the first seven to ten years after contract issue. Fixed deferred annuities also usually impose surrender charges that extend for a number of years after contract issue.
4. B. The standard free withdrawal provision in most annuity contracts provides for annual withdrawals of up to 10 percent of the contract's accumulated values. In this case, because Sal had accumulated $32,000, he can take a withdrawal of up to $3,200 without penalty from the insurer.
5. A. Financial hardship is not a common condition for waiving an annuity's surrender charge.

Chapter 4
Annuity Income Options

Overview

For many years, the income side of annuities has been largely ignored as consumers and their advisors have focused on the need for accumulation. The transition to planning for income and committing funds for distribution and consumption is a challenge, but one that advisors and clients must embrace. The fundamental issues associated with retirement income planning—to ensure that a retiree's income will last as long as he or she does and to ensure a vibrant, secure lifestyle—are precisely those for which an annuity is designed.

In this chapter, we will discuss how an annuity is designed to produce income. Upon completion, you should understand:

- the concept of annuitization
- the difference between fixed and variable annuitization
- alternatives to annuitization

Basics of Annuitization

As you know, converting an annuity contract's accumulated funds into an income stream is **annuitization**. If the product is an immediate annuity, the conversion occurs very soon after the product is purchased; if the product is a traditional deferred annuity or deferred income annuity, the conversion is scheduled for some point in the future (the contract's start date or maturity date). Annuitized income consists of both principal and interest. A portion of each income payment is a partial return of the premium the owner contributed; the balance is interest the contract earned. Funds not yet paid out under the contract remain invested and continue to accumulate. The projected earnings on these yet-to-be-distributed funds are factored into the annuitization formula.

Annuity Purchase Rate

Annuitization involves liquidating the annuity's values using an annuity purchase rate. The **annuity purchase rate** is the amount of monthly income that each $1,000 of the contract's values will generate based on specified rates of interest and the annuity payout option (term, straight life, joint life, etc.). Let's say, for example, that the annuity purchase rate for a 62-year-old man who wants to annuitize under a fixed straight life option is $6.40. This means that for every $1,000 of the contract's accumulated value, the contract will deliver $6.40 every month for as long as he lives. Therefore, if his contract were valued at $150,000 at the time he annuitized, his monthly annuity payment would be $960 (150 × $6.40 = $960).

The primary benefit of annuitization is the guarantee that the income stream will continue and income will be paid for as long as the owner wishes. In this way, annuitization offers two distinct advantages:

- a regular cash inflow
- peace of mind and security

Annuitized Payout Options

When an immediate annuity is purchased or when a deferred annuity is annuitized, a **payout option** is selected. Also called a **settlement option**, it specifies to whom and for how long payments are to be made. Annuity payout options include the following:

- **payout over a specified number of years**—An annuitization period that is defined by a specified number of years is a **term certain option**. Payouts under this election will extend as long as the defined term—typically 10, 15, 20, or 25 years—without regard to a life contingency. Upon the end of the term, payments stop. If the annuitant dies before the end of the term, payments will continue to the beneficiary. Once the payout term is reached, nothing further is payable, even if the annuitant is still living. For example, say that 65-year-old Alice elected to annuitize her $100,000 annuity fund and chose a 20-year monthly payout. She would receive payments every month until she reached 85. At that point, her payments would end. Had she died during the payout term, payments would continue to a beneficiary for the remainder of the term. If, for instance, Alice died at the age of 72, payments would continue to her beneficiary for 13 years.
- **payout for the duration of the annuitant's life**—Selecting a **life income option** for the payout of an annuity fund ensures that payments will be made to the annuitant as long as he or she lives. At death, payments stop.

- **payout for the duration of joint annuitants' lives**—An annuity income stream can be based on two lives. Called a **joint and survivor income option**, this approach pays an income stream as long as either of the two annuitants is alive. In other words, when the first annuitant dies, income payments continue to the surviving annuitant until the survivor's death. The amount of income that is paid after the death of the first annuitant is normally specified as some portion of the original income stream, such as one-half, two-thirds, or 100 percent.
- **combined life and term certain payout**—An annuity payout option can also combine a **life (or lives) contingency with a term certain**. For instance, a life with ten-year certain election would produce an income stream for the duration of an annuitant's life but would guarantee payment for ten years. Say 68-year-old Joe chose this option for the payout of his annuity fund. Six years later, Joe dies. Income will continue to Joe's beneficiary for the remainder of the ten-year period (i.e., four years). Had Joe lived beyond the age of 78, payments would have continued to him until his death, though nothing further would have been paid to any beneficiary because Joe lived beyond the ten-year guarantee period.

For any given annuity accumulation amount, a longer annuity payout period produces a lower income payment. A 60-year-old individual who selects a ten-year certain payout for her $100,000 annuity fund will receive higher income payments than a 60-year-old with the same amount of funds who chooses a life with 20-year certain payout (all other factors being equal). In addition, an annuitization option that covers more than one life produces a lower income stream than one that covers only a single life, given the same amount of funds.

As part of the payout election decision, the owner also selects how frequently the income payments will be made. As a general rule, the choices are monthly, quarterly, semiannually, or annually.

Fixed Annuitization

Depending on the type of contract—fixed or variable—the annuitized income stream is fixed or variable. **Fixed annuitization** serves to convert a fixed annuity's funds into a steady stream of income payments of the same amount for the length of the annuitization period. The amount of each income payment is guaranteed by the insurer as is the duration of the payment period. For example, annuitizing a $250,000 annuity fund under a straight life income option for a male age 65 would produce monthly income payments of approximately $1,400 for the rest of that man's life. The following chart shows approximate monthly income amounts for other payout options.

Fixed Annuitization Income Amounts $250,000 Annuity Fund	
Fixed Annuitized Payout Option	**Monthly Income**
10-year certain	$2,200
20-year certain	$1,350
Straight life income	$1,400
Life with 10-year certain	$1,320
Life with 20-year certain	$1,200
Joint life (65-year-old spouse; 100 percent survivor payment)	$1,140

This monthly income payment will not change. This consistency is both the advantage and disadvantage of fixed annuitization. The annuitant is guaranteed to receive a steady stream of payments for as long as he or she lives or for any other period desired. Obviously, this provides a measure of financial security. However, because these payments will not change, they are subject to inflation and the eroding effects inflation has on purchasing power over time. Even modest inflation rates can have a devastating impact on a fixed income stream. An inflation rate of only 2 percent, for example, will reduce the value of $1,400 of monthly income to $1,144 in ten years. In 20 years, the income would be reduced to $935. With life expectancies increasing and with retirement periods now extending 20 to 30 years, fixed income streams may fall short of meeting an annuitant's needs.

Some of today's newer fixed annuity products offer provisions for inflation-adjusted income, which serve to increase payments according to some inflation measure (such as the Consumer Price Index). Such provisions typically involve an additional fee. Though still fairly new, some insurers offer "participating contracts," which provide the potential for fixed income payments to increase through dividend payments from the issuing company.

Variable Annuitization

In contrast to fixed annuitization, **variable annuitization** does not generate a fixed, unchanging income stream. Instead, the income payments are tied to the performance of the contract's underlying investments. When the values of these investments increase over time, so does the amount of income paid to the annuitant. Income can also decrease under variable annuitization if and when the value of the underlying funds declines.

The mechanics of variable annuitization can be complex, but basically the process boils down to four factors:

- the assumed interest rate (AIR)
- the annuity purchase rate for the first payment
- the number of annuity units in each subaccount
- the ongoing growth and performance of the subaccount values

The Assumed Interest Rate

Variable annuitization begins with the selection of an **assumed interest rate**, commonly called the **AIR**. The AIR is the rate of investment return or growth that the contract is assumed or projected to experience during the annuitization stage, and it is the benchmark against which actual future growth of the contract's funds will be measured. If the actual net returns on the contract's funds are greater than the AIR, the annuitant's income payments will increase; if the net returns are lower than the AIR, the income payments will decrease. If the net returns are the same as the AIR—in other words, if the actual returns increase at the rate they were assumed to—the annuitant's income will remain the same.

The selection of the AIR can be left to the contract owner or it can be specified by the insurer. If the contract owner selects this rate, he or she usually has a choice of three or four different rates, ranging from 3 to 7 percent. Selecting a high AIR will produce larger initial payments but will also set a higher benchmark for the performance of the contract in the future. With other contracts and other insurers, the AIR is specified in the contract and is typically set at a conservative rate, such as 4 or 5 percent.

The Annuity Purchase Rate

Based on the AIR, the contract's first variable income payment is calculated by applying an annuity purchase rate to the contract's values. As noted, the annuity purchase rate is the amount of monthly income that each $1,000 of the contract's values will generate based on the assumed interest rate and the annuity payout option (term, straight life, joint life, etc.). Again, let's assume that the annuity purchase rate for a 62-year-old man who wants to annuitize under a straight life option with a 5 percent AIR is $6.40. Therefore, if his variable contract was valued at $250,000, his initial annuity payment would be $1,600 (250 × $6.40 = $1,600).

The annuity purchase rate is applied separately to each subaccount in which the contract's funds are invested. The sums that result from each subaccount are added to comprise the first annuity payment.

Converting the Contract to Annuity Units

Once the initial payment from each subaccount has been made, those amounts are converted into **annuity units**. The number and valuation of these annuity units determine the amount of the second and following annuity payments.

Converting the subaccount values into annuity units requires dividing the subaccount's initial payment by the current value of an annuity unit. Returning to our example of an initial $1,600 payment, let's assume that $600 of that amount derived from Subaccount A and $1,000 derived from Subaccount B. These were the only two funds in which the contract was invested at the time of annuitization. Let's further assume that at that point, the value of an annuity unit in Subaccount A was $10 and the value of an annuity unit in Subaccount B was $20. Therefore, the number of annuity units associated with this contract is 110:

Subaccount A:	$600 ÷ $10 = 60
Subaccount B:	$1,000 ÷ $20 = 50

The number of annuity units credited to a contract upon annuitization does not change. Throughout the annuitization period, no matter how long it lasts, the number of annuity units associated with each subaccount remains constant. The contract in our example will continue to hold 60 annuity units in Subaccount A and 50 units in Subaccount B throughout the annuitization period. What does change is the value of the annuity units.

Revaluation of Annuity Units

After the initial payment and at periodic intervals, the annuity units associated with each subaccount are revalued, reflecting the performance of the subaccount funds since the previous valuation period. This revaluation determines the amount of each future annuity payment: each payment is equal to the number of units in each subaccount multiplied by their current value.

If the total net return on all the subaccount funds is equal to the AIR, the annuitized payment will remain the same. If the total net return on the funds is greater than or less than the AIR, then the annuitized payment will increase or decrease accordingly. In our example, if the value of the subaccounts increases at a net rate of 5 percent (the assumed interest rate), the annuitant's payment will remain at $1,600.

Growth Equal to AIR Does Not Increase Payments

Many people might think that if a variable annuity's investment performance equals the AIR—that is, if the annuity funds grow at the same rate as the AIR—the annuity payments will increase. This is not the case. If the annuity's growth is the same as the AIR, the payments will remain level. Only if the growth of the funds exceeds the AIR will payments increase.

The change in a variable annuity's payments is computed as follows:

$$\frac{(1+ \text{actual investment performance}) - (1 + \text{AIR})}{1+ \text{AIR}} = \text{Percentage change}$$

For example, if a contract's total investment return is 8 percent and the AIR is 5 percent, the annuitant's payment will increase by 2.85 percent:

$$\frac{(1 + .08) - (1 + .05)}{1 + .05} = 2.85$$

This formula shows why changes in a variable annuity's investment performance do not match changes in the contract's payments. It will also help the practitioner explain to a VA annuitant why the investment values in the annuitant's stock subaccount might have risen by 10 percent but the income based on that subaccount increased by only 5 percent.

Is Annuitization Irrevocable?

Traditionally, annuitization has been irrevocable. Once a contract was annuitized, the payment stream could not be changed or halted. This has long been one of the drawbacks to annuitization, and the payout terms of many contracts still function this way. However, in recent years, a number of insurers have begun to re-engineer their annuitization structures to provide more liquidity or greater access to an annuity's values during the payout phase. These options include:

- the ability to make withdrawals during annuitization
- the ability to receive an *advance* of a given percentage of income payments (an option usually associated with a life and term certain payout)
- the ability to halt annuitization and take the contract's remaining values in a lump sum (**commutation**)

Other Annuitization Options

Annuitization does not have to involve the full amount of a contract owner's funds. He or she can choose to annuitize only a portion of the values, leaving the remainder to continue accumulation for future withdrawal or future annuitization.

Split Option

Some deferred annuity owners might prefer a "split" option: a portion of the annuity funds can be used to purchase an immediate annuity to produce income for a specified, limited time, while the balance remains invested in the deferred annuity to grow back to the original amount over the same period.

For example, let's say that 65-year-old Bob has $100,000 invested in a variable annuity. He transfers $30,000 of that amount into an immediate five-year term certain fixed annuity. That will generate about $6,400 a year in tax-advantaged income.[5] The remaining $70,000 stays in the variable annuity. If the funds in the VA net a constant return of 7.5 percent over the five-year term period, Bob will have brought his accumulation back to $100,000. At that point, he can re-evaluate his options in light of how his needs or objectives changed over the five-year period.

Alternatives to Annuitization

Deferred annuity owners do not have to annuitize their funds—they have other options. After the contract's surrender charge period expires, accumulated values can be taken in a lump sum or in any amount when and as the owner wishes. Two alternatives to annuitization that are popular among annuity owners are *systematic withdrawals* and *lifetime income withdrawals*.

Systematic Withdrawals

Systematic withdrawals provide for taking distributions from an annuity contract on a programmed basis. Thus, owners take regular withdrawals either monthly, quarterly, semiannually, or annually according to specified terms.

Under a systematic withdrawal program, the withdrawals are taken first from the contract's earnings. This arrangement leaves the principal intact so that it continues to grow. If and when withdrawals exceed the contract's interest earnings, principal will be tapped.

Systematic withdrawals are available under both fixed and variable annuities. Under a fixed annuity, the withdrawals are of specific dollar amounts or a percentage of accumulated value. With a variable annuity systematic withdrawal program, withdrawals are defined in terms of a specified dollar amount or a specified number of accumulation units. Under the first, *dollar amount* withdrawals are taken pro-rata from each of the contract's subaccounts or from any account or accounts the owner specifies. Under the second—a specified number of accumulation units—*units* are withdrawn pro-rata from the contract's subaccounts (or from any accounts the owner designates), converted into dollars at their current value and then distributed. In this way, the actual dollar amount the owner receives will vary as the value of the subaccount units fluctuates.

Systematic withdrawal programs are very flexible: they can start and stop at the owner's discretion, and the amount and timing of the withdrawals can be adjusted at any time. However, withdrawals do not receive the same tax treatment as annuitization. Each withdrawal is considered to consist fully of interest earnings until all interest earned is depleted. As such, each withdrawal is fully taxable. In addition, if withdrawals begin before the owner's age 59½, they may also be subject to a 10 percent penalty.

Furthermore, a systematic withdrawal program does not guarantee lifelong income. It's possible that funds will be depleted during the owner's life.

Lifetime Income or Withdrawals

Riders can be added to both fixed and variable annuities that provide for **lifetime withdrawals** or **income payments**. These riders, available for an additional premium, create hypothetical benefit bases from which the withdrawal or income amounts will be calculated. They then guarantee that the withdrawals or income will be available for as long as the annuitant lives (or for some other guaranteed period). When the annuitant elects to begin taking income or making withdrawals, a payout factor is applied to the income withdrawal base; this determines the guaranteed annual payout or withdrawal amount. The withdrawals are made from the contract's accumulated values; however, during the withdrawal stage, interest is still credited to the contract's cash value. This value remains available to the owner at all times, even as it is being drawn down.

Summary

- Delivering a steady income stream is one of the benefits annuities offer. The income stream can be designed to extend as long as the owner desires and generate either fixed or variable amounts.
- Fixed annuitization pays the same amount every payment period for the duration of the payout period.
- Variable annuitization will produce fluctuating income payments as the values in the contract's subaccounts rise and fall with the performance of the underlying funds. The assumed interest rate, or AIR, chosen upon annuitization sets the benchmark against which payments are made: if the performance of the underlying funds nets a return that is greater than the AIR, payments will increase. If performance is less than the AIR, payments will decrease. If the funds increase at a rate equal to the AIR, payments will remain the same.
- Though annuitization can assure a lifelong income stream, it requires the contract owner to commit his or her funds to liquidation. For this reason and many others, many people are reluctant to annuitize. They might prefer to take advantage of an alternate approach to creating income, such as a systematic withdrawal option.
- Newer annuity products offer options for partial withdrawals during the annuitization stage or can provide for lifetime withdrawals.
- As the ranks of retirees continue to grow, annuity issuers are certain to introduce ever more innovative income options and product designs that focus on flexibility for changing needs and objectives.

Chapter 4 Review Questions

1. Which of the following best defines the annuity purchase rate?
    A. the amount of monthly income that each $1,000 of the contract's values will generate
    B. the average interest rate that the contract earned between the issue date and the annuitization date
    C. the initial premium necessary to produce $1,000 of monthly income
    D. the guaranteed minimum rate of return that will be credited to the contract during its accumulation phase
2. Mary, age 65, elects to annuitize her $150,000 variable annuity under a straight life income option. As specified in her contract, the AIR is 5 percent, which produces an initial payment of $950. If the values in her contract net a constant return of 5 percent, what will Mary's next income payment be?
    A. $950
    B. $998
    C. $1,050
    D. $1,110
3. When Clyde elected to annuitize his variable annuity contract, he was credited with 100 annuity units in his equity subaccount. The market took a downswing, and Clyde's equity account lost value. To recalculate the current value of his subaccount, the insurer will reduce the number of annuity units associated with this subaccount.
    A. True
    B. False
4. One of the disadvantages to deferred annuity contracts is that they require annuitization as the only means to access the contract's full value.
    A. True
    B. False
5. Franklin is using his variable annuity to support his income. Every quarter, 20 accumulation units are taken from his contract and then converted into cash at their then current value. What kind of distribution has Franklin elected?
    A. fixed annuitization
    B. variable annuitization
    C. systematic withdrawal
    D. income optimization

Answers to Chapter 4 Review Questions

1. A. The annuity purchase rate is the amount of monthly income that each $1,000 of the contract's values will generate based on specified rates of interest and the annuity payout option (term, straight life, joint life, etc.).
2. A. If a variable annuity's values grow at the assumed interest rate, the annuitized payments will remain level.
3. B. Once a variable annuity is annuitized, the number of annuity units associated with each subaccount remains fixed. However, the value of those units changes, rising and falling with the value of the subaccount.
4. B. Annuitization is an option; owners can access their funds through full or partial withdrawals from the contract.
5. C. Franklin has elected a systematic withdrawal plan whereby a set number of his contract's accumulation units are periodically withdrawn and turned into cash distributions.

Chapter 5
Annuity Taxation

Overview

Annuities offer many advantages, chiefly favorable tax treatment. The tax treatment of annuities compared to that of other investments, such as certificates of deposit or mutual funds, is one of the reasons that many consumers choose annuities to accumulate their long-term savings. However, annuities are not tax-free. At some point, taxes will be due and owed on the product's earnings and gains. Producers who represent and sell annuities should be familiar with their tax treatment and must be able to explain this treatment to prospects and clients.

In this chapter, we examine how annuities are taxed at all phases: during accumulation, upon withdrawal, upon annuitization, and at death. Upon conclusion of this chapter, you should:

- understand the basic principle of annuity taxation
- know how annuity income and withdrawals are taxed
- be able to explain the concept of the exclusion ratio
- understand the tax consequences of an annuity's death benefit for the contract's beneficiary
- know how an annuity can be used for qualified rollovers
- understand the basics of 1035 exchanges

The tax treatment of nonqualified annuities is different from that of qualified annuities. This chapter addresses both. The first portion focuses on the tax treatment of nonqualified annuities; qualified annuity taxation is addressed at the end of the chapter.

Basic Principle of Annuity Taxation

To understand (nonqualified) annuity taxation, it's best to begin with the following basic principle: *Contract principal is not subject to taxation; interest earnings are subject to taxation.*

Amounts that are used to fund an annuity—the owner's premium deposits—are the contract's principal. Unless these funds were deducted or exempted from income when they were deposited in the contract (as might be the case if the contract funds a traditional IRA or other qualified plan), they are not subject to taxation when they are withdrawn from the contract. What *is* subject to taxation is the interest or growth on an annuity's principal when it is withdrawn or distributed. Any claim that an annuity is tax free is not true. At issue is *when and how* the contract funds are taxed.

Throughout this chapter, we will examine the when and how of annuity taxation for each of the following situations:

- during accumulation
- when funds are withdrawn
- when funds are annuitized
- when funds are distributed due to the owner's or annuitant's death

Tax-Deferred Accumulation

The tax treatment of annuities has been subject to many changes over the years. Not all of these changes have been favorable; in fact, most have not. But one advantage has held: the accumulation of funds within an annuity is not taxable. This advantage greatly enhances the product's accumulation ability. Interest compounded on interest, unhampered by taxes, accumulates at a greater rate. All earnings and returns that an annuity generates within the contract are fully available for ongoing growth and accumulation, undiminished by taxes.

For example, a $100,000 investment in an annuity that nets a constant 6 percent return over 20 years will grow to $320,700. For an investor in the 30 percent tax bracket (combined state and federal), the same 6 percent return on a fully taxable investment is reduced to 4.2 percent after tax. His or her investment will have accumulated to $227,600 over the same period. The difference—$93,100—is attributed to tax deferral.

For this reason, deferred annuities can appeal to those in higher tax brackets who seek tax-favored ways to accumulate savings, especially if they anticipate that their tax rate will drop once they reach retirement and they want to access their funds. As noted earlier, annuities remain one of the few investment vehicles outside of a qualified plan to be given tax-deferred accumulation treatment.

Taxation of Annuity Withdrawals

Most of the changes affecting the taxation of annuities have had the intent and effect of promoting these products for long-term retirement savings and discouraging their use as short-term tax-favored investments. This emphasis is apparent in the changing way that annuity withdrawals were and are taxed.

Taxation Before 1982

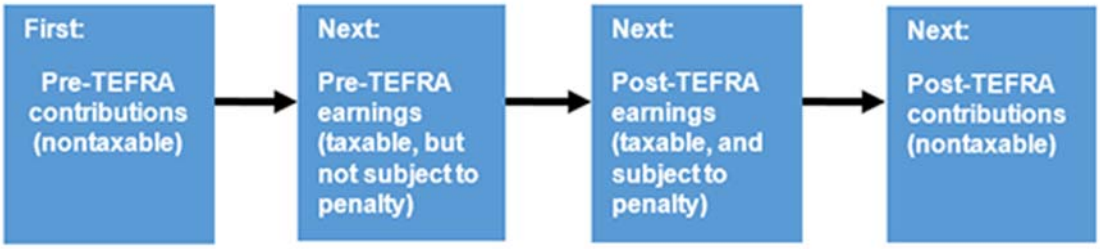
Prior to 1982 and the passage of **the Tax Equity and Fiscal Responsibility Act (TEFRA)**, the annuity product was treated very favorably for tax purposes. Not only were accumulating amounts within the contract not subject to tax, but any withdrawals that the owner took from the contract before annuitization were given **first-in/first-out (FIFO)** treatment. In other words, amounts first put into the contract (the premium deposits) were considered first to be withdrawn. Because principal is not subject to taxation, any withdrawals an annuity owner took from his or her contract were not taxed unless and until withdrawals exceeded the amount invested.

Taxation After TEFRA

TEFRA reversed this treatment. Annuity withdrawals are now treated on a **last-in/first-out (LIFO)** basis: funds last put into the contract—interest earnings—are deemed first to be withdrawn. Therefore, annuity withdrawals are completely taxable to the extent of interest the contract has accumulated.

For example, let's say that at the age of 50, Fanny deposited $50,000 in a fixed annuity. Five years later, the contract has grown to $64,000. At this point, her contract consists of $50,000 of invested principal and $14,000 of earnings. Now let's say Fanny takes a $10,000 withdrawal. The full amount of this withdrawal will be subject to tax because it is deemed to be fully a withdrawal of interest earnings. Had Fanny taken $20,000 from her contract, that withdrawal would have been considered to consist of $14,000 in interest (taxable) and $6,000 in principal (not taxable).

Annuity owners who purchased their contracts before the 1982 TEFRA change are grandfathered. That is, their contracts continue to offer FIFO treatment. To the extent of contributions made before August 14, 1982, and earnings thereon, a pre-TEFRA annuity provides for much more favorable tax treatment. Producers should be extremely careful about exchanging any pre-TEFRA contract for a newer contract because this favorable tax treatment would then be lost. The progression of distributions or withdrawals from a pre-TEFRA that was later exchanged for another annuity would be as follows:



Annuity withdrawals are taxed as income at ordinary tax rates. They are not given lower capital gains treatment.

Penalty on Withdrawals Before Age 59½

TEFRA imposed another provision on annuity withdrawals. If a withdrawal is taken before the owner's age 59½, it is subject to a penalty in addition to taxation. Originally, the penalty was 5 percent; it was later increased to 10 percent, where it remains today.

The penalty is applied to the amount of the withdrawal that is taxable; it is not applied to any principal that is withdrawn. Returning to the previous example, because Fanny was 55 years old when she took her $10,000 withdrawal, she is subject to a 10 percent penalty. Therefore, because the full amount of the withdrawal ($10,000) is taxable, the full amount of the withdrawal is penalized. In addition to income tax, Fanny must pay a penalty of $1,000 on her withdrawal.

It's important to keep in mind that the portion of a pre-59½ withdrawal that is subject to penalty is the *taxable* portion of the withdrawal. Again, neither taxes nor penalties apply to invested premium when those amounts are withdrawn (as long as those premiums were not deducted when they were contributed to the contract). For example, assume that Craig deposited $50,000 in a (nonqualified) deferred annuity at the age of 42. Ten years later, the contract has grown to $75,000: $50,000 in invested premium and $25,000 in interest earnings. Craig takes a $65,000 withdrawal. Of this $65,000 withdrawal, $25,000 would be considered a taxable distribution of interest earnings; $40,000 would be considered a nontaxable distribution of principal. Because he is younger than 59½, Craig would also be assessed a 10 percent penalty of $2,500 on the $25,000 of deemed interest earnings that were withdrawn.

Exceptions to the 10 Percent Penalty

Under the following limited circumstances, the 10 percent penalty for early withdrawals from an annuity contract is waived:

- death
- disability
- annuitization

Another way to avoid the 10 percent penalty is to take the distribution in a series of substantially equal payments over the owner's life expectancy (or the joint life expectancies of the owner and beneficiary).

Withdrawals for Long-Term Care Riders

The tax treatment of annuity withdrawals changed again with passage of the **Pension Protection Act** in 2006. This law recognized the growing need for long-term care and long-term care insurance. The act provided that, beginning in 2010, charges against or withdrawals from nonqualified annuities that are used to pay for a long-term care insurance rider attached to the contract will be treated on a FIFO basis—that is, withdrawals used for these purposes will not be subject to tax or penalty. This change allows withdrawals for these purposes to be taken as reductions of basis.

Taxation of Annuitized Income

The taxation of annuitized income recognizes that each income payment consists partly of interest or earnings and partly of the owner's invested principal. Therefore, annuitized income is taxed in such a way as to exclude principal and tax the balance. This is done by applying an **exclusion ratio**. This ratio calculates the proportion of annuitized income that is attributable to principal and is, therefore, not taxable.

For *fixed annuity* income, the exclusion ratio formula is:

$$\frac{\text{Investment in the contract}}{\text{Expected return}}$$

The investment in the contract is the amount the owner contributed in the form of premium deposits (less any previous withdrawals). The expected return is the total amount the annuitant (or annuitants) can expect to receive as income payments under the contract. If payments are for a fixed term certain (no life expectancy is involved), the expected return is simply the sum of the guaranteed payments. If payments are based on a life expectancy, the expected return is determined by multiplying the sum of one year's payments by the annuitant's life expectancy (or joint life expectancies if there are two annuitants) based on IRS life expectancy tables.

For *variable annuity* income, the exclusion formula is slightly different:

$$\frac{\text{Investment in the contract}}{\text{Number of anticipated payments}}$$

The investment in the contract is the same as for fixed annuity income: the amount the owner contributed to the contract in the form of premium deposits (less any prior withdrawals). The number of anticipated payments is the number of years that the variable annuity income will be paid based on the selected annuity payout option. If the payout is over a set number of years, such as 20 or 25, that number is used for the calculation. If the payout is based on a life expectancy, IRS life expectancy tables are used to determine the length of the payout period.

Examples

To better understand the application of the exclusion ratio for both fixed and variable annuity income, let's look at two examples.

Example 1: Fixed Annuitization

Assume Sid invested $50,000 in a traditional fixed annuity at the age of 50. Twenty years later, the contract has grown to $130,000, and Sid decides to annuitize the full amount over his life expectancy. Based on the insurer's annuitization rates, he will receive monthly payments of $930 for the rest of his life ($11,160 annually). According to the IRS life expectancy table that is used for this purpose, Sid's remaining life expectancy is 16 years. Therefore, the expected return under this contract is $178,560 (16 × $11,160 = $178,560) and the amount of his annual annuity income that is excluded from tax each year is 28 percent, or $3,125.

$$\frac{\$50{,}000}{\$178{,}560} = 28 \text{ percent}$$

Example 2: Variable Annuitization

Assume that Denny invested $150,000 in a variable annuity at the age of 58. Seven years later, the contract has grown to $250,000, and Denny opts for variable annuitization on a straight life basis. According to the IRS table that is used for this purpose, Denny's life expectancy is 20 years. Therefore, the amount of his annuity income that is excluded from taxation each year is $7,500:

$$\frac{\$150{,}000}{20} = \$7{,}500$$

If Denny's annuity income for this year was $18,000, then $10,500 would be taxed, and $7,500 would be received tax free as a return of principal.

For both fixed and variable annuities, the same exclusion amount applies every year until all principal in the contract has been recouped. The exclusion ratio is designed to allocate the return of the owner's principal equally over the duration of the payout period. In these two examples, the $3,125 per year exclusion for Sid will account for his full $50,000 investment in his contract in 16 years, which is his statistical life expectancy (16 × $3,125 = $50,000). For Denny, the $7,500 per year exclusion will account for Denny's full $150,000 investment in the contract in 20 years, which is his life expectancy ($7,500 × 20 = $150,000).[6]

If the annuitant lives beyond his or her life expectancy (or beyond the annuity period certain) and income payments continue, they will consist fully of interest earnings. At this point, the annuitized income becomes fully taxable.

Annuitized income, like annuity withdrawals, is subject to tax at ordinary rates.

Taxation of Annuities at Death

The taxation of annuities and annuity income when the owner dies can be complicated. Here we will explain the general rules.

Death Before Annuitization

If an owner dies before his or her contract has annuitized, the contract provides for a death benefit to be paid to a named beneficiary. Unlike life insurance, the death benefit paid under an annuity contract is not tax free to the beneficiary. Nor does an annuity grant a step-up in basis to the beneficiary. The amount taxable to the beneficiary is the amount of the death benefit that exceeds the contract's invested premium.

For example, let's say that Pauline's VA contract specifies the death benefit as the contract's invested principal or its accumulated values at the owner's death, whichever is greater. Pauline had deposited a total of $50,000 in the contract and, when she died, it was worth $85,000. Her beneficiary would receive the greater amount—$85,000—and would be responsible for income tax on the $35,000 gain. Alternatively, the beneficiary could choose to receive the death benefit as annuity income. In this case, the payments would be taxed according to the exclusion ratio: the investment in the contract would be the amount that Pauline contributed ($50,000); the number of payments to be received would be based on the beneficiary's life.

An annuity's death benefit can be taken in a lump sum, annuitized over the life of the beneficiary, or distributed fully within five years of the owner's death. The beneficiary owes income taxes as the income payments are made. Extending the receipt of the income payments over time enables the beneficiary to spread the tax liability. If the beneficiary is the spouse, the tax rules allow the spouse to take ownership of the contract and continue tax-deferred accumulation.

Death After Annuitization

If death occurs after a contract has annuitized but before the full amount due under the payout option has been paid—as might be the case, for example, with a term certain payout—the beneficiary can receive the remaining payments tax free until the original investment in the contract has been paid out. After that, any remaining payments are fully taxable to the beneficiary.

Estate Taxation

For purposes of the federal estate tax, the general rule is that an annuity's value is included in the owner's gross estate. If the owner dies before annuitization, the full value of the annuity is included in his or her estate. If the owner dies after annuitization has begun and remaining values are left to be paid to a beneficiary, the amount included in the owner's estate is the present value of the future payments.

1035 Exchanges

The federal tax code recognizes the value of annuities and life insurance in providing financial security. As such, it created a special provision that provides a great deal of flexibility for the use of these products and offers unique planning opportunities. This provision appears in **Internal Revenue Code Section 1035**, which addresses the exchange of life insurance, annuities, and qualified long-term care contracts.

The general tax rule regarding the sale or exchange of property is that the transaction is a taxable event. Any gain that the owner recognizes on the sale or exchange of property is taxable. Not so with life insurance, annuities, and long-term care policies. Section 1035 provides that certain exchanges of these types of contracts are *not* taxable. These include the following:

- the exchange of a life insurance policy for another life insurance policy
- the exchange of a life insurance policy for an annuity
- the exchange of an endowment policy for an annuity
- the exchange of an annuity for another annuity
- the exchange of a life insurance policy for a qualified long-term care contract
- the exchange of an annuity for a qualified long-term care contract
- the exchange of a qualified long-term care contract for another qualified long-term care contract

The ability to make **1035 exchanges** is one of the most important tax benefits that annuities offer. At any point in their lives, annuity owners always have the option to upgrade to a different annuity contract that could be more appropriate for their needs. Annuity owners now also have the option of exchanging their contracts for a qualified long-term care insurance policy.

1035 Exchange Rules

To ensure that the transaction is not taxable, 1035 annuity exchanges must comply with the following rules:

- Both annuity contracts must be nonqualified.
- Both contracts must have the same owner and, with some insurers, the same annuitant. After the exchange, the ownership/annuitant structure can be changed in the new contract if warranted.
- The exchange must occur between the insurer that issued the old contract and the insurer that is issuing the new contract. The owner cannot take possession of any funds. This arrangement is carried out by assigning the original contract to the new company in exchange for the issue of a new contract. The new company will issue the replacing contract and will then surrender the existing contract. If the client were to receive the funds directly, the transaction would be considered a contract surrender, and any gain in the contract would be taxable. (If the client were younger than 59½, the 10 percent penalty would apply, too.)

A 1035 exchange does not have to involve different insurers. A contract issued by one insurer can be exchanged for another contract issued by the same insurer. Other than reporting requirements that apply to internal exchanges, the rules remain the same.

With the new contract, the values retain the same character they had under the old. That is, the proportion of invested principal and interest earnings that the previous contract contained carries over to the new contract. If, for example, Alicia purchased a variable annuity ten years ago for $50,000 and today, when the contract is valued at $108,000, she decides to exchange it for a new VA contract, the new contract will be deemed to hold $50,000 in principal and $58,000 in interest earnings.

Partial Exchanges

For many years, the issue of partial 1035 exchanges was uncertain. Could a client exchange a portion of his or her annuity values for a new contract and, if so, what values would be exchanged: principal or interest? In 2003, following a decision of the U.S. Tax Court that found in favor of partial exchanges, the IRS released **Revenue Ruling 2003-51**, stating that partial annuity exchanges would be considered tax-free exchanges. This ruling provided guidelines as to how the cost basis (principal) and gain of the amounts in a new contract would be treated. Specifically, all values retain the same proportion of principal to earnings as they held in the original policy before the exchange.

Let's say, for example, that before an exchange, Manny's annuity was valued at $150,000: $100,000 in invested principal and $50,000 in earnings. He exchanges $100,000 of that contract's value for a new annuity. The remaining $50,000 of values in his original contract would retain the same ratio of principal to earnings (66.7 : 33.3). The $100,000 transferred into his new contract would assume the same. The following chart illustrates this concept:

Partial Exchange Example			
	Contract #1 Before Exchange	**Contract #1 After Exchange**	**New Contract #2**
Value	$150,000	$50,000	$100,000
Invested principal	$100,000 (66.7%)	$33,350 (66.7%)	$66,700 (66.7%)
Interest earnings	$50,000 (33.3%)	$16,650 (33.3%)	$33,300 (33.3%)

Caution Required for Partial Exchanges

At the same time the IRS issued its ruling that allowed partial 1035 exchanges, it also issued notice that it would view these transactions carefully to determine whether partial exchanges were being used as a way to avoid taxes on contract withdrawals. The IRS's concern is that, because a partial exchange has the effect of altering the amount of funds in a contract that are subject to tax upon withdrawal, contract owners could abuse the tax laws.

For instance, let's say the owner of the contract in the preceding example wanted to take a $40,000 withdrawal. Before the partial exchange was made, the original contract consisted of $100,000 in principal and $50,000 in interest earnings. A $40,000 withdrawal from this contract would be considered fully a withdrawal of interest and is fully taxable:

Before the Exchange:

However, once the partial exchange occurs, the original contract, now valued at $50,000, is deemed to consist of $33,350 in invested principal and $16,650 in interest earnings. A $40,000 withdrawal from this contract would result in only $16,650 being subject to tax:

After the Exchange:

The IRS was slow to define how it would treat the issue of partial withdrawals following an exchange. After several interim announcements in the form of private letter rulings, the IRS set the record straight—twice—with the release of two Revenue Procedures: Rev. Proc. 2008-24 and Rev. Proc. 2011-38.

Rev. Proc. 2008-24

Under **Rev. Proc. 2008-24**, the IRS imposed a 12-month moratorium on any further withdrawals or surrenders from contracts involved in a partial annuity exchange—both the original and the new contract. Violating this moratorium—that is, taking a withdrawal or surrender from either contract within 12 months after the partial exchange—would void the original transaction's qualification as a Section 1035 exchange. The moratorium was intended to prevent contract owners from making a partial exchange and then surrendering the contract soon afterward (which would allow tax-free recovery of more principal than if the same amount had been withdrawn from the original policy).

Rev. Proc. 2008-24 provided a number of exceptions to the partial exchange moratorium rule. It stated that a partial annuity exchange would not be retroactively disqualified if any of the following events occurred after the exchange but before the subsequent withdrawal or surrender:

- The contract owner reaches age 59½.
- The owner dies.
- The owner becomes disabled.
- The owner becomes divorced.
- The owner becomes unemployed.
- The distribution is required as part of a structured settlement.
- An "other life event," as determined by the IRS, occurs.

Rev. Proc. 2011-38

After issuing Rev. Proc. 2008-24, the IRS received numerous complaints that the rules were confusing and impractical. In the wake of these concerns, the IRS issued **Rev. Proc. 2011-38**, which modifies the previous rules:

- The 12-month moratorium on further withdrawals or surrenders from contracts involved in a partial annuity exchange was reduced to 180 days.
- The rule that required certain events be met during the moratorium period to avoid disqualification as a tax-free exchange was eliminated.

Rev. Proc. 2011-38 applies to the direct transfer of a portion of an existing annuity's funds to a new annuity contract regardless of whether the two contracts were issued by the same or different insurers. It pertains to transfers that occur on or after October 24, 2011.

Exchanges for Long-Term Care Insurance

Effective in 2010, the provisions of Section 1035 were expanded to include long-term care policies. This came about as a result of the Pension Protection Act of 2006, and today, a life insurance policy or a nonqualified annuity can be exchanged, tax free, for a qualified long-term care insurance policy. Again, this law recognizes the growing need for long-term care coverage. It will enable current life and annuity owners to use the values of their contracts to purchase this coverage with no current tax implications. This law will serve aging baby boomers as they seek ways to safeguard all aspects of their financial security in retirement.

Rollovers and the Taxation of Qualified Annuities

The financial services industry is preparing itself for what will soon be a huge movement of investor funds. As baby boomers retire, they will be bringing with them billions and billions of dollars from qualified employer retirement plans such as 401(k)s and 403(b)s and looking for new retirement investment vehicles. The movement of qualified money from one plan to another can be accomplished through a **rollover**. A qualified rollover enables funds to be transferred tax free from one qualified account to another qualified account, where they will retain their tax-deferred status and will continue to grow until they are withdrawn. The plan of choice for the rollover of most funds is an IRA. And for many retirees, an annuity may be an appropriate vehicle to fund the rollover IRA assets.

Using Annuities to Fund Rollover IRAs

As mentioned earlier in this course, using annuities to fund IRAs is often the source of criticism. The main objection is that IRAs are themselves tax-deferred, so why should a tax-deferred product be the funding vehicle for a tax-deferred account? This objection is valid if the only reason for using an annuity to fund an IRA is to achieve continued tax deferral; doing so offers no additional tax benefit beyond what is already provided under the rules that govern the qualified plan. However, as most practitioners know and should explain to their clients, annuities offer additional benefits that other investment products do not, including guaranteed death benefits and the option for lifetime income.

Taxation of Qualified Annuity Funds

When annuities are used as funding vehicles for qualified plans, such as traditional IRAs or rollover IRAs, the tax treatment of the contract's funds follows the same rules that apply to the qualified plan. For example, if premium payments were deducted when they were contributed to the plan (or if they were contributed on a pre-tax basis), they are fully subject to tax when withdrawn or annuitized. Therefore, if an annuity contains funds that have never been taxed—all premiums were deducted or were contributed on a pre-tax basis—the full value of the annuity will be subject to tax when distributions or withdrawals are made. If this annuity were annuitized, no exclusion ratio would apply.

Roth IRAs and Roth 401(k)s are the exception. Contributions to Roths are not deductible; however, if these accounts are held for a minimum of five years and if withdrawals are delayed until the owner is at least 59½, they will generate tax-free distributions. Roths can be funded with annuities.

Minimum Distribution Rule

Practitioners need to ensure that the purchase of an annuity to fund an IRA will not create a problem for owners when they have to begin taking their minimum distributions. The tax law requires that, as of age 70½, IRA owners must begin taking minimum distributions from their IRA plans every year. If an annuity would subject its owner to a surrender charge because of the IRA's minimum distribution requirement, it would not be an appropriate funding vehicle. Most deferred annuities contain a provision that waives surrender charges for required minimum distributions; however, some do not. Practitioners must check the terms of the annuity for this purpose before recommending the product for an IRA rollover.

Qualified Longevity Annuity Contracts (QLACs)

In July 2014, the IRS and Treasury Department issued new rules that permit IRAs, 401(k) accounts, and 403(b) accounts to purchase and hold "**qualified longevity annuity contracts**" (**QLACs)** within the account and gain certain benefits. A QLAC is a qualified version of a deferred income annuity. An IRA owner (or 401(k) or 403(b) participant) can use a certain amount of his or her qualified funds to purchase a QLAC and derive two benefits:

- The amount that is used to purchase the QLAC is excluded from the account balance used to determine required distributions. This lowers the account balance on which required distributions are calculated and thus lowers the amount the owner is required to take every year. The lower the distributed amount, the less income tax that must be paid.
- Because it is a deferred income annuity, the QLAC will provide a lifelong income stream, guaranteed payable for the duration of the owner's life. These income payments begin after the owner's age 70½—at whatever point the owner wishes—ensuring that he or she can count on receiving income for the remainder of his or her life regardless of how long that life may be.

For IRA, 401(k), and 403(b) participants, the QLAC rules make available more retirement income options, adding lifetime income to lump-sum distributions and discretionary withdrawals.

Summary

- Despite being subject to many changes over the years, the annuity still retains a number of distinct tax advantages.
- It is not subject to current taxation: funds accumulate on a tax-deferred basis within the contract. Only when funds are withdrawn are they taxed.
- Withdrawals are fully subject to ordinary taxation when taken as well as a 10 percent penalty if the owner is younger than 59½.
- If the funds are annuitized, the income stream is taxed according to the exclusion ratio, which taxes only the interest portion of the income. Annuitized income is taxed at ordinary income tax rates, not at capital gains rates.
- The death benefit from an annuity is taxable to the beneficiary to the extent that the contract's earnings exceed principal. The beneficiary of an annuity does not receive a stepped-up basis. A life insurance contract can be exchanged, tax free, for an annuity, and an annuity can be exchanged, tax free, for another annuity. As a result of the Pension Protection Act of 2006, annuities can now be exchanged for qualified long-term care policies as well.
- In addition, annuities can include long-term care insurance riders that will provide benefit payments in the event the owner needs long-term care. The cost of such riders is taken from the annuity's cash value; however, under the tax rules, these deductions are not considered distributions to the owner and are thus not taxable.

Chapter 5 Review Questions

1. Which of the following correctly indicates the current tax treatment of annuity withdrawals?
    A. tax free
    B. capital gains
    C. LIFO
    D. FIFO
2. At what point are an annuity's earnings subject to income tax?
    A. when they are credited to the contract
    B. when they are withdrawn from the contract
    C. as they accumulate within the contract
    D. never
3. The annuitization of a nonqualified annuity's funds is subject to taxation in accordance with:
    A. an exclusion ratio
    B. capital gains treatment
    C. Section 1035 rules
    D. stepped-up basis treatment
4. Seventy-year-old Patrice elects to annuitize her fixed deferred annuity under a straight life option. She had originally invested $25,000 in the contract; the contract was worth $80,000 at annuitization. According to IRS life expectancy tables, Patrice will live for 16 years. Her annual annuity income is $6,800. How much of that is taxable?
    A. $1,564
    B. $2,125
    C. $4,674
    D. $5,236
5. Nonqualified annuities can be exchanged for qualified long-term care contracts under the tax-free exchange rules of Section 1035.
    A. True
    B. False

Answers to Chapter 5 Review Questions

1. C. Annuity withdrawals are taxed on a last-in/first-out (LIFO) basis. Withdrawals are deemed to consist of interest earnings first and are fully taxable at ordinary rates to the extent of the contract's earnings.
2. B. An annuity's earnings accumulate tax free until withdrawn or annuitized. Upon withdrawal or annuitization, the earnings are taxable at ordinary rates.
3. A. Annuitized income is taxed in accordance with an exclusion ratio, which proportions the income into return of principal (nontaxable) and earnings (taxable).
4. D. The amount excluded from annuity income is the proportional amount of the contract's principal. In this case, the amount invested in the contract (principal) is $25,000; the expected return is $108,800 ($6,800 annual income × 16 years). Therefore, for tax purposes, the annual amount excluded from taxation is 23 percent, or $1,564. The amount that is taxable is $5,236.
5. A. The Pension Protection Act added long-term care insurance contracts to Section 1035. As of 2010, life insurance and nonqualified annuity contracts can be exchanged tax free for qualified long-term care contracts.

Chapter 6
Annuity Suitability and Disclosure Practices

Annuities can be key building blocks for a sound retirement plan. They offer the means to achieve tax-deferred growth—fixed, indexed, or variable—and a way to ensure lifelong income. Annuities have become fixtures in the retirement and investment plans of millions of Americans. However, though they offer unique advantages and benefits, they also entail a number of limitations and restrictions. Accordingly, they may or may not be suitable for any given client or prospect. More and more, producers are being held accountable for the suitability of the products they recommend; it is no different with annuities. In today's financial and regulatory environment, it is the producer—not the consumer—who is primarily responsible for ensuring that the placement of an annuity is suitable and appropriate.

In this chapter, we will examine the suitability issues and standards that apply to the recommendation and sale of all annuities, both fixed and variable. Upon conclusion, you should:

- know the regulatory framework and guidelines that support suitable annuity recommendations and sales
- be familiar with the criteria by which annuity suitability is measured
- be able to form the basis for an annuity suitability assessment
- be able to apply the principles of a needs-based selling approach to annuity placements

Regulatory Authority Dictates

Annuity producers are governed by distinct licensing and regulatory authorities as well as by their companies' guidelines and their own codes of ethics. Fixed and indexed annuities, as insurance products, are regulated by state insurance laws. Variable annuities, as both insurance and securities products, are regulated by both state insurance laws and federal and state securities laws.

For many years, annuity suitability standards varied greatly depending on whether the product was a fixed or variable annuity. This was because the different regulatory bodies adopted different consumer protection measures. However, over the past few years, these standards have become more aligned. Today, the sales, suitability, and disclosure requirements that annuity producers must follow are very much the same regardless of whether they sell fixed or variable annuities.

What Is Suitability?

Generally, the term **suitability** refers to the process of applying standard principles and business practices to determine whether a recommended product is appropriate for any given consumer. The determination is based on the consumer's objectives and needs in light of his or her risk tolerance, financial holdings, investment experience, and income. Such assessments demand individual, case-by-case reviews and evaluations—what may be a suitable product recommendation for one consumer may not be suitable for another. Suitability requires the producer to ensure that, at the time of purchase and upon future client case reviews, a recommended product is consistent with a consumer's financial profile and financial objectives.

To help producers in their suitability determinations, the industry offers specific guidelines and directives. Pertinent to the recommendation and placement of annuities are:

- NAIC Suitability in Annuity Transactions Model Regulation
- FINRA Rule 2330

The NAIC model applies to the recommendation and placement of all annuities in states that have enacted this regulation; FINRA Rule 2330 applies to the recommendation and placement of variable annuities.

NAIC Suitability in Annuity Transactions Model Regulation

Virtually every state has implemented regulations that govern the marketing and sale of annuities. The foundation upon which most states have based their annuity suitability requirements is the NAIC's **Suitability in Annuity Transactions Model Regulation**.

Originally titled "Senior Protection in Annuity Transactions Model Regulation" and set forth in 2003, this model stemmed from the NAIC's adoption of a white paper calling for suitability standards for nonregistered products similar to those established by the securities industry for registered products (including variable annuities). As a result of this white paper, the NAIC formed a working group to define and design standards for the sale of annuity products, and in 2003 the Senior Protection in Annuity Transactions Model Regulation was set forth. At the time, this model was promoted as another tool that regulators could use to protect senior consumers from inappropriate annuity sales practices. As its title suggests, this original suitability regulation applied only to seniors—consumers age 65 and older.

As it became clear that the purchase of an annuity product is often a complicated and confusing process for consumers of all ages, insurance regulators soon determined that the protections of the 2003 Annuity Suitability Model Act should not be limited only to seniors. In 2006, the NAIC membership overwhelmingly adopted revisions to the Annuity Suitability Model Regulation that extended its provisions and requirements to all consumers regardless of age.

In 2010, the model again underwent significant changes. Though it still applies to all consumers regardless of their age, much of the revised 2010 model now mirrors the requirements set forth by FINRA for the sale of variable annuities.

Producers who are licensed in states that have adopted the NAIC model (which most have, in some shape or form) are bound to follow its requirements and guidelines as each state requires. Producers who are licensed in states that have not adopted the model must follow their own state's laws but would nonetheless do well to follow the annuity suitability guidelines as outlined by the NAIC.

Provisions of NAIC Annuity Suitability Regulation

Among the important services that NAIC models provide is defining insurance issues that are otherwise subject to broad interpretation—such as suitability, for example. The Annuity Suitability Model Regulation brings meaning to the term *suitability* through its stated purpose:

> The purpose of this regulation is to require insurers to establish a system to supervise recommendations and to set forth standards and procedures for recommendations to consumers that result in transactions involving annuity products, so that the insurance needs and financial objectives of consumers at the time of the transaction are appropriately addressed.

The essence of suitability is captured in the final phrase of this provision: ". . . so that the insurance needs and financial objectives of consumers at the time of the transaction are appropriately addressed." A producer's recommendation is suitable if, at the time of the recommendation and sale, the buyer's insurance needs and financial objectives are "appropriately addressed."

What Is a Recommendation?

While the Annuity Suitability Model Regulation does not define suitability per se, it does define a related term, *recommendation*: "Recommendation means advice provided by an insurance producer, or an insurer where no producer is involved, to an individual consumer that results in a purchase, exchange, or replacement of an annuity in accordance with that advice."

Several practical points can be drawn from this definition:

- First, just about anything a producer might say in meeting with a prospect or client that results in the purchase of an annuity of any type constitutes a recommendation and is, therefore, subject to the suitability requirements.
- Second, this definition applies equally to producers and to insurance companies that deal directly with consumers.
- Third, it applies equally to the sale of new annuities and to the replacement or exchange of existing contracts.

Appropriately Addressing Needs and Objectives

The stated purpose of the Annuity Suitability Model Regulation begins, but does not complete, the process of clarifying the intent and application of *suitability*. How, for example, does a producer "appropriately address" a client's needs and objectives? A later provision of the regulation offers some guidance:

> In recommending [an annuity] to a consumer, the insurance producer or the insurer . . . shall have reasonable grounds for believing that the recommendation is suitable for the consumer on the basis of the facts disclosed by the consumer as to his or her investments and other insurance products and as to his or her financial situation and needs, including the consumer's suitability information.

Suitability Information

Added to the 2010 version of the NAIC model is a list of client attributes and characteristics that, collectively, are to be considered **suitability information**—data that must be gathered and analyzed when recommending the purchase or exchange of an annuity. This information includes all of the following:

- age (pre-retirement or post-retirement)
- annual income
- financial situation and needs, including the financial resources used to fund the annuity
- financial experience
- financial objectives
- intended use of the annuity
- financial time horizon
- existing assets, including investment and life insurance holdings
- liquidity needs
- liquid net worth
- risk tolerance
- tax status

Other suitability information deemed relevant to an annuity recommendation may include financial concerns such as the integrity of the Social Security system, the health of the applicant, any anticipated need to access the contract's funds before the surrender charge period ends, and how the applicant feels about annuitization.

The key point of this provision of the NAIC regulation underscores a common theme that runs throughout the model: an annuity recommendation can be suitable only if the producer takes the time to properly assess the client's current situation, needs, and objectives. This suitability information is best gathered as part of a formal fact-finding process. Included in the Appendix is a sample fact-finding form that details the kind of information that should be gathered and analyzed before an annuity can be recommended or sold.

Basis for Recommendation

Using the client's suitability information as a foundation, the producer must have a reasonable basis to believe an annuity is suitable before he or she can recommend and sell it. To this end, the NAIC model stipulates "reasonable basis" to include all of the following:

- The consumer has been reasonably informed of various features of the annuity, such as:
    - the surrender period and potential surrender charge
    - potential tax penalty if the consumer sells, exchanges, surrenders, or annuitizes the annuity
    - mortality and expense fees
    - investment advisory fees
    - potential charges for and features of riders
    - limitations on interest returns
    - insurance and investment components
    - market risk
- The consumer would benefit from certain features of the annuity, such as tax-deferred growth, annuitization, death benefit, or living benefit.
- The particular annuity as a whole, the underlying subaccounts to which funds are allocated at the time of purchase or exchange (for variable annuities), and riders and similar product enhancements, if any, are suitable for the particular consumer based on his or her suitability information.

In the case of an annuity exchange or replacement, the producer must have a reasonable basis to believe that the transaction as a whole is suitable. In making that determination, the producer must consider the following:

- whether the consumer will incur a surrender charge or will be subject to a new surrender period
- whether the consumer will lose any existing benefits (such as a death benefit, living benefit, or other contractual benefits)
- whether the consumer would benefit from any product enhancements or improvements and whether there are increased fees for these
- whether the consumer has had another annuity exchange or replacement, in particular within the preceding 36 months

Know your customer is the by-word for annuity recommendations and annuity placements. Producers must make reasonable efforts to obtain the suitability information, and they must have a reasonable basis to believe that the transaction as a whole is suitable based on that information and on what the customer stands to gain—or lose—if the product is placed. Insurers cannot issue a recommended annuity unless there is a reasonable basis to believe the product is suitable based on the consumer's suitability information. Most likely, this will require producers to use and submit with their annuity applications a completed fact-finding form that documents the client's suitability information. Depending on the insurer, a suitability statement may also be required. **Suitability statements** are to be signed by both consumer and producer, attesting to the producer's efforts to obtain the necessary suitability information and to use that information in recommending a product. (A sample suitability statement is included in the Appendix.)

Producers cannot in any way attempt to dissuade a consumer from responding truthfully to any suitability information that is requested.

Required Disclosures

Depending on the state in which they're licensed, annuity producers may have to deliver specific documents and specific information to their annuity prospects and buyers. The intent of these **disclosures** is to help consumers understand annuity products, thereby encouraging informed buying decisions.

In addition to the information that must be given to an annuity prospect as part of the suitability requirement, the following should also be provided:

- the generic name of the annuity contract being proposed or recommended (such as "single premium deferred annuity" or "variable deferred annuity")
- the name given to the contract by the issuing company, if different
- an explanation that the product is, in fact, an annuity
- the insurer's name and address
- a description of the contract and its benefits, including its guaranteed and nonguaranteed elements, how these elements operate, and their risks and limitations
- an explanation of the initial interest crediting rate (specifying any bonus), how long that rate will apply, and notice that the rate may change
- an explanation of periodic income options, both on a guaranteed and nonguaranteed basis

- an explanation of the reductions in the contract's values when withdrawals are made
- an explanation of the penalties assessed and the reductions in the contract's values when a surrender is made during the surrender charge period
- the ways in which contract values can be accessed
- an explanation of the product's death benefit and how it is calculated
- a summary of the contract's federal tax status and an explanation of any federal tax penalties that might apply upon withdrawal or surrender of the contract's values
- an explanation of the impact of any rider, such as a long-term care rider
- an explanation of the product's insurance and investment components
- an explanation of any specific charges (such as mortality and expense fees or investment advisory fees) and whether dollar amounts or percentage of values apply
- a notice that any current guaranteed declared rate is subject to change after the crediting period ends

The preceding information should be given to the applicant in writing in the form of a *product summary* or *contract outline*, prepared by the insurer and supported by explanation from the producer. In addition to specific information about the product being recommended, many states require that annuity prospects also be given a generic annuity **Buyer's Guide**, which provides general information about annuities: their purpose, features, benefits, and limitations. Different Buyer's Guides have been created by the NAIC for fixed, indexed, and variable annuities.

For transactions involving exchanges or replacements, most states require that a **Notice Regarding Replacement of Life Insurance or Annuities** be given to the client and a signed copy of the form be submitted with the application for the replacement product. The notice outlines what the customer should consider and the potential consequences of a replacement. (A sample of this notice is included in the Appendix.)

When Suitability Requirements Do Not Apply

The NAIC annuity suitability model recognizes that a producer's ability to ensure suitability can extend only so far and that the consumer must also support the producer's efforts to gather and analyze the information needed to determine suitability. Accordingly, the model states that neither the insurance producer nor the insurer will have any suitability obligation under any of the following circumstances:

- No recommendation is made.
- A recommendation was made but later was found to have been based on inaccurate information provided by the consumer.
- The consumer refuses to provide relevant suitability information, and the transaction is not recommended.
- The consumer decides to enter into an annuity transaction that is not based on a recommendation of the producer or the insurer.

To ensure that he or she is protected under such circumstances, the producer should have the customer sign a statement documenting his or her refusal to provide suitability information. Similarly, if the customer decides to purchase an annuity that is not recommended, the producer should obtain a signed statement to that effect.

Insurer Suitability Requirements

It is not only producers who have to meet suitability requirements with respect to the sale and placement of annuities. The 2010 NAIC model regulation makes clear that insurance companies are ultimately responsible for compliance. Under the model, insurers cannot issue an annuity that was recommended by one of its producers unless there is a reasonable basis to believe the product is suitable (based on the prospect's suitability information). In the event that no recommendation was made or when a consumer refuses to provide the necessary suitability information yet insists on purchasing an annuity, the product's issue should still be "reasonable" based on the circumstances known to the insurer at the time.

Should any violation occur—by either the insurer or its producers—the insurer must take corrective action or face possible sanctions and penalties.

Annuity insurers must establish supervision systems that are designed to comply with suitability requirements. These systems must provide:

- procedures to inform producers of annuity suitability requirements
- product training for producers
- processes that confirm consumer suitability information to identify and deter submission of inaccurate information
- a review of each annuity recommendation before contract issue to ensure that a reasonable basis exists to determine the recommendation is suitable
- procedures to detect recommendations that are not suitable

Insurers may contract with a third party (including a general agency or independent agency) to establish and maintain the supervision system. However, contracting with a third party to undertake any compliance requirement under the annuity suitability regulation does not relieve the insurer of ultimate responsibility for ensuring the suitability of its recommended products.

As part of the 2010 model, annuity producers must complete a one-time general training course on annuities before they can sell these products. Insurers must verify that their producers have completed an approved training course before they can be allowed to sell the insurer's annuity products.

Stranger-Originated Annuity Transactions (STATs)

Insurers have another duty with regard to annuities, which is to limit the exposure of the annuities and—to the extent possible—that of their client base to **stranger-originated annuity transactions (STATs or STOAs)**. In a STAT or STOA transaction, a third-party investor persuades an individual—typically a person with a terminal illness—to purchase an annuity with a guaranteed minimum death benefit and to designate the third-party investor as the beneficiary of the death benefit. In exchange, the annuity buyer is paid some upfront amount for entering into the transaction but receives nothing else of value from the contract. At death, the contract's death benefit is paid to the investor/beneficiary.

STOA transactions are generally limited to a very vulnerable consumer group—those who are terminally ill—and the originators of these transactions often seek out those who are in nursing homes or who are receiving hospice care. To avoid scrutiny or to disguise the true nature of the annuity sale, STOA producers (who represent those financing the transaction) may intentionally write the dollar amount of the contract below the level that would trigger an underwriting review, or these producers may purchase multiple contracts from a number of different insurers. A trust or an organization may be named as an additional beneficiary in order to hide the true identity of those who will benefit from the owner or annuitant's death.

As most industry experts and insurance regulators contend, STOAs run counter to every fundamental principle of life insurance and annuity arrangements. The fact that investors seek terminally ill individuals for these transactions simply reduces the contracts to a wager on someone's life. All those involved in the annuity business should be aware of the danger that STOA arrangements pose to consumers and to the industry as a whole. In many jurisdictions, the practice is now identified as a form of fraud, with consequent penalties applying to those who initiate and engage in such transactions. Though not a part of the NAIC's Annuity Suitability Model, the NAIC encourages insurers to adopt measures that can detect and prevent STOA transactions.

Suitability Standards Apply to All Annuities

Again, it's important to emphasize that the NAIC Annuity Suitability Model does not make any distinction as to product type: it applies to the marketing and sale of *all* types of annuities—variable, fixed, and indexed. Compliance with the suitability rules now being adopted by most states is required even for producers who sell only fixed annuities.

As noted, previous annuity suitability standards and associated consumer protections varied depending on whether the product was a fixed or variable annuity. The 2010 NAIC model creates a great deal of uniformity for determining suitability for all types of annuities (having borrowed heavily from the standards and requirements the securities industry imposes on the sales of VAs). At the same time, the NAIC recognizes the regulatory "jurisdiction" of the SEC, FINRA, and state securities laws regarding the sale and placement of variable annuities. Consequently, the NAIC model creates a "bridge" to FINRA suitability standards and requirements and grants a safe harbor for variable annuity transactions when they comply with the FINRA conduct rules:

> Compliance with FINRA rules pertaining to suitability and supervision of annuity transactions shall satisfy the requirements under this regulation. However, nothing in this subsection shall limit the insurance commissioner's ability to enforce the provisions of this regulation.

FINRA Suitability Requirements

Variable annuities are regulated by both state insurance laws and federal and state securities laws. Securities regulators have long maintained guidelines for assessing the suitability of variable annuity recommendations and placements. Based on the concept of fiduciary duty to customers, these guidelines have become compliance requirements. In turn, these compliance requirements support the benchmark for business practice as it has been defined by the securities industry: "A member, in the conduct of its business, shall observe high standards of commercial honor and just and equitable principles of trade."

Rule 2330

A cornerstone of the securities industry's suitability standards for the sale and placement of variable annuities is **Rule 2330**. This rule is titled **Members' Responsibilities Regarding Deferred Variable Annuities** and sets forth precise actions and activities that must be followed for the recommendation and sale of deferred variable annuities in order to enhance and tighten the standards for placement of these products. The primary objective of Rule 2330 is straightforward: "to provide more comprehensive and targeted protection to investors regarding deferred variable annuities."

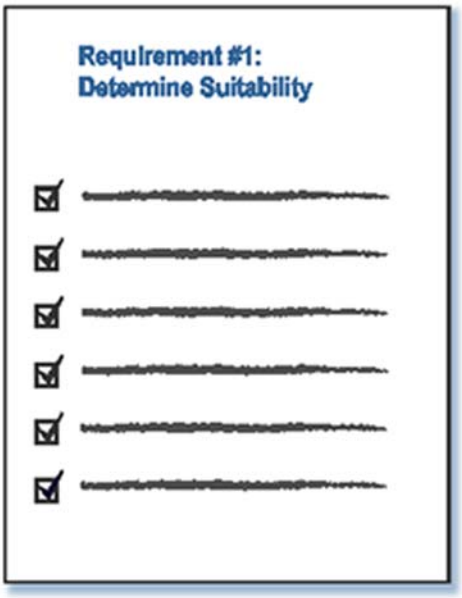
A Regulation in Four Parts

Rule 2330 applies to recommendations for an initial purchase or exchange of deferred variable annuities and the initial subaccount allocations. It does not apply to reallocations of subaccount funds after a purchase or exchange. The rule contains four primary sets of requirements:

- It imposes a *suitability obligation* requiring the representative to match the characteristics of a deferred variable annuity to the customer's needs.
- It requires that a *firm principal review* any recommended variable annuity purchase or exchange and approve the transaction before the customer's application is forwarded to the issuing insurance company for processing.
- It requires member firms to establish and maintain *specific written supervisory procedures* "reasonably designed to achieve compliance with the standards set forth in the . . . rule."
- It requires members to develop and document *specific training policies or programs* designed to ensure compliance with the requirements of the rule and salespersons' understanding of the material features of deferred variable annuities.

The main points of each of these requirements are explained in the following sections. The similarities between FINRA's Rule 2330 and the NAIC's 2010 Annuity Suitability Model Regulation are readily apparent.

Requirement #1: Determine Suitability

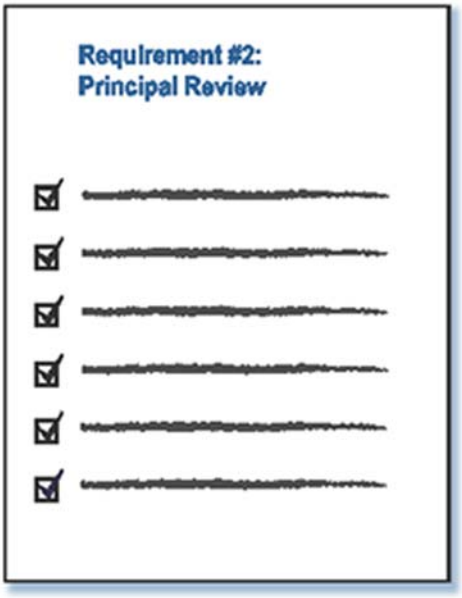


FINRA Rule 2330 requires that a member representative have a reasonable basis to believe that the variable annuity transaction is suitable for the customer before recommending the purchase or exchange of a variable annuity. Specifically, the member must do the following:

- Make a reasonable effort to obtain and consider various types of customer-specific information that constitutes an "investor profile." This information includes:
    - age
    - annual income
    - financial situation and needs
    - investment experience and objectives
    - intended use of the deferred variable annuity
    - investment horizon or timeline
    - existing assets, liquidity needs, and liquid net worth
    - current investment and life insurance holdings
    - risk tolerance
    - tax status
- Have a reasonable basis to believe the customer has been informed of the various features of a deferred variable annuity, such as any surrender charge, potential tax penalties for early withdrawals, various fees and costs (including the mortality and expense fee and investment advisory fees), the insurance and investment components of a VA, the risk that is inherent in separate account investing, and charges or fees associated with any rider.
- Have a reasonable basis to believe that the customer would benefit from certain features of deferred variable annuities, such as tax-deferred growth, annuitization, or a death or living benefit. This provision does not require that the producer determine that the customer will derive benefit from all features, but the product must offer some insurance-related aspect that the customer wants or that will fulfill his or her objectives.

- Determine the suitability for the customer as to the investment in the deferred variable annuity, the investments in the underlying subaccounts at the time of purchase or exchange, and all riders and other product enhancements and features contained in the annuity contract. The determination must consider the product in its entirety as well as its component parts.
- Have a reasonable basis to believe that, if the transaction involves a contract exchange, the exchange transaction is suitable given that the customer could incur a surrender charge, be subject to a new surrender period, lose existing benefits, be subject to increased fees or charges, or has had another exchange within the preceding 36 months. The information that forms the representative's "reasonable basis" must be documented.
- Document and sign the determinations that support the recommendation and purchase of a deferred variable annuity. This documentation must be reviewed by a principal and must provide enough information and detail to enable the principal to judge whether the registered representative has complied with the requirements of Rule 2330.

Requirement #2: Principal Review



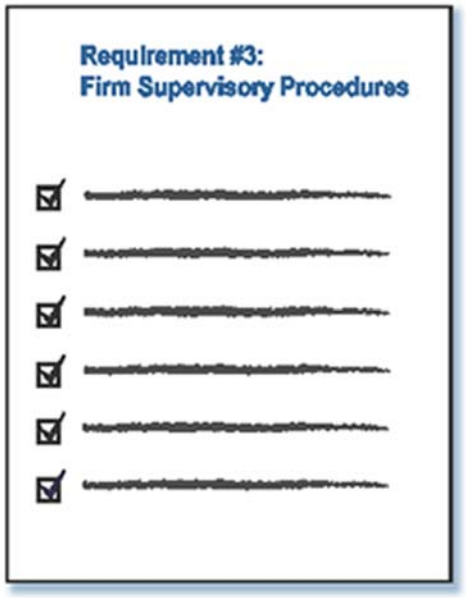
Before a recommended deferred variable annuity application is submitted to the issuing insurance company, Rule 2330 requires that a registered principal review and determine, based on the suitability criteria, whether the transaction (including the recommended initial subaccount allocations) is, in fact, suitable. The principal review and suitability determination must be done no later than *seven business days* after a completed and accurate application is received by the principal's office.

The principal can approve the transaction only if he or she determines that there is a reasonable basis to believe that it would be suitable based on the specified customer profile factors just listed. The approval—or rejection—of the sale must be documented and signed by the principal.

The primary purpose of requiring presubmission review by a principal is to determine the suitability of a recommended variable annuity placement *before* the contract is issued. A review is not required if an agent or broker does not recommend the transaction; however, firms must implement measures to detect and correct recommendations that are incorrectly or mistakenly characterized as *nonrecommended*.

Note that Rule 2330 does not prevent consumers from buying any variable annuity product they wish, regardless of whether it was recommended by the representative. If a consumer, at his or her own initiative, were to ask a representative to effect the purchase of a variable annuity—with no recommendation by the representative—the transaction could occur. However, it would not be subject to a principal review or to the suitability requirements of Rule 2330.

Requirement #3: Firm Supervisory Procedures



Rule 2330 requires broker-dealers to establish and maintain written supervisory procedures to achieve compliance with the rule's standards. As explained by FINRA, this requirement means that the member firm must:

- establish a suitability surveillance program and procedures
- take corrective measures to remedy inappropriate exchanges or purchases
- take corrective measures to "remedy the conduct of those registered representatives identified by the member firm as having participated in inappropriate annuity exchanges"

While not prohibiting contract replacements, the last point suggests disciplinary action may await representatives who engage in unacceptably high numbers of 1035 exchanges as well as those who do not apply appropriate suitability standards to their recommendations. In fact, members must implement procedures to determine whether any of their associated persons have rates of exchanges that would be considered inappropriate by other applicable FINRA rules and federal securities laws.

Requirement #4: Member Firm Training Program

Lastly, Rule 2330 requires member firms to create training programs for registered representatives who sell deferred variable annuities and for registered principals who review deferred variable annuity transactions. The training should focus on the suitability requirements of Rule 2330 as well as the unique characteristics of variable annuities.

Annuity Suitability and Needs-Based Selling

The standards by which suitable annuity recommendations are made and the requirements for complying with suitable annuity placements should pose no obstacles for the professional producer. The professional producer approaches every prospect and every client with the intent to provide an appropriate solution to a stated need or objective. This approach, in turn, leads naturally to the process that defines the suitable product solution:

- determining a general need that an annuity product can meet
- performing a thorough fact-finding to obtain suitability information
- honestly analyzing the suitability information

- thoughtfully and precisely evaluating the product options in light of the customer's situation and resources
- explaining the recommended product and its application to the client
- conducting a question and answer process to ensure that the client understands the recommended product

This process has the benefit of being *client*-centered as opposed to *product*-centered. Annuities can be complex products. As a result, many sales presentations—as well as the sales and marketing material developed by annuity insurers—tend to focus on the product instead of the consumer. Annuity product presentations should be made from the customer's perspective and should stem from his or her needs and objectives. As the consumer's needs are uncovered, and as the product's features and benefits are explained, the producer should emphasize what the product does and what value it will provide in terms of the customer's unique situation.

At the same time, the producer must also make clear the product's limitations and restrictions. Assessing whether the product's value and benefits outweigh its drawbacks should be a collaborative exercise, with the customer participating. In this way, the customer is informed of the full scope of the product's features and operation. Understanding a financial product and evaluating it on their own terms empowers consumers to make purchase decisions that are appropriate for them. In addition, by focusing on the client's needs and his or her desire to meet those needs—as opposed to the product's details—the producer stays on track and can more clearly draw the connection between the client's objectives and what the annuity can deliver. This connection reinforces the suitability assessment.

Special Considerations for Seniors

Producers who represent and sell annuities will undoubtedly encounter a number of older consumers. Increasingly, senior consumers represent a large and dynamic market for financial services and products; however, they are also among the most vulnerable for unsuitable or inappropriate product sales. Seniors tend to more freely trust others but may lack the capacity to manage their personal financial affairs or make decisions that are in line with their interests and needs. At the same time, they might not be aware that their financial skills have diminished. Producers face unique ethics and compliance issues when dealing with seniors and have a duty to be alert to prospects and clients who may lack the ability to make informed decisions due to lessened capacity. In some cases, producers may have to work with the senior in conjunction with a close relative or the senior's attorney, or ultimately, may have to disengage completely from the prospect and forego pursuing a sale.

Though by no means complete, the following are common indicators that a consumer may be suffering from some form of diminished capacity and thus may not be in a position to knowingly make appropriate decisions about purchasing a financial product or understand how the product functions:

- has trouble planning or problem-solving
- has difficulty remembering or concentrating
- is unable to perform simple financial calculations
- has difficulty understanding comparisons or alternative options
- responds to basic fact-finding questions with "I don't know" or "I don't remember"
- is unable to describe or explain basic facts or circumstances related to his or her financial situation
- repeatedly asks the same question or questions
- has trouble focusing on a single topic
- is unable to process information
- defers questions to another, such as a family member
- has difficulty with communicating
- is unable to provide feedback that confirms understanding

Client Engagement

The objective of an annuity suitability analysis is to ensure that the client's needs and objectives are addressed. Consequently, the client should also be engaged in the suitability determination. One of the best ways to involve clients is to encourage questions, which will help them better understand how a recommended product applies to their situation and how it will advance their goals. At the same time, the kinds of questions that clients ask are often good indicators of how well they do—or do not—understand the product. If a client is not forthcoming with questions or does not vocalize any objections or concerns, the producer should take the lead. The producer should initiate dialogue that prompts the client to raise questions about his or her situation and about the associated applications of the proposed annuity product.

The following are the kinds of questions producers should encourage their annuity customers to ask of themselves:

- When do I expect to access the contract funds?
- How long will my money be tied up?
- Am I going to need the money before the surrender charge period expires?
- What costs or penalties would I incur if I were to access the contract's values?
- How can I access the contract's values without costs and penalties?
- What kind of investments do I want to support the growth of the contract?
- What are the risks that my investment will decline in value? Can I accept these risks?
- Am I fully funding any retirement plan to which my employer contributes?
- What is my tax bracket now and what do I expect it will be when I retire?
- Will this product meet my objectives for my dependents/beneficiaries/heirs?
- Do I understand all of the charges and fees associated with this product?
- Are those charges and fees outweighed by the value that this product will provide me?
- What additional features am I paying for—and do I really want or need them?
- If, after purchasing this product, I were faced with a financial emergency, would I be able to meet it?
- Does the investment aspect of this product match my risk profile?
- If this purchase will cause me to surrender or exchange an existing contract, what fees must I pay and what benefits will I be giving up?
- Do I fully understand the benefits this product will provide me and the limitations or risks it poses for me?
- What are my expectations for this product?
- How comfortable am I with the control I have (or don't have) over the investment of funds in this product?
- What happens to this product if I die?
- What effect might this purchase have on my estate plan and wealth transfer objectives?

As these questions are asked and answered, the suitability of the recommended product will become even clearer. If the proposed annuity meets the client's needs and advances his or her goals—and if the client understands how the product applies to his or her situation and is able to accept the product's limitations as well as its benefits—then the basis for a suitable product placement is firm.

Summary

- Annuities are unique financial products, appropriate for a variety of long-term needs and objectives. However, they are not suitable for everyone. To ensure that these products are appropriately presented, recommended, and placed, the insurance industry and the securities industry have both created specific guidelines that must be followed.
- The NAIC Suitability in Annuity Transactions model regulation and FINRA Rule 2330 offer precise procedures to guide the recommendation, approval, and issue of all annuity products: fixed, indexed, and variable.
- Central to the suitability determination is the information that is to be gathered and analyzed for every annuity prospect. This client information is now very similar, regardless of whether the product is a fixed, indexed, or variable annuity.
- Annuity producers have an obligation and duty that extends well beyond mere selling. They stand at the forefront for ensuring that annuity recommendations are suitable and appropriate for the consumer.
- This determination is based on the client's unique situation and his or her specific needs and objectives.
- The producer should follow a needs-based approach to annuity product placements: determine the client's needs and objectives; match the client's needs and objectives with the appropriate product design; disclose to the client the facts associated with the product; and encourage client questions to reinforce the product's suitability.
- Only when an annuity is appropriate and only when it will advance the buyer's goals and objectives should it become a part of the client's financial portfolio.

Chapter 6 Review Questions

1. The NAIC Annuity Suitability model regulation applies only to fixed and indexed annuities; FINRA Rule 2330 applies to variable annuities.
    A. True
    B. False
2. In which of the following circumstances would a producer have a suitability requirement under the NAIC Annuity Suitability model regulation?
    A. The producer initiates a client meeting but does not recommend a product.
    B. The buyer does not provide accurate suitability information.
    C. The buyer decides to purchase an annuity that is not based on a producer's recommendation.
    D. The buyer decides to exchange an existing annuity for a new annuity under the rules of Section 1035.
3. To what market segment does the current NAIC Suitability in Annuity Transactions model regulation apply?
    A. only to prospects who are age 65 and older
    B. to any prospective annuity buyer
    C. only to prospects or clients who do not follow a producer's product recommendation
    D. only to those who apply for fixed annuities
4. Which statement is true of FINRA Rule 2330?
    A. It imposes specific sales practice standards and supervisory requirements on variable annuity transactions.
    B. It prohibits the sale of variable annuities to anyone older than 65.
    C. It disallows the use of variable annuities in qualified plans.
    D. It bans the exchange of any variable annuity purchased before 1982.
5. The suitability standards of FINRA Rule 2330 apply to both the purchase of a variable annuity as well as the recommendations for subaccount investments.
    A. True
    B. False
6. According to the standards of both the NAIC Annuity Suitability model and FINRA Rule 2330, which of the following is the standard for a suitable annuity recommendation?
    A. knowledge beyond all doubt that the recommendation is suitable
    B. an educated opinion that the recommendation is suitable
    C. best-guess projection that the recommendation is suitable
    D. reasonable basis to believe that the recommendation is suitable

Answers to Chapter 6 Review Questions

1. B. The NAIC Annuity Suitability model applies to all annuities: fixed, indexed, and variable. It does provide a bridge to FINRA regulation, stipulating that a producer will be deemed compliant with the NAIC guidelines if he or she follows FINRA Rule 2330 when recommending and placing variable annuities.
2. D. Under the NAIC Annuity Suitability model, there are limited circumstances in which a producer does not have suitability requirements, including when no product is recommended, when the buyer does not or refuses to provide accurate suitability information, or when the buyer purchases an annuity that the producer did not recommend. However, the NAIC model applies to both the sale of new annuities and to the exchange of existing annuities.
3. B. As revised in 2006 and again in 2010, the NAIC model law applies suitability standards to the purchase of any annuity product by any individual, no matter what age he or she may be.
4. A. In recognition of the product's complex nature, Rule 2330 imposes specific sales practice standards and supervisory requirements on variable annuity transactions.
5. A. FINRA Rule 2330 requires that the representative determine the investment suitability of the product as a whole as well as the investments in the underlying subaccounts at the time of purchase or exchange.
6. D. The standard that both the NAIC model and FINRA Rule 2330 apply to suitability determinations is a "reasonable basis to believe the product is suitable."

Appendix

Included in this Appendix are three documents that support the suitability standards and requirements for placing annuity products: a data-gathering form, a suitability statement, and a copy of the "Notice Regarding Replacement of Life Insurance or Annuities," which most states now require to be given to consumers and submitted to insurers for replacement transactions.

(Sample) Annuity Suitability Data Form
The questions on this form are intended to confirm that an annuity purchase is suitable for your individual situation and long-term objectives. Please complete the following, which will be submitted with your application.

Owner: _____ Joint owner: _____

Beneficiary: _____ Owner age: _____

Premium deposit: _____ Product type: _____

Financial Status

Annual income: ❒ $0 - $24,999 ❒ $25,000 - $49,999 ❒ $50,000 - $99,000 ❒ $100,000+

Estimated net worth: ❒ $0 - $49,999 ❒ $50,000 - $99,999 ❒ $100,000 - $249,999

(exclusive of home or auto) ❒ $250,000 - $499,999 ❒ $500,000 - $749,999 ❒ $750,000 - $999,999 ❒ $1,000,000 +

Federal tax bracket: ❒ 10% ❒ 15% ❒ 25% ❒ 28% ❒ 33% ❒ 35%

Sources of income: ❒ Wages/salary ❒ Social Security ❒ Investments ❒ Pension ❒ Other _____

Percent of net worth invested in this annuity: _____

Financial Objectives / Profile

Please indicate the reason(s) why you are purchasing this product (check all that apply):

❒ Current income ❒ Safety of principal ❒ Tax deferral ❒ Long-term growth ❒ Growth, followed by income

❒ To supplement retirement income ❒ To pass on to beneficiaries ❒ Other _____

Which of the following best defines your risk tolerance?

❒ Conservative ❒ Moderately Conservative ❒ Moderate ❒ Moderately Aggressive ❒ Aggressive

Please indicate the source of funds for the annuity premium:

❒ Current savings (such as a CD) ❒ Current investments ❒ Life insurance ❒ Annuity ❒ Other _____

Please indicate the investments you own:

❒ Stocks/bonds/mutual funds ❒ Certificate(s) of deposit ❒ Fixed annuity ❒ Variable annuity ❒ Real estate

❒ Other _____

Are you fully contributing to any qualified retirement plans, such as a 401(k) or 403(b)? ❒ Yes ❒ No

How do you plan to take money from this annuity?

❒ As an annuitized income stream ❒ In a lump sum ❒ Through systematic or periodic withdrawals

When do you expect to take money from this annuity?

❒ Less than 1 year ❒ 1 to 3 years ❒ 4 to 6 years ❒ 7 to 9 years ❒ 10 to 14 years ❒ 15 years or more

Do you have sufficient liquid funds or regular income to meet monthly living expenses and emergencies, other than the funds that will be used to purchase this product? ❒ Yes ❒ No

Do you anticipate any change in your overall financial situation in the foreseeable future? ❒ Yes ❒ No ❒ Not sure

Customer/Producer Acknowledgements

I understand that the recommendation for the purchase of this product is based on the information in this form and, to the best of my knowledge, this information is factual and current. I believe the product meets my needs and objectives at this time.

(Sample) Annuity Suitability Data Form

The questions on this form are intended to confirm that an annuity purchase is suitable for your individual situation and long-term objectives. Please complete the following, which will be submitted with your application.

_____ _____

Owner/Applicant Signature Date

_____ _____

Joint Owner Date

I have a reasonable basis to believe that the recommendation to purchase/exchange an annuity is suitable for this customer, based on the information the applicant disclosed and all other information known to me regarding the applicant's insurance needs and financial objectives.

_____ _____

Producer's Signature Date

(Sample) Annuity Suitability Statement

State regulatory requirements set suitability standards for the sale of annuity contracts. As part of those requirements, our representative must try to determine if our annuity is appropriate for your needs. To make that determination, our representative must consider your financial and tax status, investment objectives, and any other information that appears to be relevant to your particular situation and preferences.

Because we believe that it is important for our product to be appropriate for your needs, we have developed this form. Please read the statements below and select the one that is a true statement. Do not sign this form if you do not believe that any of the statements are true.

( ) I am satisfied that your representative asked for the information that is reasonably necessary to determine if the annuity applied for is suitable for my needs. I am also satisfied that the annuity is suitable to me, based on the information that I am aware of at this time.

( ) After careful consideration, I decided not to share the information that your representative determined was necessary to make a determination as to the suitability of this product for my needs. I made this decision without any prompting from your representative.

( ) After careful consideration, I decided to apply for this annuity in spite of the fact that your representative did not recommend its purchase. I made this decision without any prompting from your representative.

X _____

Applicant's Signature

Producer's Statement

To the best of my knowledge and belief, the box checked above is correct, based on the information that I was or was not provided by the applicant. I undertook all reasonable efforts to determine that the annuity applied for is suitable for the applicant's needs.

X_____

Producer's Signature

Notice Regarding Replacement of Life Insurance or Annuities

IMPORTANT NOTICE:

REPLACEMENT OF LIFE INSURANCE OR ANNUITIES

This document must be signed by the applicant and the agent, if there is one, and a copy left with the applicant.

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interests. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on the back of this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract?

   ___ YES ___ NO

2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? ___ YES ___ NO

   If you answered “yes” to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured or annuitant, and the policy or contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

INSURER NAME	CONTRACT OR POLICY #	INSURED OR ANNUITANT	REPLACED (R) OR FINANCING (F)
1.			
2.			
3.			

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. If you request one, an in force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer. Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

The existing policy or contract is being replaced because _____.

I certify that the responses herein are, to the best of my knowledge, accurate:

_____ _____

Applicant's Signature and Printed Name Date

_____ _____

Agent's Signature and Printed Name Date

I do not want this notice read aloud to me.__(Applicants must initial only if they do not want the notice read aloud.)

End Notes

[1] *2013 Survey of Owners of Individual Annuity Contracts*, The Gallup Organization and Mathew Greenwald & Associates.

[2] The types of investments that insurers can make with their general account funds are regulated by state insurance commissions. Regulations typically limit the fund's exposure to higher risk assets and require certain minimum levels of capital reserves.

[3] "*2013 Survey of Owners of Individual Annuity Contracts*," The Gallup Organization and Mathew Greenwald & Associates.

[4] *2009 Insured Retirement Institute Annuity Fact Book*, citing Morningstar data.

[5] Of the $6,400 of annual income, a portion is taxable and a portion is not taxable. Taxation of annuity income is explained in detail in Chapter 5.

[6] Variable annuitization is subject to ups and downs based on the performance of the subaccount investments and the revaluation of the contract's annuity units. If variable annuity income in any year is less than the exclusion amount, then the exclusion ratio can be recalculated for future years. This change will account for the decline in the annuity's value and the greater portion of the contract's funds that the principal now represents.

Life and Health Insurance Law
Contents

Introduction

Insurance is an essential aspect of not only our personal lives but also of our businesses. Individuals acquire life and health insurance to transfer some portion of the risks associated with their everyday lives. Businesses acquire life and health insurance to transfer some of the risks associated with the loss (through death) of key employees, to ensure that funds are available to facilitate business succession plans, to provide employee benefits, and to meet other business needs.

Health and accident insurance provides coverage and benefits to millions of people each day. It holds great significance to all people as protection against the financial consequences of illnesses, diseases, and accidents. It is an important part of our federal government's Social Security system, as well as being a trillion-dollar industry employing thousands of individuals. The investment dollars generated by premiums paid to insurance companies play a significant role in, and are a pivotal part of, the U.S. economy.

Given the vital role that insurance plays in our society, it is no surprise that the study of insurance is influenced and shaped by legislation, court decisions, litigation, and administrative actions. Insurance law is evolutionary. Judicial decisions involving insurance contribute to the continuous development of fundamental legal doctrines. This evolution of legal doctrines results from the resolution of insurance disputes.

The purpose of this course is to provide a broad overview of insurance law as it relates to insurance agents and brokers as well as other professionals in the financial services industry, such as accountants and financial planners.

The course discusses the general principles and doctrines of insurance law. It describes in depth the role that insurance law plays in areas such as risk, indemnity, insurable interest, and consumer protection.

The chapter summaries provided below identify the scope of this course and describe the type of information you can expect to find in each chapter:

Chapter 1, **Introduction to Insurance Law**, introduces you to the topic of insurance law and provides a brief history of insurance regulation. A discussion of contracts and insurance classification is also provided in this chapter.

Chapter 2, **Law, Indemnity, and Insurability**, describes the principle of indemnity and the doctrines of insurable interest and subrogation. The "other insurance" provision is also explained.

Chapter 3, **The Law and Insurance Protection**, describes the typical language used in policy contracts and the confusion that may arise. Assignments of insurance contracts and the provisions of life insurance policies are explained in depth.

Chapter 4, **The Law and Consumer Protection**, defines "agent" and discusses the evolution of life insurance regulation.

Chapter 5, **Issues Affecting Insurer Liability**, defines the agency relationship, who the involved parties are, and an insurer's potential defenses against liability.

Chapter 6, **Issues Affecting Life Insurance Taxation**, explains the tax consequences of an insurance policy's failure to meet the definition of life insurance and the consequences of a life insurance policy becoming a modified endowment contract (MEC). This chapter also discusses the concept of transfer for a valuable consideration, split-dollar plans, and qualified retirement plans.

Chapter 7, **Unauthorized Entities**, discusses the problem of unauthorized entities in the insurance industry.

Glossary. A comprehensive glossary is located at the back of this book.

References. Several references are listed should you want further information on the topics in this course.

Chapter 1
Introduction to Insurance Law

Insurance law is a system of rules of conduct as well as rights and obligations that are formally recognized by our society or prescribed by federal or state authority. It distinguishes between what is permitted and what is prohibited. For more than 300 years, insurance law has been developing. Its beginnings were in England, and those early laws were the basis of United States insurance laws.

United States law derives principally from two sources: *common law* and *statute law*. Common law is the law that developed out of customs and usage and from the decisions and opinions of the courts. Because the United States had its beginnings in 13 English colonies, it is not unexpected that its system of laws has its basis in English common law. Statute law—sometimes referred to as legislative law—is the law established by a legislative body; in short, it is law drafted and passed by lawmakers.

Definition

Common law was the unwritten law derived from the customs or ideas of justice that prevailed in England. In its modern meaning, common law refers to the collection of judicial decisions, customs, and concepts of justice that define right and wrong. England, Canada, and the United States are common law countries.

Insurance law is a system of rules of conduct for those operating within the business of insurance. It includes rights and privileges that are formally recognized by our society and mandated by our federal or state governments. While much of the law that has come to be known as *insurance law* is codified in statute, many of the concepts and rules are not.

Insurance law distinguishes between those activities and practices permitted by law and those that are prohibited. Because modern insurance has evolved largely over the last three centuries, insurance law has been growing and changing for more than three hundred years and continues to grow and change today.

The influence of insurance law extends beyond the insurance industry, however. In fact, many of the common law contract rules used in modern commerce resulted from the judicial resolution of insurance disputes. And many of the principles that provided the foundation for consumer law began with insurance litigation.

Insurance litigation often is a forum in which issues of great contemporary and public concern are considered by the courts. An increasing and recent concern has been the matter of treating people differently with respect to their sex, race, or physical handicaps. These issues often have been at the center of litigation over the appropriate use of actuarial data that is used in establishing premiums and benefits for annuities, life insurance, health insurance, and various other types of insurance products. Often, insurance disputes actually help to resolve some of the most important questions and relevant issues that people confront in our society today.

So as you can see, insurance issues surround us. Individuals and businesses are confronted daily with important insurance-related decisions, such as when to buy insurance, how much insurance coverage to buy, from whom to purchase the insurance, what types of insurance to buy, and what kinds of risks to insure against.

Brief History of Insurance Regulation

Before 1944, insurance rating practices were generally the subject of state regulation. Most state regulation involved some type of administrative approval of rates. These rates were developed almost exclusively by insurers, and state regulatory review varied considerably. It was generally assumed, however, that the insurance marketplace itself would largely determine rates and that a strict examination by insurance regulators was not really needed.

In 1944, the Supreme Court of the United States held that the insurance industry was subject to federal regulation, including anti-trust regulation. However, facing severe doubts about the Supreme Court's decision, specifically with respect to rating practices and to state regulation, Congress passed the McCarran-Ferguson Act. This act exempted the insurance industry from federal anti-trust legislation to the extent that state law regulates the insurance business.

The McCarran-Ferguson Act did not, however, return the regulation of insurance rates entirely to the individual states. It merely exempted the insurance industry from federal anti-trust legislation to the extent that the insurance business is actually regulated by state law. Therefore, there was the immediate pressure from the insurance industry for the states to assume full responsibility for their own insurance regulation. This industry pressure was intended to avoid the possibility of the industry's becoming subject to federal anti-trust regulation.

By 1951, every state had enacted rate regulatory legislation. State regulatory statutes are essential to avoid federal anti-trust laws from being applied to the activities of insurers. Because most insurers act together through rating organizations to establish premiums, the activities of these rating organizations would violate the federal anti-trust legislation if state regulation did not exist.

Until the rise of modern insurance and consumer legislation, the common law principle known as **caveat emptor**, or "let the buyer beware," prevailed. This principle had governed business and consumer transactions in England and the United States for centuries. By virtue of caveat emptor, an unprincipled insurance company or a negligent agent or broker could avoid liability resulting from their actions by claiming that it was up to the buyer to be cautious when making the purchase.

Caveat emptor has largely been replaced by the principle of **caveat vendor**, literally meaning "let the seller beware." Under this more recent pro-consumer principle, sellers generally face strict product and service liability and are required to fully and accurately disclose all material facts to buyers concerning their product or service.

Objectives and Goals of Insurance Regulation

Insurance regulatory measures are generally designed to:

- ensure the solvency of insurers
- ensure that policyowners, claimants, and insureds are treated fairly and equitably
- ensure an adequate and healthy insurance market, characterized by competitive conditions
- provide for an office that is expert in the field of insurance
- improve and preserve the regulation of insurance
- maintain freedom of contract and freedom of enterprise consistent with other purposes of the law
- encourage self-regulation of insurance
- encourage loss prevention as an aspect of the operation of the insurance enterprise
- keep the public informed on insurance matters

To achieve the objectives of insurance regulation, some measures are focused on regulating insurance transactions, while others are primarily concerned with the insurance institutions and those engaged in insurance transactions.

Federal vs. State Regulation

The insurance industry is highly regulated by government at both the federal and state levels.

Although insurance laws vary from one state to another, state insurance regulation generally governs the following:[1]

- licensing of insurers and agents
- approval of unit prices for various types of insurance
- specification of the accounting system to be used by insurers
- control of investments
- onsite audits of insurers
- approval of the language of insurance policies
- prohibition of various marketing and underwriting practices

Federal regulation generally governs the following:

- antitrust activities
- investment activities
- marketing activities

As part of the Dodd-Frank Wall Street Reform and Consumer Protection Act signed into law in 2010, the **Federal Insurance Office (FIO)** was established. Its purpose is to advise on major domestic and international insurance issues and consult with state insurance departments on insurance matters. Specifically, the FIO is responsible for:

- monitoring all aspects of the insurance industry
- tracking the availability of affordable insurance to traditionally underserved income groups and minority communities
- identifying regulatory issues that could lead to a systemic crisis in the insurance or overall financial system
- making recommendations as to whether any insurer or its affiliates should be subject to supervision by the Federal Reserve
- assisting in the administration of the Terrorism Risk Insurance Act
- representing the U.S. with respect to international insurance matters

The FIO's authority extends to all lines of insurance, except health insurance, long-term care insurance (except that which is included with life or annuity products) and federal crop insurance. The FIO does not have general supervisory or regulatory authority over the business of insurance in general. That responsibility remains with state authorities.

Administrative regulation of insurance continues to be primarily the responsibility of the state authorities. However, this subject is surrounded by controversy, and proposals are made occasionally suggesting that the major insurance regulatory responsibilities should be shifted from state regulatory authorities to federal agencies. The rationale behind such proposals is that federal regulation would combine the

strengths of the various states with a national database and technical expertise; in addition, it would provide greater uniformity of regulation.

The position of the National Association of Insurance Commissioners (NAIC), an organization comprised of the insurance commissioners in each of the states and the District of Columbia, is that federal intervention should be limited. While the federal government does have a significant role to play in regulating insurance, the NAIC feels that the state regulations are effective and that commitments have been made and accomplishments achieved in pursuing sound and secure regulation. Furthermore, the NAIC proposes model legislation concerning the regulation of insurance that it makes available to the various states.[2] Model legislation, when passed by the states, tends to bring a certain level of uniformity to insurance regulation.

Regulatory Measures for Various Types of Insurers

Obviously, it is necessary to develop different regulations for the various types of legal entities that are permitted to provide insurance. So, different sets of regulatory criteria have been developed for the six major types of private insurers.

Because of voluntary developments in the market place, increasing statutory regulations, and administrative controls, the various insuring organizations are more similar than ever before. However, differences still exist between these types of insurers and the regulatory provisions that apply to each of them.

The main types of private organizations authorized to provide insurance are as follows:

- **persons**—This can be a natural person, an association, or a corporation. The most fundamental statutes now commonly declare it illegal for natural persons to be engaged in "doing an insurance business" without having first qualified as an insurer under the state law.
- **Lloyd's associations**—These insurers are individuals, as opposed to insurance companies or corporations. The liability for loss is "several liability,"[3] which is separate and distinct, and no joint liability exists. In those states that authorize Lloyd's associations, severe restrictions and regulations moderate the business of insurance.
- **stock companies**—These companies are regulated with specific requirements for the amounts of paid-in capital and the surplus that must be retained rather than distributed to the stockholders. These requirements are designed to ensure that the insurer can perform its obligations. Assets must be sufficient to meet potential liabilities.
- **mutual insurers**—Although mutual insurers do not have stockholders, they are also heavily regulated to ensure their financial responsibility. This includes maintaining reserves that must bear a reasonable relation to the risks presented by outstanding obligations.
- **fraternal societies**—These organizations are also referred to as **mutual benefit societies**. When fraternal societies were first created, people had great confidence in them. As a result, these societies were not generally regulated as strictly as other types of insurers. However, because of many financial failures, these groups are now regulated more closely.
- **reciprocal associations**—These associations are also referred to as **inter-insurance exchanges**. Members of reciprocal exchanges were assessed if losses of other members were higher than anticipated. States impose stringent regulation on reciprocal exchanges, which has reduced their risk of potential financial failure.

Insurance Constitutes Risk Transfer

Although a precise definition of "insurance" that includes all types is difficult, insurance is generally considered the transfer of risk from one person—a policyowner or beneficiary—to an insurer. Insurance is sometimes defined as "a contract whereby, for a specified consideration, one party undertakes to compensate the other for the loss of a specified subject by a specified peril."

Insurance Concepts

Some insurance concepts must be addressed when studying insurance law. These concepts are prevalent in all insurance transactions. Understanding them is essential to understanding the insurance transaction, which is a fundamental component of insurance law.

The concept of risk is central to all insurance transactions. Through insurance, the financial burden of risk is transferred from an individual or business to an insurance carrier that is willing to assume the risk. If all the facts about a situation could be fully known and understood, including the effects of all outside forces, it would be possible to know whether a loss would occur. However, in that situation, no risk would be involved. In the real world, it is seldom that all relevant facts of any situation are known. Because of that, predictions about a potential loss are based on probabilities.

Risk Management

Many situations involve a degree of uncertainty. However, an increased awareness and understanding of the relevant facts generally helps in estimating the risks involved. Although completely eliminating uncertainty is normally impossible, risk management is an achievable goal.

With respect to life and health insurance, the risks involve mortality and morbidity, respectively. Mortality refers to the risk of death, and morbidity refers to disease and disability rates. While both risks can be reduced—through a healthful lifestyle, for example—individuals continue to become ill and die, regardless of the measures taken. However, the *financial* consequences of illness and death can be transferred to insurers through the medium of life and health insurance. Before we move further into a discussion of insurance, an understanding of the basic insurance policy *as a contract* is important.

Defining Contracts

An insurance policy is a contract, so it should not be surprising that its basic elements are the same as those that form any contract. These elements are the following:

- offer
- acceptance
- consideration

Before considering each of these elements of a contract, we need to understand the nature of a contract. A contract is nothing more or less than *an agreement enforceable at law*. In other words, a contract involves a binding promise for which the law creates a duty of performance. The duty to perform that is created out of the contract is a duty imposed on the party that makes the promise; that party is known as the **promisor**. In basic contract law, the party to whom the promise is made is known as the **promisee**. Once the offer is made and before the contract is entered into, the party making the offer is known as the **offeror**; the party to whom the offer is made is known as the **offeree**.

If the promisor fails to perform as required by the contract, the promisee can generally take one of two courses to enforce the contract. The promisee can sue for money damages under the contract, a course known as an **action at law**, or the promisee can sue for specific performance of the terms of the contract. This latter course is generally referred to as an **equitable action** and is taken when money damages are insufficient. An **insurance contract**, as we will discover in the next section, is simply a special kind of

contract—one that is an aleatory and unilateral contract of adhesion. Those terms will be defined and discussed later in this chapter.

Of course, as in any contract, the contract must be for a legal purpose; a contract entered into to commit a crime, for example, would be void. Also, the parties to the agreement must be legally competent.

Offer

In general, an offer can be written or verbal but must be conveyed to the other party to the agreement. To be a valid offer, the offer must express a willingness to enter into an agreement in such a way that the other party understands that his or her accepting the offer results in an agreement. Although it is a generally held belief that a contract must be in writing and signed, neither is usually required to form a valid contract. However, both documentation and a signature may be needed to make the contract enforceable.

Not all offers rise to the level of an "offer" in the context of insurance law. In contract law, an offer:

- must be sufficiently definite such that a court could enforce the agreement based on the terms offered
- remains in force and can be accepted, thereby forming a valid contract, until it is terminated (see inset below)
- cannot be revoked by the offeror when the parties have created a valid option

Note

Terminating an Offer

An offer can be terminated by certain events or actions of the parties. The events that terminate an offer are:

- the death of the offeror or offeree
- the destruction of the subject of the offer
- a supervening illegality

The actions that terminate an offer are:

- revocation of the offer by the offeror (unless it is a valid option)
- rejection by the offeree
- a counteroffer by the offeree

In certain cases, the offeror will have created a valid option, which is an **irrevocable offer**. Such an irrevocable offer guarantees to the offeree that the offer will remain open for the designated duration. A valid option—an irrevocable offer, in other words—is created when the offeree gives the offeror something of value to keep the offer open. In other words, the offeree pays the offeror an option premium. In such a case, the offeree is paying for time to consider the offer, knowing that the offeror cannot revoke it before the agreed-upon termination date.

Acceptance

The simple extending of an offer does not result in a contract unless, among other conditions, the offer is accepted by the offeree. But, what constitutes acceptance? Or, when is "acceptance" not really acceptance of the offer?

Under the common law, an offeree who wants to accept an offer must:

- abide by any stipulations in the offer
- accept every term of the offer

For example, if the offer conveyed to the offeree states that he or she must accept the offer in person or must accept it by April 1st at 5:00 pm, those conditions must be met. If such an offer is accepted by mail or at 5:30 pm on April 1st, the acceptance—even when accompanied by sufficient consideration—will not require the offeror to enter into a binding contract. In fact, the offeree's deviation from the terms of the offer renders the acceptance a rejection of the offer. Unless the offer specifies differently, the offeree's dispatching of his or her acceptance is a valid acceptance and will thus create a contract. (This is known as the **mailbox rule**.)

To create a contract, the offeree must accept each term of the offer, which is known as the **mirror image rule**.[4] His or her failure to accept a particular term of the offer while accepting the remainder of the offer is deemed to be a **counteroffer**. A counteroffer under common law is a rejection of the original offer. For example, suppose that Tim makes an offer to Joe to sell him his 20-year-old automobile for $500 and season tickets to the local college football games. If Joe agrees to the $500 but instead suggests season tickets to the local college basketball games, his acceptance is not sufficient to bind Tim to the agreement.

In the case of a counteroffer, the offeree (of the original offer) becomes the offeror of the counteroffer, and all of the rules regarding offer and acceptance now apply to the other party. This is an important concept to keep in mind when we consider the formation of an insurance policy in the next section. As we will see, an insurer's offering an applicant a rated policy or issuing it *other than as applied for* constitutes a rejection of the original offer made by the applicant and is conveyed by he or she submitting an application and initial premium and the insurer making a counteroffer.

Consideration

The third element in the formation of a contract is "consideration." Consideration, when used in connection with the elements required for a valid contract, means *something of value that is bargained for and requested by the offeror and given by the offeree in exchange for the offeror's promise.* Under contract law, not all promises are enforced or enforceable as valid and binding contracts. In most cases, contract law only enforces promises that are given in exchange for something of value.

Consideration sufficient to create a contract must be:

- mutual (given by both parties to the contract)
- bargained for
- a legal detriment and/or benefit

If these three elements of consideration are not present, no contract has been entered into—the contract is *void* for lack of consideration. It is important to understand that, under contract law, consideration does not need to be reasonable, fair, or equitable. It just needs to meet the three requirements stated previously.

An Insurance Policy as a Contract

With that basic understanding of the elements of a contract, it becomes somewhat easier to understand the special contract known as an insurance policy. As we begin the discussion of the common characteristics of insurance policies, bear in mind that an insurance policy is a contract and, as a contract, is generally subject to the concepts and rules that govern virtually all contracts.

Common Characteristics of Insurance Contracts

The common characteristics of insurance contracts, regardless of the type of insurance involved, are that they are the following:

- aleatory
- unilateral
- conditional
- contracts of adhesion

Aleatory

Most contracts are **commutative**, which means that each party to the contract expects to receive from the other party something that is of equal value to what he or she is giving. For example, if one party to the contract agrees to pay $1,000, he or she expects to receive some benefit approximately equal to $1,000. In such a contract, both parties anticipate a relatively even exchange of value. This is not the case in an insurance policy.

An insurance policy is not commutative in nature; instead, it is **aleatory**. In an aleatory contract, one party can receive a benefit that is completely out of proportion to what he or she is giving. Receiving a disproportionately large benefit, however, depends on whether a chance event occurs.

Insurance policies, for a relatively modest premium (relative to the possible benefit to be received), may provide huge benefits on the occurrence of the insured-against event. For example, if a $1 million warehouse burns to the ground, the $2,000 premium paid by the insured for fire insurance coverage is insignificant. Similarly, an insured can insure his or her life for $1 million and, depending on age, can pay an annual premium of as little as $500.

It is that element of uncertainty that is essential for an aleatory contract. Obviously, if the chance event does not occur during the term of the coverage, the insured normally receives nothing for the premium except the assurance that a benefit would have been forthcoming if this event had occurred.

Definition

Aleatory contract—A contract under which performance is conditioned on the occurrence of an uncertain event.

Unilateral

The essence of most contracts is that both parties make promises, and both can be held to them; in other words, most contracts are **bilateral**. This exchange of mutual promises is the essence of a bilateral contract. Each party can bring suit to force the other party to keep his or her promise. Conversely, the unilateral nature of an insurance policy represents a significant deviation from most contracts.

In a **unilateral contract**, only one party makes an enforceable promise. In the case of an insurance policy, only the insurer makes a promise that can be enforced. The non-promising party in an insurance policy, i.e., the policyowner, fulfills his or her part of the agreement by paying a premium before the insurer fulfills its part.

Definition

Enforceable promise—only the insurer makes an enforceable promise. The insurer cannot require the policyowner to pay ongoing premiums.

The insurer cannot obligate the policyowner to pay ongoing premiums. However, if the policyowner does not pay ongoing premiums as specified in the policy, the insurer is released from its promise to pay the benefit at the conclusion of the term of coverage for which premiums had been paid.

The policyowner incurs no legal penalties resulting from his or her failure to pay any further premiums. However, the insurer is required to accept further premiums from the policyowner to maintain the coverage in force according to its original terms.

Conditional

An insurance contract often contains many **conditions**. The number of conditions and their type depend on the kind of insurance policy. In virtually all types of insurance, payment of the benefit is conditioned on the policyowner's payment of premiums. If the policyowner fails to pay the fire insurance premium on his or her warehouse, he or she will receive no benefit if the warehouse is destroyed by fire. Another property/casualty condition can be that a home insured must not be left vacant for more than 60 days or some other duration.

A condition that applies in the case of a life insurance policy is the insured's not committing suicide during the period covered by the policy's suicide provision. A condition that applies universally to all types of insurance is the requirement that the policyowner or beneficiary provide due proof of the insured loss. Regardless of the condition or conditions that apply, every condition must generally be satisfied before the legal right to the benefit is created. If a condition is not satisfied, the insurer is normally not obligated to pay the promised benefit.

A Contract of Adhesion

In most contracts other than insurance contracts, the parties negotiate terms, price, and any other part of the contract until they are able to agree; in other words, bargaining occurs between the parties. However, anyone who has ever purchased an insurance policy knows that, in most cases, insurance contract terms and price are determined quite differently; little, if any, bargaining occurs.

In other words, an insurance policy is a **contract of adhesion**.

Definition

Contract of adhesion—a contract that is drafted by one party and is offered on a take-it-or-leave-it basis, with little opportunity for the other party to bargain terms, price or other elements.

A common characteristic of contracts of adhesion is that they typically contain lengthy provisions, written in language that can be difficult for ordinary consumers to understand. Because policyowners have limited or no opportunity to change the terms of the policy, courts generally rule in favor of a policyowner if an ambiguity exists in policy provisions.

Parties to an Insurance Contract

Like any other commercial contract, an insurance contract generally involves two parties. Those parties are the following:

- the insurer
- the contract owner

In the case of a policy of life insurance, the policyowner is normally the person whose life is insured and who is referred to as the **insured**. Although the policyowner and insured are usually the same, that is not always the case. Sometimes the person insured under the policy does not own it. For example, a mother

may own a life insurance policy on the life of her son. The mother would be the policyowner, and the son would be the insured under the policy.

The natural or nonnatural person who applies for insurance on an individual's life is known as the **applicant** or **policyowner** (after the policy is issued). Typical cases in which the life insurance policyowner or applicant is different from the insured are the following:

- A trust or other third party owns the life insurance policy to keep its death benefits out of the insured's federal gross estate when he or she dies.
- A partner or co-stockholder of the insured owns a life insurance policy on an insured's life to provide funds to complete the purchase of the insured's interest under a buy-sell agreement.
- An employer who is using the policy benefits to fund a nonqualified benefit plan (deferred compensation, for example) or to provide key-person coverage owns the policy under which the employee is the insured.

The other case in which a party other than the original contract owner and the insurer are parties to the insurance contract involves policy assignments. A policy assignment is a transaction in which some or all rights in an existing insurance contract are conveyed from the policyowner to another person. There are two types of assignment: an **absolute assignment** and a **collateral assignment.** The person conveying the insurance policy is known as the **assignor.** The person obtaining rights in the policy under the assignment is known as the **assignee.**

In the case of an **absolute assignment**, the assignee stands in the shoes of the original contract owner after the assignment of the policy and becomes a party to the contract. A collateral assignee, however, does not become a party to the insurance contract. (A **collateral assignee** is a person to whom a life insurance policy is assigned as collateral, usually for a loan.) Instead, the collateral assignee obtains a limited right to a portion of the death benefit only for so long as the loan or obligation remains outstanding.

Although the beneficiary is the person (an individual, corporation, trust, etc.) that can eventually receive the death benefits payable under the policy, the beneficiary is not a party to the insurance contract unless the beneficiary is an irrevocable beneficiary. Any rights that the beneficiary has in the life insurance policy are conferred as a result of an agreement between the insurer and the policyowner rather than as a result of the insurance contract.

Life Insurance Contracts

The submission of a completed application for a life insurance policy to an insurer may or may not be considered an "offer," depending on whether the first premium for the policy is remitted to the insurer with the application:

- In the case of the formation of a life insurance contract, a completed application accompanied by the first premium is deemed to be an offer that the insurer can accept or reject.

  If the insurer issues the policy applied for in such a case, the issuance constitutes acceptance of the applicant's offer. However, an insurance company sometimes responds to an application for insurance by offering coverage that is different from the coverage the applicant applied for or at a premium rate that reflects the insurer's assessment of the risk as **substandard**. When the insurer makes this offer, it is treated as a rejection of the applicant's offer and is considered a counteroffer. In such a case, a contract is formed only if the applicant accepts the insurer's tendered policy (the counteroffer) and pays any required premium.

- When a life insurance applicant submits an application without paying the first premium, that application is not an offer; instead, it is considered an invitation to the insurer to make an offer.

  If and when the insurer issues a life insurance policy in response to the unbound submitted application, the applicant is then free to accept the insurer's offer or reject it. Accepting delivery of the policy and paying the first premium is an acceptance by the applicant of the insurer's offer; failure to take delivery constitutes rejection of the insurer's offer.

Immediate Coverage

The bulk of life insurance applications are accompanied by the applicant's first premium and, thus, constitute offers. When an applicant submits an application for life insurance, together with the payment of the first premium, an agent normally issues the applicant a conditional receipt that provides *conditional* interim coverage. Under the typical **conditional receipt**, life insurance coverage begins on the later of the application date or the date of any required medical examination *provided the proposed insured is found to be insurable for the coverage applied for*. If the proposed insured is found not to be insurable for the coverage applied for, no interim coverage was created by the conditional receipt. In any case, coverage under a conditional receipt normally expires at the end of 60 days following the date of the application if no underwriting action has occurred.

An alternative to the conditional receipt that insurers sometimes use in their application process is known as a **temporary insurance receipt**. Unlike the conditional receipt, a temporary insurance receipt does not require the proposed insured to be insurable for the coverage applied for in order for the receipt to provide temporary coverage. Instead, the application generally asks 3 to 6 questions about the proposed insured's medical history, all of which must be answered "no" for the applicant to be issued a temporary insurance receipt.

The questions for a temporary insurance receipt typically ask whether the proposed insured:

- was admitted to a hospital or other facility or had surgery performed or recommended within the previous six months
- was treated for various named diseases or conditions
- ever had an insurance application modified, declined, or rated

The insurance coverage provided under a temporary insurance receipt normally ends at the earlier of the end of the 90-day period following the date of application or the issuing of the applied-for policy. The maximum amount of life insurance coverage provided by a conditional receipt or temporary insurance receipt generally varies depending on the insurer's size and the age of the proposed insured. Coverage limits under the receipt can be as little as $50,000 or as much as $1 million, but never more than the amount of the life insurance coverage applied for. The maximum coverage available under a temporary or conditional receipt usually increases as the size of the insurer increases and declines as the age of the proposed insured increases.

Types of Life Insurance Beneficiaries

Life insurance beneficiaries are classified as:

- primary beneficiaries
- contingent beneficiaries

A primary beneficiary has the first claim to the life insurance policy's death benefits. A contingent beneficiary, sometimes called a **secondary beneficiary**, has a claim against the life insurance policy's death benefit proceeds only upon the death or removal of the primary beneficiary.

The number of primary or contingent beneficiaries to receive death benefits under a life insurance policy has no theoretical limit. Furthermore, these beneficiaries can be individually named or can simply be members of a class. For example, a policyowner can designate his or her "son, John, and daughter, Kate, to share equally." Alternatively, he or she can designate a class of beneficiaries. Such a designation might direct death benefit proceeds to "children of the insured in equal shares."

In the majority of personal life insurance cases, a married policyowner-insured with children designates his or her spouse as the primary beneficiary and names any children to share the proceeds equally as contingent beneficiaries. Such a beneficiary designation is normally written as follows:

Primary beneficiary:	Insured's wife, Sarah, if living
Contingent beneficiary:	Children of the insured, equally

With such a beneficiary designation, the children have no rights to the life insurance policy death benefit unless the policyowner removed his wife, Sarah, as beneficiary or Sarah predeceased the insured. Multiple levels of contingent beneficiaries could also exist, where beneficiaries at each level are entitled to benefits only upon the removal or death of beneficiaries at higher levels.

Multiple beneficiaries can share death benefits equally, or benefits can be apportioned unequally. For example, instead of "children of the marriage to share equally," the policyowner in our previous example could have directed death benefits to his children John and Kate as follows:

Children of the marriage to share as follows: Daughter Kate, 75%; Son John, 25%

In the case of multiple beneficiaries, directions must be provided for how the death benefit is to be paid if one of the beneficiaries dies before the insured. For example, suppose the beneficiary designation provided for benefits to be paid to:

My children, Kate and John, to share equally

Per Stirpes and Per Capita

Suppose that in the above beneficiary designation Kate and John both have children of their own. If Kate dies before the policy insured, what happens to her share of the death benefit? Is her share paid to her brother, John? Or, should Kate's share of the death benefit be paid to Kate's children?

Either approach can be desirable or undesirable, depending on the wishes of the policyowner. The law has created two Latin terms to describe each of these dispositions:

- per stirpes
- per capita

If the policyowner wants any death benefit that would have been paid to his daughter, Kate, to be directed to Kate's children were Kate to pre-decease him, he would indicate that the beneficiary designation was *per stirpes*. Such a designation might read:

My children, Kate and John, to share equally, per stirpes

The Latin expression *per stirpes* literally means "by the trunk" and, in terms of beneficiaries, means that the deceased person's issue or lineal descendants take the share of the death benefit that the beneficiary would have taken had he or she lived.

In some cases, a policyowner will choose to have any death benefits that would have been payable to one child go to another child in the event of the first child's death. To return to our example, suppose that the policyowner did not want to have any death benefits payable to his grandchildren. Instead, he wanted the surviving child to receive all of the death benefit. To produce such a result, he might have written the beneficiary designation as follows:

My children, Kate and John, to share equally, per capita

Under this beneficiary designation, John receives the entire benefit if Kate predeceases the policyowner. Kate's children receive no part of their grandfather's death benefit. The Latin expression *per capita* literally means "by the head" and restricts allocation of the death benefit to the remaining members of the beneficiary class. Because John is the only remaining member of the class of beneficiaries, he receives the entire death benefit under a *per capita* beneficiary designation.

Revocable and Irrevocable Beneficiaries

Today's life insurance policyowners generally have certain rights in their life insurance policies unless they give the rights away. Those rights normally include the right to borrow against the policy, to receive dividends, and to change the beneficiary. Such was not always the case, however.

In the nineteenth century, at what might be considered the dawn of modern life insurance, life insurance policies had no provision for changing a beneficiary. At this time in the product's development, surrender values or other prematurity rights did not exist. As a result, an insured purchased a life insurance policy and designated a beneficiary who was considered to be the policy's owner. If the beneficiary were to die before the insured, the policy's death benefit proceeds became payable to the estate of the beneficiary who had been named in the policy when the insured subsequently died.

It was only at the beginning of the twentieth century that some of the life insurance companies began to include a policy provision allowing a policyowner to change the policy beneficiary provided the right to do so had been reserved. Following the Armstrong investigation of 1905 to 1906, a change of beneficiary clause was mandated.

In modern insurance law, in contrast to the law that existed in the nineteenth century, a life insurance policy's revocable beneficiary's interest is only an **expectancy** and is subject to every other right exercisable by the policyowner. That expectancy in the policy's death benefit proceeds materializes only if all of the following four conditions are met:

- The policy is in force at the date of death of the insured.
- The beneficiary designation has remained unchanged.
- The policy is not assigned at the time of the insured's death.
- The beneficiary has outlived the insured.

Even if all of these conditions are met, the policyowner can significantly compromise the death benefit by taking loans or withdrawals under the policy.

Although a policyowner has reserved the right to change his or her beneficiary, some circumstances could prohibit the change. For example, a policyowner can be unable to change the policy's beneficiary if:

- the policy were subject to a collateral assignment agreement or
- a court order prohibited the change, such as in an agreement in contemplation of divorce

Although the overwhelming majority of beneficiary designations are revocable, a policyowner can choose to name an irrevocable beneficiary. If a policyowner has designated an irrevocable beneficiary, neither the irrevocable beneficiary nor the policyowner can exercise any policy rights—to take a loan, for example—without the consent of the other. For virtually all purposes, a policyowner and an irrevocable beneficiary

are considered to be the policy's joint owners. Under a policy containing an irrevocable beneficiary designation, the irrevocable beneficiary's interest in the policy terminates at the beneficiary's death and reverts to the policyowner.

Common Disaster

Determining if a life insurance policy's beneficiary outlived the insured and became entitled to receive the policy's death benefits is normally easy to do. In certain situations, however, it is not nearly so simple. The all-too-common situation where such a determination frequently cannot be made involves the highway deaths of a husband and wife. Following a fatal accident in which both are killed, it can be virtually impossible to determine which of the two survived the longest. Although it can be impossible to tell whether a beneficiary survived an insured, the rights and benefits of various parties can be significantly affected by the determination.

To avoid litigation in multiple death cases where it is difficult or impossible to determine who survived longer, virtually every state has passed the Uniform Simultaneous Death Act. Under this act, each individual, absent evidence to the contrary, is deemed to be the survivor with respect to his or her own property. In the case of life insurance, the insured is deemed to have survived the beneficiary. Whether the policy beneficiary is revocable or irrevocable is immaterial to a determination of the survivor in a common disaster.

Classification by the Nature of the Risk

Many classifications are used in insurance law. Insurance is classified by the nature of the risk being transferred to the insurer. Voluntary specialization by insurers and statutory regulations adopted by many states created three main classes of insurance:

- marine and fire insurance
- casualty insurance
- life and health insurance

At one time, regulatory statutes in many states limited insurers to writing only coverages that were within a single class. In other words, a life and health insurer could write only those coverages and was not permitted to sell insurance coverage included in other classes, such as casualty insurance.

Over time, many states relaxed their rules to permit insurers to underwrite various types of insurance. These companies are generally referred to as **multi-line insurers**. For example, marine and fire insurers could sell life insurance in those states permitting multi-line insurance marketing. In many cases, however, insurers limit their underwriting to one type of insurance.

Even in states that did not allow a company to engage in multi-line underwriting, many insurers developed a comparable form of underwriting by arranging affiliation between several insurance companies. Agents associated with these insurers provided insureds with a wide range of coverages, each written by an affiliated company.

In many states, multi-line underwriting evolved into a broad approach known as **all line underwriting**, which embraces all of the three main classes of insurance. Despite the growth of all line underwriting, distinctive and significant regulations, doctrines, and practices continue to exist with respect to each of these classes of insurance.

The laws and doctrines surrounding marine, fire, and casualty insurance are addressed in courses specifically focused on those coverage types. In this course, we narrow the focus considerably to look at those legal concepts that impact life and health insurance, the companies that write those coverages, and the consumers who purchase them.

Life and Health Insurance

The following types of coverage are generally included under the broad heading of life and health insurance:

- life insurance
- medical insurance
- disability insurance
- long-term care insurance
- annuity contracts

These coverages can be purchased by a group or an individual.

Life Insurance

Life insurance can be **permanent life insurance**, which is designed to remain in force throughout the insured's life no matter how long that lifetime turns out to be, or it can be life insurance designed only to remain in force for a specified duration, known as **term life insurance**. Permanent life insurance can be whole life insurance that is *guaranteed* to remain in force until the insured's death or until the limiting age at which time the policy endows for its face amount, requiring only that the policyowner make premium payments in an amount specified at the time the policy is issued, or it can be **universal life insurance**.

Universal life insurance, while also falling into the category of permanent life insurance for most purposes, can also remain in force throughout the insured's life.[5] However, unless a universal life insurance policy contains a secondary guarantee that ensures its continuity for the insured's lifetime, no universal life policy premium level guarantees the continuation of the policy. Instead, the policy remains in force only so long as the policy's cash value (sometimes referred to as the **accumulated value** in universal life insurance products) is sufficient to enable the insurer to make its monthly deductions.

Term life insurance is available in any of three broad plan designs:

- level term life insurance
- decreasing term life insurance
- increasing term life insurance

The most popular plan designs are level term life insurance and decreasing term life insurance. (Increasing term life insurance is mainly sold as a rider attached to a permanent life insurance policy to meet specific policyowner objectives, such as ensuring a level personal death benefit under a life insurance policy sold in a split-dollar plan despite an employer's increasing interest.) While increasing term life insurance is almost always sold as a rider, both level and decreasing term life insurance can be sold as stand-alone policies or as riders attached to other policies.

Term life insurance is often sold to meet life insurance needs that are temporary: to cover a term loan, for example. When sold as level term life insurance, the premium and death benefit remain level for the specified term, which can be one year, five years, ten years, or up to as many as 30 years. Some insurers also offer level premium term-to-age-100 policies that may compete with types of policies considered permanent life insurance. Level term life insurance policies generally contain provisions known as **renewability provisions** that allow a policyowner to continue the coverage for additional term periods equal to the initial term period. (For example, a one-year term life insurance policy can be renewable for additional one-year periods; a five-year term policy for additional five-year term periods, etc.) Alternatively, insurers may offer level term insurance coverage under which the renewal period is limited to one year despite the length—five years, ten years, etc.—of the initial term insurance period.

In addition to renewability provisions, many term life insurance policies allow a policyowner to exchange the term life insurance coverage for permanent life insurance coverage under provisions known as **conversion provisions**. When a term life insurance policy or rider contains both renewability and conversion provisions, it is known as **renewable and convertible term insurance**.

When term life insurance is sold as decreasing term life insurance, the premium normally remains level throughout the term period, but the death benefit decreases. The decrease in death benefit usually occurs monthly, and the policy or rider can decrease evenly over the period (a product known as **straight-line decreasing term**) or can decrease more slowly in the early years and more quickly in later years (a product known as **mortgage term decreasing term**). Decreasing term life insurance policies and riders are generally issued in durations of 10 years to 30 years. Regardless of the design of its decrease and the duration of its term, decreasing term life insurance is often convertible but seldom renewable.

In addition to its popularity as life insurance coverage designed to meet temporary life insurance needs, term life insurance is often used by individuals who need permanent life insurance coverage but are unable to afford it. For many of these insurance buyers, the purchase of term insurance with the intention of converting it to permanent life insurance coverage when the policyowner's income increases makes good sense.

Medical Insurance

The category of insurance known as medical insurance covers a wide spectrum of products that are designed, generally, to cover the costs of the treatment of an insured's illness or injury. Medical insurance includes:

- traditional indemnity plans, such as:
    - hospital expense plans
    - surgical expense plans
    - basic medical expense plans
    - major medical expense plans
    - comprehensive plans
- managed care plans, such as:
    - health maintenance organizations (HMOs)
    - health maintenance organizations with point-of-service option (POS)
    - preferred provider organizations (PPOs)

Like life insurance plans, these medical insurance plans can be purchased as individual policies or, if the customer is a member of a group, as group policies.

Although the traditional types of medical insurance continue, the Affordable Care Act has effected monumental changes with respect to health care coverage. Among the principal provisions of the legislation are those that:

- generally require all nonexempt individuals to maintain at least minimum essential health care coverage or be subject to a tax penalty (Note: As a result of the Tax Cuts and Jobs Act of 2017, the penalty for failing to maintain individual health insurance coverage is reduced to zero beginning in 2019.)
- base the variability of insurers' health insurance premiums only on the insured's age and use of tobacco

- forbid exclusions for pre-existing conditions
- prohibit insurers from placing limits on the amount of benefits provided for essential health benefits
- limit insurers' ability to rescind health insurance coverage
- guarantee certain patient protections for individuals whose coverage requires participation in a network of health care providers
- extend the age at which insurers must provide coverage for covered participants' adult children

Disability Insurance

The term "disability insurance" also includes several different plans differentiated mainly by their use by the policyowner:

- disability *income* insurance plans designed to replace a part of the insured's income when he or she becomes disabled
- disability *overhead* insurance plans designed to pay a disabled insured's business overhead expenses during his or her disability
- disability *buyout* insurance plans designed to provide funds with which a partner or co-stockholder can buy the business interest from a disabled business owner

Although disability *income* insurance can be purchased on an individual or group insurance basis, both disability overhead and disability buyout coverages are generally available only as individual policies. The common thread running through disability insurance policies is the requirement that the insured be disabled (this term is defined in the policy) for benefits to be payable.

Long-Term Care Insurance

Long-term care insurance is designed to provide funds to pay some or all of the costs of an insured's long-term care. It is available as an individual or group policy or as hybrid coverage issued in connection with an annuity or life insurance policy.

Although coverage can vary dramatically among policies, long-term care insurance coverage can provide benefits if the insured requires any of the following:

- skilled nursing care
- intermediate nursing care
- custodial care

Depending on policy provisions, the coverage can provide benefits for care provided only in an institutional setting, only in the care recipient's home, or in both an institution and in the recipient's home.

Most of the long-term care need is for custodial care, which involves the need for assistance with the activities of daily living (ADLs). ADLs include the following:

- bathing
- dressing
- feeding

- toileting
- continence
- transferring (mobility)

Long-term care policies can be **qualified** or **nonqualified contracts**. Qualified long-term care policies must meet certain federally mandated requirements. However, qualified long-term care contracts receive certain tax benefits:

- Premiums are included in the costs for medical care and are eligible for itemized tax-deduction subject to a 10 percent of adjusted gross income threshold and certain dollar limitations that change as the insured ages.
- Benefits from a qualified long-term care contract are generally treated as reimbursement for expenses incurred for medical care and are generally not included in gross income, subject to *per diem* dollar limitations.

The IRS has not ruled on the tax benefits available under nonqualified long-term care contracts.

Annuity Contracts

The traditional definition of an annuity is a "vehicle for the systematic liquidation of a principal sum." Accordingly, an annuity contract provides for the periodic payment of income benefits beginning at a specified date and continuing for the period prescribed in the annuity contract. That prescribed period can be for a term of years, in the case of a temporary annuity, or for the duration of the payee's life under a life annuity.

An annuity may be an *immediate annuity* under which periodic payments begin shortly after purchase or a *deferred annuity* in which cash values are built up during an accumulation period for eventual distribution as periodic payments. Only a small fraction of deferred annuity funds are actually annuitized by owners, however. In the majority of deferred annuity cases, contract owners withdraw funds from, or surrender, the contract rather than taking periodic income payments from it. Because of the reluctance of many contract owners to annuitize, annuity contracts have taken on a greater accumulation role apart from their traditional role as a vehicle for the liquidation of funds. Since nonqualified annuities, i.e., annuities *not* used for qualified plan purposes, are unlimited with respect to the premium amounts that can be paid into them and offer tax-deferral of accumulated value growth, many annuity consumers prefer them to other products for long-term savings and investment.

Summary

The insurance industry is regulated principally by the individual states, whose regulation is designed to accomplish various objectives, including the following:

- ensuring the solvency of insurers
- ensuring that all parties to the insurance transaction receive fair and equitable treatment
- ensuring an adequate and healthy insurance market, characterized by competitive conditions
- providing for an office that is expert in the field of insurance
- improving and preserving the regulation of insurance
- encouraging loss prevention as an aspect of the operation of the insurance enterprise
- keeping the public informed on insurance matters

Insurance involves the contractual transfer of risk to an insurer. The contract evidencing the transfer is an insurance policy. An insurance policy, because it is a contract and subject to contract law, involves the normal contractual elements of offer, acceptance, and consideration.

When an insurance application along with the initial premium is tendered to the insurer, the applicant is deemed to have made an offer that the insurer may accept or decline. In contrast, an applicant's completing and submitting an insurance application *without the initial premium* does not constitute an offer; instead, it is considered an invitation to the insurer to make an offer. If the applicant has made an offer by submitting both the application and initial premium, the insurer's issuing a policy *as applied for* is an acceptance of that offer. An insurer's refusal to issue the policy as applied for—by charging higher rates or changing the requested coverage in any way—is legally considered a rejection of the applicant's offer and the making of a counter-offer.

Although an insurance policy is a contract, it is a special type of contract that is considered an aleatory, unilateral and conditional contract of adhesion. Because of the special contractual nature of insurance policies, only one party—the insurer—makes an enforceable promise. In addition, because the terms of an insurance policy generally cannot be negotiated with the insurer, it is considered a *contract of adhesion* under which a buyer's options are limited solely to purchasing or refusing to purchase it. Accordingly, any ambiguity in a policy is generally decided in favor of the policyowner and against the insurer.

Life insurance policies are designed principally to pay a death benefit to a beneficiary upon the death of the insured. Beneficiaries are designated as *primary* beneficiaries and *contingent* beneficiaries. Such beneficiary designations may be *revocable* or *irrevocable*. In addition, a beneficiary may involve a *per capita* or a *per stirpes* beneficiary designation.

Chapter 1 Review Questions

1. Which of the following is correct concerning the system of justice known as common law?
    A. Its public practice does not require a law degree.
    B. It is a written code of law.
    C. It is derived from statutes passed by a legislature.
    D. It is derived from customs and usage rather than statute.
2. All of the following are goals of insurance regulation EXCEPT:
    A. to ensure the solvency of all insurers
    B. to encourage loss prevention
    C. to ensure protection is provided at the lowest premium
    D. to keep the public informed on insurance matters
3. Insurance always involves which of the following?
    A. risk avoidance
    B. risk transfer
    C. permanent coverage
    D. retrocession
4. Ellen submitted a life insurance application to her insurer without payment of the initial premium. What is the application submission considered?
    A. an offer
    B. a counteroffer
    C. an acceptance
    D. an invitation to the insurer to make an offer
5. Why is ambiguity in the terms of a life insurance policy normally decided in favor of the policyowner rather than the insurer?
    A. because it is a unilateral contract
    B. because it is an aleatory contract
    C. because it is a contract of adhesion
    D. because it is a conditional contract

Answers to Chapter 1 Review Questions

1. D. United States law derives principally from two sources: common law and statute law. Common law is the law that developed out of customs and usage and from the decisions and opinions of the courts.
2. C. The goals of insurance regulation are manifold and include:
    - ensuring the solvency of insurers
    - ensuring that all parties to the insurance transaction receive fair and equitable treatment
    - ensuring an adequate and healthy insurance market, characterized by competitive conditions
    - providing for an office that is expert in the field of insurance
    - improving and preserving the regulation of insurance
    - encouraging loss prevention as an aspect of the operation of the insurance enterprise
    - keeping the public informed on insurance matters

    However, ensuring that insurance protection is provided at the lowest premium is not a goal of insurance regulation. Such a goal is normally furthered by competition in the marketplace.
3. B. Insurance is generally considered the transfer of risk from one person-a policyowner-to an insurer.
4. D. When an insurance application along with the initial premium is tendered to the insurer, the applicant is deemed to have made an offer. In contrast, an applicant completing and submitting an insurance application *without the initial premium* does not constitute an offer; instead, it is considered an invitation to the insurer to make an offer.
5. C. Because the terms of an insurance policy generally cannot be negotiated with the insurer, it is considered a contract of adhesion under which a buyer's options are limited solely to purchasing or refusing to purchase it. Accordingly, any ambiguity in a policy is generally decided in favor of the policyowner and against the insurer.

Chapter 2
Law, Indemnity, and Insurability

One of the basic characteristics of any insurance system is its use of contracts. The contract is an agreement, enforceable in the courts, for the transfer of the financial consequences of a loss to the insurer by obligating the insurer to provide a benefit to the beneficiary if the event insured against happens while the policy is in force. In the case of life insurance, that event is the death of the insured.

This chapter describes the principle of indemnity and the doctrines of insurable interest and subrogation. Also described is the "Other Insurance" provision.

Principle of Indemnity

Public policy requires that speculation in insurance be avoided. A fundamental principle of insurance is that opportunities for net gain to an insured through the receipt of insurance proceeds exceeding his or her loss should be considered adverse to the public interest. In other words, the beneficiary should not make a profit under the policy. It is easy to see that the failure to avoid such speculation could easily lead to insurance wagering, destruction of insured property, and murder—significant societal ills that must be avoided. The fundamental insurance concept that avoids these problems is the concept of **indemnity**.

Insurance contracts are agreements calling for the transfer of a loss by obligating the insurer to pay a benefit to the party suffering the loss if it occurs while the policy is in force. Property and casualty insurance contracts are contracts of indemnity, under which an insurer "indemnifies" an insured for his or her loss. Indemnification means that compensation has been given to make the insured party whole again.

A contract of indemnity is one under which an insured is reimbursed *only* for actual losses incurred. Although it can provide a benefit that is less than the actual loss suffered, this type of insurance is designed to provide no more than reimbursement for an insured. The payments made by the insurer are generally limited to an amount not greater than that required to restore the insured to a condition "relatively equivalent" to what existed before the loss. The concept that insurance contracts should confer no benefit greater in value than the loss suffered is known as the **principle of indemnity**.

However, the principle of indemnity does not imply that the amount of an insurance payment must be equal to the loss. When insurance provides only partial reimbursement, the principle of indemnity is not compromised. In fact, in many situations, purchasers acquire insurance contracts that do not provide complete and total indemnification in the event of a loss.

While property and casualty contracts are usually contracts of indemnity, life insurance contracts are not. Instead, a life insurance contract is one designed to pay a stated sum upon the death of the insured, irrespective of the actual financial loss suffered by the survivors. That life insurance is not an indemnity contract is based on the principle that the value of a human life is without limit and that no amount payable upon death is in excess of the loss suffered.

Doctrine of Insurable Interest

The principle of indemnity shares some of its objectives with the doctrine of insurable interest. The doctrine of insurable interest requires that a significant relationship must exist between the insured and the person, object, or activity that is the subject of the insurance transaction. The specific justification for the doctrine of insurability is one that is similar to that involving the principle of indemnity. This is to avoid the possible abuses that can result from allowing insurance contracts that enable a beneficiary's net gain as a result of a loss to be placed in force.

In the case of life insurance, **insurable interest** involves a relationship between the person applying for insurance and the person whose life is to be insured. The applicant who has an insurable interest in the life of an insured is one who can reasonably expect a benefit or advantage from the continued life of the insured or can expect a loss or detriment if that life ends. In short, the party obtaining the life insurance benefit must suffer a financial loss as a result of the insured's death.

Insurers usually determine whether the required insurable interest exists *before* entering into the insurance contact. However, in the case of some types of property insurance, insurers make a careful examination only after a loss occurs. This examination explores whether the required insurable interest exists and the value of the insured's interest.

The objectives underlying the doctrine of insurable interest and the principle of indemnity include:

- avoiding inducements to wagering
- avoiding inducements to the destruction of insured property
- avoiding net gain to an insured through receipt of insurance proceeds that exceed the loss suffered

The answer to when an insurable interest must exist—at the time of the loss or at the inception of the insurance—varies based on the type of insurance being considered. With respect to life insurance, it is only necessary for an insurable interest to exist *at the time of entering into the life insurance contract.* If an insurable interest exists when the life insurance policy is purchased, the contract is enforceable even though no insurable interest exists when the insured dies.

It is considered unfair for an insurer to either reduce or to avoid paying life insurance death benefits because the recipient of the proceeds either did not have an insurable interest in a decedent's life at the time death occurred or did not have the same insurable interest that existed at the inception of the contract. This generally recognized rule concerning life insurance and insurable interest results principally from three factors:

- Life insurance is often acquired for the benefit of relatives and spouses. The existence of familial relationships, such as the relationship between parents and children, does not end with the passage of time. So if an insurable interest based on a family relationship exists at the time the life insurance is initially purchased, normally the interest still exists at the time the death occurs. Furthermore, this rule originally evolved at a time when marital relationships were generally more stable than they are today, and it was reasonable to have the same rule for a spouse as for a blood relative.
- Substantial amounts of life insurance are marketed as investments in addition to providing needed life insurance death benefits. A rule that only requires an insurable interest for life insurance at the inception of the contractual arrangement facilitates the liquidity of such investments. Requiring an insurable interest when death occurs limits the transferability of the asset, thereby reducing its value.
- Protecting the integrity of the life insurance transaction in terms of both preserving the contractual freedom of the parties and assuring the stability of the contractual commitment is strongly upheld.

In addition to the purchase of life insurance to meet family financial needs, it is used extensively in business arrangements. For example, life insurance is often used to offset the financial consequences that result from the death of a business owner or key employee. Life insurance is also used by partners and partnerships. When used by partners and partnerships, it is frequently used to ensure that sufficient liquidity exists to allow a withdrawal of the decedent's interest in the event of a partner's death without forcing the sale of the partnership's assets. Often, life insurance owned on employees or partners is maintained even after the business relationship has ended, and no continuing insurable interest exists. Depending on the nature of the business relationship between the insured and the third-party policyowner, the normally income tax-free nature of the death benefit in such a case may be affected.

In 1881, the U.S. Supreme Court commented on the type of relationship that must exist with respect to life insurance for there to be an insurable interest:

> In all cases, there must be reasonable ground, founded upon the relationship of the parties to each other, to expect some benefit or advantage from the continuance of the life of the insured. Otherwise, the contract is a mere wager, by which the party taking the policy is directly interested in the early death of the insured.

This suggests that two classes or types of relationships are appropriately recognized as insurable interests for a life insurance policy:

- pecuniary (monetary) interest
- family relationship

The common or unifying characteristic of these two types of relationships is that the beneficiary of the life insurance anticipates that some economic benefits can result from the continuation of the insured's life and that those benefits will be lost when the insured dies.

Life insurance transactions can be divided into two other general groups based on whether an applicant purchases the policy:

- on his or her own life or
- on the life of another person

Each of these situations has one or more distinctive characteristics that have significantly influenced the question of just what constitutes insurable interest.

Every person is deemed to have an unlimited insurable interest in his or her own life. Furthermore, an individual insuring his or her own life is entitled to designate any individual or entity as the beneficiary of the life insurance death benefits. To purchase life insurance on the life of another individual, the purchaser must have an insurable interest in the other's life.

The existence of an insurable interest based on a blood relationship or other close relationship is predicated on the presumption that love and affection normally exist between family members and that this relationship provides an adequate safeguard against the destruction of a person's life. The insurable interest requirement with respect to family members usually rests on characteristics of the relationship between the family members. Generally, an individual has an insurable interest in all the members of his or her nuclear family.

When a beneficiary of a life insurance policy is a relative but not a member of the insured's nuclear family, a demonstration of some pecuniary interest is sufficient to satisfy the insurable interest requirement for a life insurance policy. The family relationships in these cases have included uncles, aunts, nephews, nieces, stepbrothers, stepsisters, stepchildren, stepmothers, and stepfathers. A minor child also has an insurable interest in the life of his or her parents. In addition to the love and affection that normally exists, the parents have a legal duty to support the minor child.

When a question of insurable interest arises in a situation not involving family members, courts usually focus attention on the nature of the relationship between the individuals. The presence of the required insurable interest usually depends on whether some economic connection exists. Thus, an insurable interest can be based on many types of relationships, such as:

- a creditor on the life of a debtor
- one partner on the life of another
- a business entity on the life of a key employee
- business associates who accommodate each other through exchanges of information, equipment, and employees

These are known as **affinity relationships**.

When a beneficiary is not a relative and would not appear to suffer any quantifiable monetary loss as a result of an insured's death, the claim of the beneficiary has presented difficult questions for courts. Generally, when there is no reasonable expectation of benefit resulting from the continued life of an insured or when the amount of the life insurance is grossly disproportionate to the beneficiary's monetary relationship to an insured, the requisite insurable interest has been held not to exist.

Beneficiaries and Assignees

A person who obtains insurance on his or her own life is free to designate anyone as a **beneficiary**. However, the policyowner's assignment of an insurance policy on his or her own life to a person who has no insurable interest is less straightforward.

Some courts have held that an assignment of a life insurance policy to one having no insurable interest is void as a matter of law. Several reasons support this rule:

- No material distinction exists between the assignment of a policy to a person without insurable interest and the procurement of a policy by such a person.
- Such an assignment constitutes a wagering contract.
- Such an assignment may induce murder.

However, the majority rule on this issue is that the assignment of a life insurance policy to a person who does not have an insurable interest is, nonetheless, valid. This is supported because the objectives of the person who makes the assignment could be accomplished easily in other ways.

For example, in many instances, the desired result could be produced by changing the beneficiary of the insurance policy to the estate of the person whose life is insured, and then including a provision in the will for the insurance proceeds to go to the intended assignee.

More simply, in many circumstances, the insured could change the designation of the beneficiary to name the intended assignee. So a rule that invalidates assignments to those who do not have an insurable interest does little more than prevent people who do not receive adequate guidance from learning other ways to accomplish the desired result.

If the assignment of an insurance policy can be invalidated, this leads to the question of whether an insurance company escapes full liability or still must pay the policy proceeds when death occurs. Generally, a persuasive case can be made for limiting the payment to the assignee to the amount of the insurable interest. Any excess above the loss of the assignee is paid to the previously designated beneficiary or to the estate of the insured decedent. Using this approach, full insurance benefits are payable in all cases.

If an assignment is said to be void, this implies that the beneficiary could question the validity of an assignment on the grounds that the assignee lacked an insurable interest. However, allowing a beneficiary to raise the issue of the lack of insurable interest conflicts with the general notion that only an insurer can do so.

Insurable Interest Does Not Apply to Industrial Life Insurance

Industrial life insurance is life insurance written with death benefit amounts that are barely adequate for burial expenses—typically less than $1,000. Policy premiums are paid in frequent installments, perhaps even weekly. Industrial workers were among those to whom these policies were first offered, hence the name. The frequency of premium payments and small face amounts are the distinguishing characteristics of industrial life insurance.

An industrial life insurance policy usually cannot be assigned and contains a provision known as a **facility of payment clause**. This clause authorizes payment to anyone who is fairly entitled to the insurance proceeds by reason of having incurred expenses on behalf of the insured for medical treatment and/or burial. It was designed to avoid the need to appoint an administrator, executor, or guardian to collect the insurance proceeds and expedites the settlement of disputes among rival claimants without the delay and expense of litigation. The doctrine of insurable interest does not apply to industrial life insurance, because its application interferes with the free use of the facility of payment clause. In addition, the small amount of insurance coverage provided by such policies is less likely to be an inducement to murder.

Consent of the Person Being Insured Required

The insurable interest requirement usually provides an adequate safeguard for the person whose life is insured. However, a valid concern lies with the incentive to murder, which is inherent in allowing someone to insure another person's life. Not surprisingly, this concern is even greater when life insurance can be arranged without securing the insured's consent.

Few cases have addressed whether consent of the person whose life is insured is essential to the validity of an insurance contract. In situations where the purchaser of the life insurance does not appear to have a significant relationship with the person to be insured, it is necessary not only to have the insured person's formal consent to the coverage but also to have his or her active participation in the application for the coverage. Even when the person obtaining the insurance is someone with a substantial and generally recognized insurable interest, it still is desirable to require the consent of the person whose life is being insured.

History of the Doctrine of Insurable Interest

The doctrine of insurable interest was not always so faithfully followed. In fact, underwriters in the early 18th century did not demand proof of an insured's interest in the ship or cargo being insured. Not surprisingly, a great number of ships and their cargoes soon were fraudulently lost or destroyed. Because of this, the doctrine of insurable interest was created.

The **Statute of George II** declared that there had been a "mischievous kind of gaming or wagering, under the pretense of assuring the risk on shipping." The statute further declared that "no assurances shall be made . . . without further proof of interest than the policy." In simpler terms, insurance agreements could no longer be transacted without proof of some insurable interest.

The issue of gaming with respect to lives had to be addressed under the **Statute of George III**. This statute declared that no insurance could be made on lives or other events when the person who benefited from the policy had no insurable interest. The insurable interest requirement is a result of legislative and judicial actions, and it applies to all types of insurance transactions. Any insurance transaction that appeared to be a wager was generally declared to be illegal.

Application of the Doctrine of Insurable Interest

Generally, the objectives of the doctrine of insurable interest are accomplished by requiring the self-interest of the insurer. That is, the insurer would ordinarily provide life insurance coverage only for the benefit of those who have an interest in the insured.

However, although life insurance policy provisions do not require that the purchaser or beneficiaries have an insurable interest, the information on an application for life insurance typically enables the insurer to decide whether an insurable interest exists. So, ultimately, the objective of requiring such an interest usually is attained, although there is no express contract provision for this. Further, the doctrine of insurable interest is of such importance that it generally is enforced by the courts, even when no explicit clause states it.

Although insurers determine whether the required insurable interest exists *before* entering into a life insurance contact, in some types of property insurance, the determination of insurable interest is made only after a loss occurs. This examination explores whether the required insurable interest exists and what the value is of the insured's interest.

Insurable Value

Similar to the concept of insurable interest is the concept of **insurable value**. Simply stated, the concept of insurable value refers to the amount of the loss, assuming that insurable interest exists. In the case of property and casualty insurance, the insurable value is generally deemed to be the total value of the property based on a property valuation method (for example, actual cash value, replacement cost, functional replacement cost) recognized by the insurance underwriters.

Insurable Value in Life Insurance

Insurable value in the case of life insurance can be significantly more difficult to determine and depends, in part, on the use to which the life insurance is intended to be put. In the case of life insurance for personal and family purposes, underwriters generally determine insurable value based on the aggregate amount of capital needed to:

- replace the insured person's earned income
- provide for the education and maintenance of children
- pay final medical and burial expenses
- pay any estate taxes and settlement costs due
- pay any outstanding debts

For example, the application for a $10 million life insurance policy submitted by an unmarried individual with an income at the federal poverty level and few assets would clearly exceed the insurable value. While an apparent imbalance between the applicant's situation and the requested amount of life insurance is obvious in such a case, the "proper" amount of life insurance in any family or business situation is often a matter of judgment.

It was noted earlier that life insurance is often used in business situations to indemnify an employer upon the death of a key executive, to retire a decedent's business interest, and for many other purposes. Determining insurable value for some of these purposes is fairly straightforward; for others, it is more a matter of "feel" than arithmetic. Despite the imprecision involved, life insurance underwriters normally use ranges within which a particular life insurance death benefit is considered reasonable.

An example of such a range is one typically used in cases of key-person life insurance.[6] Life insurance underwriters generally limit key-person life insurance benefits to no more than five to ten times the key person's annual compensation. (Whether the limit is five times compensation or ten times compensation

generally depends on other factors, such as the individual's position in the firm, the number of executives, etc.)

Insurable Value in Disability Income Insurance

Insurable value in the case of disability income insurance generally involves a balance between two things: (1) ensuring the policyowner has sufficient income to meet his or her basic needs in the event of disability and (2) maintaining some economic motivation for the insured to return to gainful employment as soon as possible. The factors in this equation are the following:

- earned income
- unearned income
- existing disability income coverage
- the identity of the premium payor

As a general rule, insurers limit the amount of replacement disability income to between 60 percent and 90 percent of the insured's gross earned income. The actual replacement percentage offered is significantly affected by the level of the applicant's income, any other disability income coverage the applicant owns, the extent of the applicant's unearned income, and whether the applicant or his or her employer will pay the premiums. The rationale behind the applicant's existing disability coverage affecting the amount of any new coverage an insurer issues is obvious. However, the effects of earned income, unearned income, and the premium payor's identity on the *percentage* replaced may not be obvious.

The level of the applicant's earned income clearly affects the *amount* of the replacement disability income offered. The reason for the level affecting the *percentage* replaced lies in the fact that disability income is generally received tax free, and U.S. income taxation is progressive in nature. Because insurers avoid issuing more disability income than the insured would realize from employment, the greater percentage of gross income that the insured receives as net income (that is, after income taxes are paid) clearly plays a part. Also, because applicants with higher incomes can expect to pay a greater percentage of their income in taxes, their net income represents a smaller percentage of their gross income.

Note

Effect of Progressive Income Tax Rates on Disability Replacement Percentage

To understand the effect of the progressive income tax rates on disability income replacement percentages, consider the hypothetical case of two applicants: John, a computer programmer with a taxable income of $70,000 annually, and Shirley, a surgeon with a taxable income of $400,000 annually. Assuming that both:

- are married and file jointly with their spouses
- are the only family breadwinners
- take the standard deduction
- pay federal income taxes at 2018 tax rates

John would have a net annual income after federal income tax of $61,981, while Shirley's net annual income after federal income tax would be $308,621. John's net annual income represents 88.5 percent of his gross annual income; Shirley's net annual income represents 77.2 percent of her gross annual income. A disability insurer can replace John's gross income at 80 percent but would likely limit Shirley's replacement income to about 65 percent.

Unearned income is generally defined as dividend and interest income received by the applicant. In fact, however, underwriters often consider all types of unearned income, including royalties, rents, and renewals. The approach taken by insurers to account for unearned income is to reduce the amount of replacement income otherwise available by $.50 for each $1 of unearned income over a stated amount. That stated threshold amount tends to rise over time, but can be as low as $12,000 to $18,000 per year.

If an employer pays premiums for disability income coverage the insured owns, then insurers generally offer a higher replacement percentage—typically as high as 85 percent or 90 percent. The reason for the higher replacement percentage is because the disability benefits paid under a disability income policy owned by an insured with premiums paid by the insured's employer are taxable as ordinary income in the year received, reducing their value as received by the insured.

Subrogation Doctrine

Subrogation developed as an equitable doctrine. It facilitates an adjustment of rights to avoid unjust enrichment. To subrogate means "to substitute." So subrogation substitutes one person for another, with respect to a claim or right that the second person has against a third party. In simpler terms and with respect to insurance, subrogation is the right of an insurer to replace the injured insured that it has compensated for the loss and to sue the party that is responsible for the damages incurred.

Subrogation Rights

In the context of insurance, when an insurer indemnifies an insured who is entitled to recover compensation for a loss from another source, the insurer can be subrogated to the insured's rights. This means that the insurer is substituted for the insured with respect to all or some portion of the rights that the insured has to receive compensation from the other source.

Consider the following hypothetical situation to illustrate subrogation.

Example

Bob purchased automobile insurance coverage from MegaInsurer, Inc. As Bob was commuting to work in his automobile, he was involved in an accident caused by the negligence of a drunk driver. MegaInsurer, Inc. paid Bob's hospital, medical, and auto damage expenses. MegaInsurer, Inc. then exercised its subrogation rights and brought a lawsuit against the drunk driver who negligently caused the auto accident. If MegaInsurer, Inc. wins the lawsuit, it is permitted to recover any amounts paid to Bob *plus* any expenses it incurred in enforcing its subrogation rights (attorney costs, court costs, etc.).

An insurer who asserts a subrogation right is generally considered to be "standing in the shoes" of the insured, so that the insurer's rights are equal to, but no greater than, those of the insured. An insurer's subrogation right can be provided for by a clause in the policy or in a settlement agreement with an insured. This type of subrogation right is often referred to as **conventional subrogation**. Sometimes the right of subrogation for insurers is specifically conferred by statute.

When no policy provision or legislative act expressly confers the right of subrogation, an insurer can be entitled to seek subrogation on the basis of a judicially created right. A judicially created right is a right of subrogation that exists as a consequence of some determination by the courts. This type of subrogation is known as **legal subrogation**.

When the court considers whether a subrogation right should exist in the absence of a provision in the policy contract or in the absence of a legislative provision, the concern is usually whether the insured will receive compensation that provides more than full indemnification. The courts tend to favor subrogation if it appears that a third-party **tortfeasor** (the person who is responsible for the act) would escape his or her financial responsibility if the insurer were not accorded a subrogation right.

Subrogation is an important technique for serving justice by placing the economic responsibility for injuries upon the person who caused the loss, without allowing the injured person to recover from both the insurer and the negligent or willful party. That type of an action clearly violates the principle of indemnity.

Generally, an insurer is not entitled to subrogation rights that can exist as a consequence of a liability claim against its own insured. An insurer has no right of subrogation against a person who is the named insured or against any party who is covered as an additional insured. The insurer's subrogation interest is typically limited to the rights an insured can have against third persons, that is, against those who are not parties to or beneficiaries of the insurance relationship.

Subrogation and Life Insurance

Life insurance policies usually do not include subrogation clauses. In addition, the courts rarely impose an implied subrogation right with respect to claims that can exist in connection with losses compensated by such coverage. For example, a life insurer would not have any subrogation right in connection with a legal action for wrongful death.

Coordination of Benefits

Insurance policies providing property and casualty or liability coverage typically contain provisions that limit the total benefit payable when an insured is covered under multiple policies. This provision is known as the "Other Insurance" provision. Under these Other Insurance provisions, three possible approaches can be taken:

- **escape clause**—The insurer has no liability if there is other insurance.
- **pro-rata clause**—The insurer's liability is limited to a proportional share of the loss.
- **excess clause**—The insurer provides only excess insurance over any other insurance.

Although life insurance policies have no similar provision, health insurers sometimes face multiple coverage issues that must be addressed. In situations where double health insurance coverage exists, such as two health insurance policies with the same or different companies or where two spouses are covered under employer/employee plans, payments for claims could potentially result in **overinsurance**. To ensure that claim payments are not duplicated, states have generally adopted a **Coordination of Benefits Provision**.

If an insured is covered under more than one plan, the insurer who has the claim is called the **primary company** and must pay as much of the claim as the policy limits permit. Other companies covering the insured are called **secondary companies.** The secondary company pays whatever the primary company does not pay up to the limits of the secondary company policy. This is to ensure that an insured does not profit from insurance by collecting from multiple companies under the same claim. In other words, the plan that covers the claimant as a member, employee, or named insured is the primary insurer and pays as though no other plan existed. Remaining covered expenses are paid under a plan that covers the claimant as a dependent.

As to children covered under two policies, the birth months and days are normally used to decide which plan is primary. The parent whose birthday comes earliest in the year is the primary plan.

Summary

The concept of indemnity—a principle basic to insurance—is employed to avoid insurance wagering, destruction of insured property, and murder. Pursuant to the principle of indemnity, payments made by an insurer are generally limited to no more than the amount required to restore the insured to a condition that is relatively equivalent to the condition existing before the loss.

Although property and casualty insurance policies are typically contracts of indemnity, life insurance policies are not. Instead, a life insurance policy pays a stated death benefit amount regardless of the financial loss suffered by the survivors. Since the value of a human life is without limit, no amount payable upon death is in excess of the loss suffered. However, although a life insurance policy may pay any amount of death benefit upon the death of an insured, it requires that an insurable interest exist.

In a general sense, insurable interest requires that a significant relationship exist between the person, object, or activity that is the subject of the insurance transaction and the person receiving the insurance benefit such that the occurrence of the event insured against would cause substantial harm or loss to the beneficiary. Such a requirement is designed to avoid the possible abuses that could result from permitting insurance policies to be placed in force that result in a beneficiary's net gain following a loss.

Insurable interest, when applied to the purchase of life insurance, requires that a relationship exist between the person—whether a natural or nonnatural person, such as a corporation—applying for insurance and the person whose life is to be insured. A life insurance insurable interest exists when the applicant for the insurance can reasonably expect to:

- obtain a benefit from the insured person's continued life or
- suffer a loss or detriment when the insured person's life ends

Thus, for the finding of insurable interest, the interests of the party applying for life insurance must be better served by the insured's continued life than by his or her death.

Subrogation refers to the right of an insurer who has compensated an injured insured to stand in the shoes of the injured party and sue the party responsible for the injury. Although life insurance policies normally do not provide for subrogation—for example, an insurer cannot sue the person responsible for its insured's wrongful death—such provisions are routinely included in property and casualty policies. In the case of health insurance, insurers are sometimes faced with the prospect of paying out benefits that, because duplicate coverage exists, may exceed an insured's actual costs. To avoid such a result, health insurance policies generally contain a provision providing for coordination of benefits.

Under a coordination of benefits provision, benefits for a covered claim are paid first by a primary insurer up to its policy limits. A secondary insurer then pays benefits for the balance of the covered claim up to its policy limits. When both the primary and secondary insurer benefits are totaled, the amount does not exceed the total claim. Thus, an insured will not profit from being on claim.

Chapter 2 Review Questions

1. Which of the following statements correctly characterizes the role of insurable interest in a life insurance policy?
    A. Insurable interest is required to exist only at the inception of the policy.
    B. The doctrine of insurable interest does not apply to life insurance.
    C. The time when insurable interest occurs is unimportant.
    D. Insurable interest is required to exist only at the time of claim.
2. In addition to a family relationship, which of the following may constitute an insurable interest for life insurance?
    A. a monetary interest
    B. a close acquaintanceship
    C. being a co-worker
    D. being a member of an investment club
3. What is required before someone may purchase a life insurance policy on the life of another person?
    A. The purchaser must be a family member.
    B. The purchaser must be bonded.
    C. The purchaser must have insurable interest in the other's life.
    D. The purchaser must not have a criminal record.
4. When a person applies for life insurance on his own life, who may he or she designate as a beneficiary for the death benefit?
    A. only family members
    B. anyone
    C. only those from whom the policyowner has obtained consent
    D. no one
5. What does "to subrogate" mean?
    A. to speak in confidence
    B. to yield authority
    C. to bring under control
    D. to substitute

Answers to Chapter 2 Review Questions

1. A. Unlike property and casualty insurance coverage, life insurance insurable interest is required to be present only at the time the life insurance policy is purchased.
2. A. A life insurance applicant's insurable interest may arise from either a family relationship or a monetary interest, such as an interest an employer may have in its key executives.
3. C. For a person, whether a natural or nonnatural person, to purchase a life insurance policy on the life of another person, the applicant for the insurance must have an insurable interest in the proposed insured.
4. B. A person applying for life insurance on his or her own life may designate anyone as the beneficiary of the policy, whether or not the beneficiary has an insurable interest in the insured.
5. D. To subrogate means to substitute. The term "subrogation" is generally used in connection with an insurer's ability to stand in the shoes of an insured it has compensated and sue the person who caused the injury to its insured.

Chapter 3
The Law and Insurance Protection

Unfortunately, insurance policies have long been recognized for their contract provisions, but not in a positive way. These contracts and their numerous provisions can be confusing, even troublesome. Insurance policy contracts present statements of broad protection in general terms. Often this extensive language is found in large print. Then, these contracts limit the protection by including various restrictive provisions, typically found in much smaller print.

Although truly misleading practices with respect to contract language have been curtailed, most policy contracts still begin with broad statements that describe the extent of protection. Naturally, this is followed by numerous restrictive provisions.

This chapter describes the typical language used in policy contracts and the confusion that may result because of its complexity. Assignments of insurance contracts and the provisions of life insurance are also explained.

Defining Those Who Are Protected

Insurers use many methods and techniques to define, designate, and distinguish those covered by a policy contract. They also define and limit the interests covered by the policy.

These methods and provisions vary with the type of coverage purchased. Insurance contracts also generally include provisions that concern the nature of the risks being transferred to the insurer.

Unfortunately, the terminology insurers use to describe the various restrictions and provisions is not the same as that used by judges, lawyers, and other commentators. Many have advocated a standard terminology. For example, some standard terminology might be used to distinguish between “excluded events” (exclusions) and “excepted causes” (exceptions). Currently, no uniform terminology distinguishes among the different restrictions.

Designation and Life Insurance

In life insurance contracts, the term **insured** refers to the person whose life is the subject of the insurance contract. Usually the insurance proceeds are intended as a financial benefit for those who suffer an economic loss when the insured dies. The term “beneficiary” signifies the person who receives the proceeds of a life insurance contract upon the death of the insured.

When the insured purchases a life insurance policy and his or her death is the cause for an insurer’s liability, little or no confusion surrounds who the insured is.

However, if someone other than the insured applies for and owns a life insurance policy on the insured’s life, confusion often arises if the term “insured” is used to describe the purchaser of the policy. So, the term “insured” should not be used to refer to the purchaser of a life insurance policy. The owner of a life insurance policy is correctly referred to as the “policyowner.” It is preferable to use the term “insured” to refer only to the person whose death prompts the payment of the insurance death benefit proceeds. Technically, the insured is the person whose death is the subject of the contract, regardless of who buys the policy, who pays the premiums, or who receives the benefits upon the insured’s death. Inexact language produces misunderstanding and confusion.

Assignments

An **assignment** occurs when a policyowner transfers a right in an insurance policy to another person. Insureds sometimes assign some or all of the rights of an insurance contract. For example, an insured can assign to someone else the right to receive payment from the insurer. These arrangements present many legal issues and problems. Their outcome is notably influenced by the type of insurance that is involved.

Whether it is created before or after the insured event, the right to receive the payment of the insurance proceeds is considered **derivative**, or secondary. It is the assignor's right to payment that is transferred. Therefore, it is not the benefits per se but rather the assignee's right to receive the benefits that is subject to any defense that could be asserted against the assignor, i.e., the person assigning the policy.

The right to assign an insurance policy depends on the type of insurance involved and whether the policy includes terms restricting the right to transfer ownership.

Assignment of Life Insurance

When the phrase **assignment of the policy** is used in the context of a life contract, it describes two possible transactions that are distinct from one another:

- the transfer of all rights to another, referred to as an **absolute assignment**
- the pledging of a life insurance contract as security for a loan, known as a **collateral assignment**

The word **assign** when used in connection with insurance policies means to transfer. So an assignment of an insurance policy transfers some right to another party known as an **assignee**. (The party making the transfer is known as the **assignor**.)

Confusion can result from the difference in these two types of assignment, so let's review them more closely.

Absolute Assignment

An absolute assignment is a complete transfer of the policyowner's right, title, and interest to the assignee; the former policyowner retains no rights to the policy. As such, the assignee stands in the shoes of the former policyowner with respect to any rights in the policy and becomes, in fact, a party to the contract with the insurer. Absolute assignments are normally encountered in three situations:

- when a policy is being gifted by the policyowner to another person, for example, to the policyowner's children or to a trust
- when a corporate policyowner transfers ownership of an executive's policy to the executive when the need for the insurance ends
- when a policyowner transfers ownership of a life insurance policy to a viatical settlement provider and receives some portion of the death benefit in return

In the first case (transfer of the policy to another person as a **gift**) the transfer of the policy is a noncharitable gift and is subject to gift taxation. Depending on the circumstances, it may or may not qualify for the annual gift tax exclusion. The value of the gift that is made is approximately equal to the policy's cash surrender value at the date of the gift.

In the second case (transfer of a policy to the insured when no longer needed by the employer-policyowner), the former policyowner may or may not require the insured to purchase the policy for its cash value. If the policyowner requires payment of an amount equal to the cash value as part of the assignment transaction, equal value is deemed to have been paid for the policy. If the policyowner does not require payment of an amount equal to the policy's cash value, the amount by which the cash value of

the policy exceeds any payment is normally considered compensation to the employee-insured and is subject to income taxation at ordinary income rates.

When a life insurance policy is absolutely assigned *and payment is made for the policy*—that is, the policy is *sold*—it is considered a **transfer for a valuable consideration**, and the death benefits normally lose their favorable income tax treatment. However, absolute assignment of the life insurance policy to the insured or to certain other specified persons or entities, even when compensation is paid for the policy, is an exception to the transfer for value rule.

The third common absolute assignment situation involves a **viatical or life settlement**. In a typical viatical settlement, a company known as a **viatical settlement provider** purchases the life insurance policy of an insured suffering from a terminal illness. In a life settlement, a relatively healthy older insured policyowner sells his or her life insurance policy to a viatical settlement provider.

Regardless of whether the assignment involves a viatical settlement or a life settlement transaction, the insured policyowner assigns the policy to the viatical settlement provider, and the viatical settlement provider names itself the policy's beneficiary. The viatical settlement provider's "investment" in the life insurance policy matures when the insured dies. As in the previous example, this is a transfer for a valuable consideration. However, it is not an exception to the transfer for value rule. As a result, the favorable income tax treatment given to life insurance policy death benefits is lost to the viatical settlement provider.

Collateral Assignment

The situation in a **collateral assignment** is quite different from the absolute assignment just discussed. A collateral assignment is the transfer of a life insurance policy's death benefit to another, i.e. the assignee, *to the extent of his or her interest*. It is designed to enable the life insurance policy's death benefit to act as collateral and, thereby, to secure a debt. Because the assignment in such a case transfers the death benefit to the assignee to the extent of his or her interest, the portion of the death benefit payable to the assignee decreases as the assignor's debt decreases.

In a typical collateral assignment situation, a debtor might assign his or her $100,000 life insurance policy to a bank as collateral for a $40,000 loan. If the debtor were to die immediately after making the assignment, the bank would be entitled to $40,000 of the death benefit proceeds; the policy's beneficiary would receive the remaining $60,000. If the loan were an installment loan, the amount payable to the bank would decrease as the assignor's outstanding loan balance decreased until, when the loan is paid off, the collateral assignment was released. *A collateral assignment does not make the assignee a party to the insurance contract*.

Creditors as Beneficiaries or Assignees

A life insurance policyowner often designates a creditor as a beneficiary or as an assignee of his or her policy. When this happens, questions can ensue regarding the extent of the creditor's rights to the proceeds of the policy at the death of the insured. Other issues to be examined are rights, such as the authority of the policyowner to change the beneficiary or to arrange a loan from the insurer.

When the Insurance Is Acquired by the Debtor

When the proceeds of the insurance policy do not exceed the amount of the debt to a creditor, including any accumulation of interest and charges, typically no disputes arise. If the debt is unpaid at the time of the insured's death, the entire insurance proceeds are paid to the creditor.

Sometimes, however, the debt at the time of death, including any accumulation of interest and charges, is less than the policy proceeds. In such a case, someone else, such as the original beneficiary, a contingent beneficiary, or the insured's estate, can claim the policy proceeds that exceed the debt. The argument asserted in these situations is that the designation of the creditor as a beneficiary or collateral assignee

was intended as security to pay the debt and no more. Usually, a case can be made against allowing the creditor to receive the full amount of the insurance if it exceeds the amount of the debt.

Ordinarily, the document that designates the creditor as the beneficiary or assignee is the main evidence of the policyowner's intentions. If the document expressly limits the arrangement to security for the payment of the debt (usually by stating that proceeds are payable to the assignee *to the extent of his or her interest*), that limitation is enforced.

When this document does not state whether the creditor's right to the insurance proceeds is to be limited to the amount of the debt, a creditor's claim to all of the insurance benefits is stronger. This is especially true in the unusual case where the creditor is designated the primary beneficiary of the policy rather than as a collateral assignee. It is common to make an assignment as security for a debt. It is not common, however, to change the beneficiary for this limited purpose.

When the Insurance Is Acquired by a Creditor

Often disagreements occur about whether a creditor who has taken out a policy on the life of the debtor can recover the full amount of the policy if the policy amount exceeds the debt. When a creditor obtains a life insurance policy on the life of a debtor, the debtor really has no interest in such a policy.

However, when a life insurance policy is obtained and issued as an integral part of the loan transaction, as opposed to being obtained by the creditor at a later time and at the creditor's insistence, the debtor bears the cost of the insurance. The reason is the interest or repayment terms of the loan agreement are influenced by the amount of the insurance premium that the creditor expects to pay for the life insurance.

The mere fact that a creditor obtains a life insurance policy does not necessarily prove that the debtor and his or her estate have no legal interest in the insurance. Even if the creditor arranged for the insurance and paid the premiums, it is possible for the policy to include a beneficiary clause designating the estate of the debtor (the person whose life is insured) as the contingent or additional primary beneficiary. Although the creditor is designated as the primary beneficiary, the debtor's estate can have a right to the part of the proceeds in excess of the debt.

Provisions of Life Insurance Policies

Life insurance policies afford the policyowner the right, among others, to:

- designate or change the beneficiary
- elect settlement options
- receive dividends in the case of participating life insurance policies
- exercise all of the other rights normally associated with property ownership

Life insurance policies often are sold with an investment or savings feature. These policies usually include a variety of additional rights and interests. For example, whole life insurance contracts provide a right to borrow from the insurer using the policy as security for the loan. They also provide a right to surrender the policy in exchange for the payment of a sum of money. This sum is known as the **cash surrender value** of the policy.

However, in certain situations, some or all of the rights are not retained by the purchaser. Ownership rights, normally granted to the purchaser, can be transferred to someone else. This can be a voluntary action by the buyer or by an operation of law. Some examples of these situations are the following:

- A buyer may choose to transfer all right, title, and interest to a third party because of estate tax laws that make this transaction attractive.
- An assignment can be made to a named beneficiary that irrevocably grants the beneficiary a vested interest in the insurance proceeds.
- The right to change the beneficiary can be assigned or transferred when the insurance contract is used to secure a loan.
- The ownership rights can be subject to commitments made in the provisions of a divorce or a marriage dissolution agreement.
- In community property states, the purchaser's spouse can be entitled to an interest in a life insurance policy by law, independent of the insurance contract's terms or the purchaser's actions or intent.

Community Property Laws

Naturally, community property laws vary among the states. In all community property states, each spouse has an interest in any life insurance policy that is purchased with the assets of the marital community. The holder of a right in a life insurance policy, which is classified as community property, is responsible to a spouse and to others who assert claims through the spouse.

All of the cases in community property jurisdictions agree that if during a marriage a spouse takes out a policy on his or her own life and pays for it with community funds, the following applies:

- If the policyowner assigns the benefits to his or her estate, executor, or administrator, then when the policyowner dies, the proceeds belong to the "community."
- If the policyowner names his or her spouse as the beneficiary, then the proceeds are the surviving spouse's separate property.

Beneficiary Clauses of Life Insurance Policies

Early beneficiary designation forms only allowed a policyowner to designate on the form who he or she wanted to receive the policy proceeds. There was no provision for alternative dispositions of the policy proceeds if the beneficiary died before the insured died. Many insurance contracts of that time did not even address the issue of changing the beneficiary. The courts generally held that a policyowner could not take any action, such as an assignment of the policy or changing the beneficiary, without obtaining the beneficiary's consent.

Today, insurance contracts usually include provisions that reserve the policyowner's right to change the beneficiary. A revocable beneficiary has no rights with respect to beneficiary changes. In other words, the policyowner can change the policy beneficiary even if the current revocable beneficiary objects to the change. Life insurance contracts now usually detail contingent beneficiaries or provide that if no designated beneficiary can receive the insurance benefits, the proceeds of the policy will be paid to the estate of the person whose life is insured.

Changing Beneficiaries

Most life insurance policies reserve the policyowner's right to change the beneficiary. Several formalities are specified in a change of beneficiary clause. These include provisions such as the following:

- The policyowner must submit a written request to the insurer for a change of beneficiary, usually on a form provided by the company.
- The insurer must receive the original insurance policy or proof that the policy has been lost.
- The insurer's endorsement of the change must be noted in the original policy or in a replacement policy issued to replace a lost policy.

Payment Arrangements

In the past, life insurance companies used insurance policy contracts that provided that upon the insured's death, the beneficiaries would be paid the policy proceeds in cash. Today, life insurance companies generally offer choices of how the benefits can be paid; these choices are known as **settlement options** and provide for death benefits to be paid as periodic payments. Clauses specify how and when payments will be made, and they can conform to the specific wishes of the policyowner. In the event the policyowner has not made an irrevocable selection of a particular settlement option, the beneficiary can decide how the benefits will be paid.

Life insurance is an important part of estate planning, often providing a significant part of the assets of an estate, especially if the insured's death occurs at an early age. Even when estates include considerable other property, life insurance is often used to ensure liquidity sufficient to meet estate taxes and other settlement costs by providing a readily available cash fund.

Life insurance is also used to fund agreements for the sale and purchase of business interests in the event of the death of a proprietor, a partner, or a principal in a corporation. In these circumstances, the survivors are provided insurance proceeds that can be used to acquire the interest of the deceased. The agreements providing for the purchase of a deceased business owner's interest are known as **buy-sell agreements**.

Double Liability for Insurers

Judicial precedents show that an original beneficiary can contest a change of beneficiary that does not conform to the requirements in the insurance contract. This means that insurers are subject to a risk of double liability if a payment is made to the wrong person.

For example, an insurer might be held liable to an original beneficiary after paying the insurance proceeds to someone else. This someone might be the person that the policyowner later designated and that the insurer accepted as the new beneficiary, although requirements in the insurance contract were not met.

In most circumstances, it is the policyowner's actions rather than the insurer's response that decides the reliability of the policyowner's intention. The policyowner's actions should decide the issue. However, "shoulds" do not always prevent litigation.

Disqualification of Beneficiaries

A beneficiary can be disqualified from receiving insurance proceeds if the beneficiary is responsible in some way for the death of the insured. The principle underlying such disqualification is that "no one shall be allowed to benefit from his own wrong." The disqualification is nearly always limited to situations where the killing was intentional and unlawful. Beneficiaries rarely are disqualified in cases where the death results from the beneficiary's negligent or reckless conduct.

In many states, legislation specifically prevents the payment of life insurance to a beneficiary who intentionally kills an insured. However, these statutes also require that the insurance benefits still be paid. In New Jersey, for instance, the statute specifies that life insurance proceeds are to be made "as though

the killer had predeceased the decedent." In Texas, the statute specifies that the nearest relative of the insured shall receive the proceeds. In Washington, the proceeds are paid to the insured's estate.

Although the states have varying provisions addressing this issue, it seems that their intents are similar in that "no one shall be allowed to benefit from his own wrong."

Summary

Understanding three terms helps to clarify the roles of persons involved in a life insurance policy. Those terms are "insured," "policyowner," and "beneficiary." The insured is the natural person whose death causes the benefits promised under the policy to be paid. The policyowner is the person who may exercise the various rights in the policy. Such rights include, but are not limited to, the right to name the beneficiary, the right to obtain a policy loan, the right to transfer ownership of the policy to another person, the right to receive dividends if declared by the insurer, and the right to surrender the policy for its cash value. In the vast majority of cases, the insured owns the life insurance policy under which his or her life is covered and may exercise all of the rights to which ownership entitles him or her.

In many other cases, a person other than the insured owns the life insurance policy. Such ownership arrangements are common in business insurance and in situations in which an insured wants to avoid inclusion of the life insurance policy's death benefits in his or her federal gross estate by having the policy owned by an adult child or by an irrevocable trust.

The beneficiary of a life insurance policy is the person designated by the policyowner to receive the policy's death benefits when the insured dies. As noted in an earlier chapter, a beneficiary may be a primary beneficiary or a contingent beneficiary.

One of the rights that may be exercised by a policyowner is the right to transfer ownership of the policy to another person. Such an ownership transfer is generally referred to as an "assignment" of the policy. Two types of assignment exist: an absolute assignment, in which all rights are transferred to another, and a collateral assignment, in which only the right to receive a portion of the death benefit not exceeding the assignee's interest is transferred. A collateral assignment is one in which the life insurance policy acts as collateral for a loan.

Chapter 3 Review Questions

1. Arthur collaterally assigned his $200,000 life insurance policy to Big Banks, Inc. as security for a $50,000 loan. When Arthur died four years later, he had reduced the loan principal by $10,000. How much, if any, death benefit would be received by Big Banks, Inc.?

    A. $10,000

    B. $50,000

    C. $40,000

    D. $200,000

2. Alan was a key executive for his employer, who maintained a $1 million key-person life insurance policy on Alan's life. When Alan retired, his employer gave him the policy, which then had a cash value of $50,000. What tax treatment results from the absolute assignment of the policy to Alan?

    A. The absolute assignment of the policy is deemed a gift equal to the policy's cash value, subjecting the employer to gift tax liability.

    B. The absolute assignment of the policy is deemed compensation to Alan equal to the policy's cash value at the time of assignment.

    C. The absolute assignment of the policy is deemed compensation to Alan equal to the policy's face amount at the time of assignment.

    D. The absolute assignment of the policy is deemed a gift equal to the policy's death benefit, subjecting the employer to gift tax liability when Alan dies.

3. What is assigned in an absolute assignment of a life insurance policy?

    A. all right, title, and interest in the policy

    B. the right to receive payment of the death benefit to the extent of the assignee's interest only

    C. the right to receive payment of the death benefit to the extent of the assignor's interest only

    D. only the right to designate the policy beneficiary

4. What is the term for the person to whom a life insurance policy is assigned in an absolute assignment?

    A. the assignor

    B. the assignee

    C. the trustor

    D. the attorney

5. John assigned his life insurance policy to his son. What role does John play in the assignment?

    A. He is the assignee.

    B. He is the trustee.

    C. He is the assignor.

    D. He is the attorney-in-fact.

Answers to Chapter 3 Review Questions

1. C. In a collateral assignment, a life insurance policyowner assigns the death benefit to a lender in an amount not exceeding the lender's interest. The lender's interest, however, is limited to the amount of the outstanding loan. Because Arthur has repaid $10,000 of the $50,000 loan, the lender's interest-and its death benefit-is $40,000.
2. B. When an employer assigns a cash value life insurance policy to the employee or former employee who was the insured under the policy as a gift, any cash value thus transferred is deemed to be compensation to the employee and subject to income taxation.
3. A. In an absolute assignment of a life insurance policy, the assignor transfers his or her entire right to the policy to another person. Accordingly, such an assignment transfers all "right, title, and interest" the policyowner has in the policy to the absolute assignee.
4. B. In the transfer of ownership of a life insurance policy to another person, a transaction known as an assignment, the person to whom the policy ownership is transferred is known as the assignee.
5. C. A person making an assignment of a life insurance policy is known as its assignor.

Chapter 4
The Law and Consumer Protection

Before 1850, insurance companies operated with little regulatory supervision. The powers of these insurers were defined by their charters, and insurance consumers were basically at the mercy of the insurers to be treated fairly.

Unfortunately, with the proliferation of insurers in America during this time came unethical and unprincipled practices by some insurance companies and their agents. Sometimes policies were sold only to have the insurers refuse to pay claims on the grounds that the insurer was not licensed to do business in a particular state. Some insurers who were authorized to do business in various states simply refused to meet their obligations.

As the number of insurance companies grew, so did the need for regulation. During this time, incompetence and deceit on the part of the insurers caused many company failures. Naturally, many policyowners were devastated, and the entire insurance industry came under a cloud of suspicion.

This chapter identifies how the concept of agency developed and the role of Congress and state regulation in shaping the insurance industry as it is today.

The Concept of Agency

During the late 1800s, the U.S. Supreme Court ruled on many so-called “public interest” cases involving the insurance industry. These rulings resulted in regulating the industry where the public was involved. At this time, the states were still in control, and various states enacted legislation intended to hold insurance companies responsible for their acts as well as for the acts of their agents.

An insurance agent is any person involved in soliciting, transmitting, examining, or collecting, or in any way associated with the sale of, insurance. Insurance companies are responsible for the acts of their agents because agents serve as legal representatives of their companies. Originally, these agents were personally liable for any taxes or fees assessed upon the company and were also liable to the policyowners for losses. A discussion of the concept of agency and its attendant authorities and liabilities is presented in Chapter 5.

State Regulation Prevails

In 1905, Congress investigated the life insurance industry. This investigation was known as the **Armstrong Investigation**, the result of which was the **Armstrong Report**. The Armstrong Report related serious financial reporting abuses in the insurance industry.

Despite the poor reviews of the insurance industry, the prevailing view was that the states rather than the federal government should continue to be responsible for ensuring fair competition among insurers, fair insurance practices, and the protection of insurance consumers.

The individual states established their own licensing programs. Subsequent legislation required adequate assets to support the volume of policies in force, sufficient reserves to meet legal requirements, and other specified financial obligations. By the early 1920s, the general financial condition of insurance companies had improved.

Until 1944, insurance was not considered "commerce" and was not subject to federal regulation. But in *United States v. South-Eastern Underwriters Association*, the Supreme Court held that Congress could regulate insurance transactions that were truly interstate. Congress then enacted the **McCarran-Ferguson Act**, which provided that the laws of the several states should control the insurance business but that the **Sherman Anti-Trust Act**, the **Clayton Act**, and the **Federal Trade Commission Act** applied to the insurance business to the extent that it was unregulated by state law.

The Sherman Anti-Trust Act of 1890 is noninsurance legislation that makes setting prices illegal. Premium rates were considered "prices" and, therefore, came under the Sherman Anti-Trust Act.

The McCarran-Ferguson Act of 1945, broadly speaking, gives states the power to regulate the insurance industry. While state insurance statutes override most federal laws, some portions of federal law (like federal tax laws) take precedence. Therefore, when researching whether a particular law governs, a good rule to follow is to ask whether the inquiry is related to the "business of insurance" (where state law governs), or whether it is related to some peripheral area of the industry—labor, tax, or securities, for example—where federal law governs.

The McCarran-Ferguson Act essentially urged the individual states to preempt the federal anti-trust laws. The states again prevailed as being responsible regulators for the insurance industry within their own jurisdictions.

The Industry Is Revolutionized

During the 1950s and through the 1970s, issues other than legislation of the insurance industry were receiving the most attention; insurance was not a major legislative subject. However, the 1970s and 1980s saw new trends in the industry and the introduction of new products to the market place.

In fact, the entire financial services industry was revolutionized during this period. Banks began to offer discount brokerage services in addition to their more traditional savings products. Brokerage firms began to sell insurance, bank certificates of deposits, and even residential real estate. Insurance companies began to offer the following:

- mutual funds
- life insurance policies whose premiums and death benefits could be adjusted, almost at will, by the policyowner
- other investment products capable of competing in the financial services industry for investment dollars

Note

Universal Life Insurance and the Insurance Industry Revolution (excerpted from Universal Life Insurance, p.3)

In order to fully appreciate universal life insurance and its place among life insurance products, it's necessary that you have an understanding of the market and other conditions that prevailed at the time of its introduction.

The factors that played a part in the development of universal life insurance were:

- extraordinarily high interest rates in the economy
- the phenomenon known as disintermediation
- a Federal Trade Commission report that was critical of whole life insurance
- precipitously declining whole life insurance sales trends

For many years, the life insurance industry met the needs of its customers principally through the sale of three products:

- term insurance
- whole life insurance
- endowment insurance

Term life insurance offers policyowners pure protection with typically no usable cash values. Generally as the insured ages, the premiums increase to reflect the greater mortality associated with increasing age.

Endowment insurance represents the other end of the spectrum from term insurance. Endowment insurance provides a life insurance element that declines rapidly until it disappears entirely at the point that the policy's cash value equals its face amount. When the endowment policy's cash value and face amount are equal, it pays out the face amount to the policyowner, and the life insurance coverage under the policy ends. Endowment periods are typically 10 years, 20 years, or at the insured's age 65.

The flagship product of the life insurance industry was neither term nor endowment insurance, however. It was whole life insurance. Whole life insurance represents a middle ground between term insurance and endowment insurance. In a sense, it combines the cash values of an endowment contract with the significant death benefits found in term insurance and provides policyowners with important guarantees that extend throughout their life. Despite the obvious benefits of whole life insurance and its formidable guarantees, however, whole life insurance had—and still has—detractors.

During the 1970s—the decade that witnessed the turmoil in the life insurance industry and the introduction of universal life insurance—consumer interest groups gained considerable recognition. In 1972, the Fair Credit Reporting Act was passed, giving greater voice and protection to consumers. As these consumer groups found their voice, they eagerly engaged in battle with any institution that appeared vulnerable. One of those institutions was the life insurance industry.

As we will see, this clash had a certain inevitability about it considering the long-term life insurance commitments and the assumptions that need to be made to guarantee them.

When life insurance company actuaries price their life insurance products, they base those prices on three factors:

- mortality—the rate of death of individuals in groups that the insurance company anticipates
- insurance company earnings—the income the insurance company can expect on premiums it receives
- insurance company expenses—the costs that the insurance company can expect to incur for all of its operations

For purposes of insurance product pricing, past performance can give the actuaries some indication of possible future results. There is no assurance, however, that past performance will be repeated. In fact,

the likelihood that the results achieved in the past will be repeated in the future is extremely remote. As a result, actuaries do not know the mortality that will be experienced, the level of earnings that the company will enjoy, or the expenses the insurer will incur in the future—a future that may be 100 years distant.

Faced with the task of determining adequate premiums for life insurance products with guaranteed values in an uncertain future, pricing actuaries took the only reasonable approach; they intentionally underestimated future earnings and overestimated future mortality and expenses. The result was a higher product premium than might be needed. If the actual results achieved by the company were more favorable than the assumptions, the insurer could refund some or all of the premium overpayment through dividends. Since the assumptions were conservative, they were likely to give the insurer adequate safety.

Because of the need to ensure adequate financial safety margins, it is not uncommon for an insurer to assume—for purposes of developing whole life insurance premiums—that it will earn only 2.5 percent or 3 percent on the premiums it receives. It was primarily this conservative assumption, springing from the need to provide for the insurer's financial integrity, that caused many consumer groups to take issue with the insurance industry over whole life insurance.

The decade of the 1970s—the time during which much of this turmoil occurred—was a period of rising inflation that the Federal Reserve attempted to dampen by increasing the discount rate. The discount rate is the interest rate at which the Federal Reserve bank makes temporary loans to any deposit-taking institution that needs the money. It affects the cost of borrowing and the short-term interest rates available in the economy. Since the discount rate had increased dramatically, the interest rate available to investors was correspondingly high—a level much higher than assumed in whole life insurance policies

Discount Rates in the 1970s Decade*			
Year	**Discount Rate**	**Year**	**Discount Rate**
1970	5.5%	1975	6%
1971	4.5%	1976	5.25%
1972	4.5%	1977	6%
1973	7.5%	1978	9.5%
1974	7.75%	1979	12%
**Federal Bank of New York Source: Global Financial Data, 2000*			

To make the comparison of earnings between whole life insurance and other savings vehicles seem even more unbalanced was the growing investor sophistication enjoyed by the increasingly large population of mutual fund investors. While mutual funds had been available to investors for many years, the boom years of the 1960s caused small investors to flock to them in unprecedented numbers. Intoxicated with the returns they experienced by investing in mutual funds, whole life insurance policyowners could not easily understand why their policies talked about a 2.5 percent or 3 percent earnings level.

The high interest rates in the economy coupled with generous mutual fund returns had two direct results on the life insurance industry:

- Whole life insurance sales levels fell as applicants turned to term insurance.
- Whole life insurance policyowners took policy loans in record numbers.

Whole life insurance policies in existence during this period guaranteed policyowners the right to borrow against their policy's cash value at a 5 percent or 6 percent level, depending upon the policy. (The

policyowner's state of residence at the time the policy was purchased determined the policy's loan interest rate.) Furthermore, the tax law in effect at this time enabled borrowers to deduct any paid loan interest from their income for tax purposes. The almost inevitable consequence was wholesale disintermediation—the movement of funds out of banks and other savings institutions, such as insurance companies, to invest them at higher rates of return in mutual funds, stocks, money market funds, or other investments.

Since a policyowner could borrow from a life insurance company at a guaranteed 5 percent and invest the borrowed funds in a money market fund offering 12 percent or 13percent, many did. The policyowner enjoyed a substantial profit, and the insurer achieved only the 5 percent or 6 percent on its borrowed funds, rather than the much higher returns provided by other investments that were generally available.

Investing Borrowed Funds

Substantial leverage and resulting profit was available to the policyowner who was able to borrow funds from a life insurance company at a 5 percent guaranteed rate; and invest them in a money market fund having minimal risk and paying much more than that.

These minimal-risk results could be significant as seen in the following table that assumes a money market fund paying 13 percent annual interest:

Year	Amount Borrowed	Interest Paid @ 5%	Money Market Interest Earned @ 13%	Net Gain	Total
1	$100,000	$0	$0	$0	$0
2	$0	$5,000	$13,000	$8,000	$8,000
3	$0	$5,000	$13,000	$8,000	$16,000

In this case, the policyowner is earning an additional $8,000 each year with virtually no risk and with minimal effort. Interestingly, this ability underscores the value of whole life insurance with low guaranteed loan interest rates—an irony that may have been lost on many policyowners.

By the late 70s, the life insurance industry could be described as embattled. Consumer groups demanded to know why life insurance could not also provide the high interest levels found in other savings and investment vehicles and, at the same time, continue to offer its traditional guarantees. Applicants were avoiding whole life insurance in favor of term insurance. Whole life insurance policyowners were borrowing from some whole life policies and surrendering others. What else could happen?

The answer to that question came in a July 1979 Federal Trade Commission (FTC) report that labeled whole life insurance a bad investment that resulted in the loss by policyowners of billions of dollars. An equally damaging press release accompanied the unfavorable FTC report, referring to "ill-informed and inappropriate life insurance choices." The superficiality of the report was irrelevant; the damage was done. Whole life insurance sales, already badly affected by high interest rates and vocal consumer interest groups, plummeted. It was into this environment that universal life insurance was born.

Initially labeled a "flexible premium adjustable life insurance policy," universal life insurance was introduced to the marketplace in 1979, the same year the FTC issued its unfavorable report on whole life insurance. The product offers a level of flexibility previously unknown in the life insurance industry, and it responded to the critics of whole life insurance in two important areas:

- Current interest rates are applied to the policies' cash values.
- Transparency is provided in the product with respect to expenses, mortality costs, and interest crediting.

Largely unnoticed in the introduction of this versatile and long-awaited product was the loss of many of the important guarantees that are integral to the whole life insurance policy.

Universal Life Insurance, © 2012 by Paul J. Winn.

Today, insurance companies offer a wide assortment of life insurance products that provide protection and potential investment growth to policyowners. Depending on the type of life insurance purchased, the policyowners may assume the investment risk in return for the potential for increased cash values.

Disintermediation was rampant in the high-interest-rate environments that were characteristic of the late 1970s and early 1980s as consumers demanded an opportunity to participate in the higher yields available at the time. The insurance industry, being market driven, had no choice but to credit short-term money market interest rates on new universal life insurance policies' cash value. Life insurance sales roared back—particularly universal life and variable universal life insurance policies—as many individuals began to understand the attraction of current interest rates coupled with the traditional life insurance tax advantages. However, these new products not only revolutionized the industry but also led to increased regulation. The insurance industry was about to become even more complex.

Life insurance owes its favorable income tax treatment to its traditional role of providing much needed resources to widows and children—survivors who might require public assistance without the benefit of life insurance. As the investment benefits of universal life insurance and variable universal life insurance became apparent to investors, they began to purchase these products solely to enjoy the investment and tax benefits, with, in many cases, little thought to death benefits. In short, the purchase of life insurance became a thinly veiled investment strategy, offering tax deferral and other advantages.

To overcome the problem of life insurance, with its favorable tax treatment, competing unfairly with traditional investment products, Congress passed two laws that tended to limit the favorable tax treatment given to life insurance. These laws:

- statutorily defined life insurance in order for it to receive favorable income tax treatment
- created a category of life insurance known as a **modified endowment contract** that was eligible for favorable death benefit tax treatment but not for other tax advantages normally enjoyed by life insurance

Statutory Definition of Life Insurance

Life insurance policies have long enjoyed extremely favorable income tax treatment when compared to other financial products. Consider some of the differences in how financial products are taxed. Interest paid on savings accounts and dividends received on stocks are normally subject to income taxation in the year in which the interest is paid or dividends are received. In contrast, interest credited to life insurance policy cash values grows tax deferred, and policy dividends are generally received entirely tax free.

The tax benefits given to life insurance do not stop there, however. Death benefits are generally received completely free of income taxation. Thus, even if an insured policyowner paid a premium of only $100, and his or her beneficiary received a death benefit of $100,000, no part of that death benefit would normally be taxable to the beneficiary as income. The significant disparity in the tax treatment given to life insurance compared to other financial products is partly because of the reluctance of the federal government to impose income taxes on a product designed to provide a financial life preserver to widows and orphans.

In the last half of the twentieth century, several life insurance products were introduced that have the potential to compete as investments with other noninsurance financial products. These new product offerings included the following:

- variable life insurance
- universal life insurance
- variable universal life insurance

Life insurance agents and consumers were quick to see the investment potential in life insurance products that could produce highly competitive returns and enjoyed the favorable income tax treatment given to life insurance. For those reasons, universal life insurance and variable universal life insurance sales began to grow substantially.

Frequently, a policyowner would structure his or her policy to minimize its death benefits. By reducing death benefits, a smaller portion of the policy's cash value would need to be taken via monthly insurer deductions to pay mortality costs. The net effect was to further increase cash value gains. Because the policy's increase in cash value imposed no current income tax liability, funds that might have been needed to pay any income taxes if the cash had been allocated to traditional investment products could remain in the tax-deferred environment and could continue to produce additional tax-deferred cash value gains.

To maximize their sales, certain life insurance companies emphasized this combination of tax benefits and substantial cash value growth in their advertising. As a result of the blatant inequity in the tax treatment between noninsurance products and life insurance policies that were little more than investments thinly veiled in a life insurance contract, and as a result of the advertising done by these life insurance companies, Congress re-visited the issue of favorable tax treatment for life insurance policies. That revisiting led to the passage of new legislation creating Internal Revenue Code § 7702 and the definition of life insurance.

IRC Section 7702

To limit the favorable tax treatment of life insurance in light of the proliferation of life insurance policies with competitive investment characteristics, Congress needed to define "life insurance." It did that in legislation that became IRC § 7702.

Note

IRC § 7702

(a) General rule

For purposes of this title, the term "life insurance" means any contract which is a life insurance contract under the applicable law, but only if such contract:

1. meets the cash value accumulation test of subsection (b), or
2. A. meets the guideline premium requirements of subsection (c), and

   B. falls within the cash value corridor of subsection (d).

As a result of that legislation, life insurance contracts issued after December 31, 1984, must meet the definition of life insurance prescribed in IRC § 7702 for policy death benefits to be fully excludable from the beneficiary's income for tax purposes. Furthermore, cash value growth in such contracts failing to meet the definition of life insurance is generally not tax deferred.

To meet the Code definition of life insurance, a life insurance contract must meet one of the following:

- cash value accumulation test (CVAT)
- guideline premium and cash value corridor test

It is important to understand that the life insurance contract need not meet both tests; it only needs to meet one of them. Having said that, let's briefly consider what each of these tests involves.

Cash Value Accumulation Test

To understand the CVAT, it is important to understand the concept of **net single premium**. When an actuary determines the premiums to be charged for a life insurance policy being developed, he or she begins by determining the net single premium for that policy at each age. To calculate the net single premium, the actuary multiplies the amount of the death benefit by the probability of payment (based on a mortality table) for each insured age. The result is then multiplied by a discount factor that reflects an end-of-year payment. The values thus calculated for each year are added to determine the net single premium. In somewhat simpler terms, the net single premium can theoretically be seen as the single premium that an individual must pay to purchase a fully paid-up policy.

Under the CVAT—the first test prescribed in Code § 7702—the life insurance policy's cash surrender value must not exceed the net single premium that is needed at that time to fund future benefits under the policy. In other words, if the policy's cash value is more than sufficient to make the policy fully paid-up, the policy does not meet the CVAT.

Guideline Premium and Cash Value Corridor Test

Under the second test prescribed by Code § 7702, the life insurance contract must meet certain guideline premium requirements, and then the contract must fall within the prescribed cash value corridor. To meet the first part of this test (guideline premium test), the sum of the premiums paid under the contract must not exceed the following *at any time*:

- guideline single premium
- guideline level premiums to such date

The **guideline single premium** is the premium needed to fund future benefits under the contract, determined at the time the contract is issued. The **guideline level premium** is the level annual premium amount payable over a period not ending before the insured becomes age 95. Insurers customarily indicate the guideline single premium and guideline level premiums for the life insurance policy when the policy is issued.

If the policy meets the first part of the test, it then must meet the second part (**cash value corridor test**). A life insurance contract meets the cash value corridor test if its death benefit payable is at least equal to an applicable percentage of the cash surrender value shown in the following table:

Insured's Attained Age at Start of Contract Year		Applicable Percentage Decreases Ratably for Each Full Year	
More Than	**But Not More Than**	**From**	**To**
0	40	250	250
40	45	250	215
45	50	215	185
50	55	185	150
55	60	150	130
60	65	130	120
65	70	120	115
70	75	115	105
75	90	105	105
90	95	105	100

We can illustrate the cash value corridor with an example. Suppose a 40-year-old insured's life insurance policy has a cash value of $10,000. For that policy to meet the cash value corridor test under § 7702, it must have a death benefit of at least $25,000 ($10,000 × 250% = $25,000).

Modified Endowment Contracts

Although establishing a statutory definition of life insurance by way of § 7702 was a significant step in eliminating the favorable income tax treatment of investments disguised as life insurance, it was not the end of Congressional tinkering with the taxation of life insurance policies. Approximately four years after Congress created Code § 7702, Congress further tightened the tax rules that apply to life insurance by creating an additional test to identify cash-value-rich life insurance contracts.

Under these expanded rules governing the taxation of life insurance, any life insurance contract that:

- is entered into after June 20, 1988 and
- meets the statutory definition of life insurance but
- fails to meet the 7-pay test

. . . becomes a **modified endowment contract** (MEC) and is subject to less favorable income tax treatment than a life insurance policy that is not a MEC. Although the less favorable tax treatment of a MEC applies to distributions from the policy during the insured's lifetime, MEC status does not adversely affect the tax treatment of death benefits.

The 7-Pay Test

Then Congress created a test to determine if a life insurance policy is considered a MEC, which works as follows. If the total of the premiums the life insurance policyowner pays in the first seven years exceeds the amount of premiums that would have been required to make the policy paid-up in seven years, the policy is considered a MEC. If a life insurance policy that has previously met the 7-pay test undergoes a material change in its benefits or terms, the life insurance contract is treated as though it were a new contract entered into on the day the material change was effective, and the 7-pay test must be met again.

Generally, if a life insurance policy is deemed to be a MEC, nothing can be done to change that status. Once a policy is considered a MEC, it is always a MEC.

The consequences for a policyowner and his or her beneficiary of a life insurance policy's failure to meet the statutory definition of life insurance or of its becoming a modified endowment contract are examined later in this course when we consider issues that affect life insurance taxation.

The Effects of Modern Legislation

Modern legislation concerning insurance consumer protection permits private causes of action in cases of unfair insurance practices.[7] All states have statutes that protect insurance consumers from deceptive or unfair trade practices, unfair competition, unfair claims settlement practices, and other inequitable practices. Many of these were enacted in the 1970s, during the height of consumer activism, and have generally been extended through judicial fiat.

As a result of improved legislation and the enforcement of the insurance industry, the public has been offered greater protection from predatory and unfair practices. Amid a number of high-profile lawsuits involving several giants of the industry, the life insurance industry has emerged as more consumer-oriented than ever before.

Note

From Caveat Emptor to Caveat Vendor—Judicial Extension of Liability

In a sense, the law is like language. It is a dynamic, living thing that changes over time. In no area is that more true than in the areas of product and professional liability. As time has passed, the courts have generally increased a person's liability for his professional actions.

Caveat emptor is a term that encapsulated the judicial approach to product liability in the first half of the twentieth century. The term translates to "let the buyer beware." It was a clear acknowledgment that the buyer of goods or services was expected to watch out for himself, and it was the prevailing common law doctrine regarding the transaction between buyers and sellers. It informed the buyer not to rely on the legal system to protect him from sellers that might not treat him fairly. Over time this doctrine has fallen out of favor and has been effectively replaced by a doctrine of *caveat vendor*.

Caveat vendor translates to "let the seller beware." It characterizes an environment that goes so far as to permit lawsuits against sellers of high-calorie meals in which plaintiffs seek damages because they have become obese. This is the environment in which agents are selling their products and one in which they are at great risk of professional liability.

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Federal Legislation Provides Additional Consumer Protections

The year 2010 saw increased federal monitoring and regulation of the insurance industry. Two important pieces of federal legislation affecting the insurance industry emerged:

- Dodd-Frank Wall Street Reform and Consumer Protection Act
- Patient Protection and Affordable Care Act

Dodd-Frank Wall Street Reform and Consumer Protection Act

Pursuant to **Dodd-Frank**, the Federal Insurance Office (FIO) was created within the Treasury Department. Among other activities, the FIO is to advise the Secretary of the Treasury on domestic and international insurance matters and provide insurance industry oversight. Thus, it:

- monitors the insurance industry
- tracks the availability of affordable insurance
- recommends federal supervision of insurers, if and when it determines that an insurer should be subject to such supervision

Patient Protection and Affordable Care Act

The **Patient Protection and Affordable Care Act (PPACA)** gives the federal government increased power over the health insurance industry. PPACA requires the following:

- Health plans are prohibited from excluding health insurance coverage for pre-existing conditions.
- Health plans are prohibited from imposing annual or lifetime benefit limits on essential health benefits.
- Health plans are prohibited from rescinding coverage except for fraud or intentional misrepresentation of a material fact.
- Health plans providing emergency services must permit participants to obtain emergency services without insurer authorization and must provide out-of-network emergency services benefits in a manner consistent with its provision of in-network benefits.
- Health plans using a network of providers must:
    - permit participants to choose any participating primary care provider
    - allow participants to select an available pediatrician as the primary care provider for a participating child
    - permit female participants to obtain OB/GYN care without authorization or referral
- Most individuals are required to buy health insurance or pay a penalty (though the penalty for not having individual coverage is set to be eliminated after December 31, 2018).
- An employer who employed an average of at least 50 full-time employees must offer its full-time employees affordable health insurance coverage and make contributions towards its premiums or face the possibility of a penalty.

Insurance Consumer Protection

Insurance consumer protection is often divided into two categories:

- **post-claim representation**—Consumers have access to post-claim representation by way of the state bar after they have a claim. Laws have been enacted to protect insurance consumers, and certain remedies are available if they have been treated unfairly.

- **pre-claim representation**—Consumers have had little or no representation with respect to important issues that arise before the handling of a claim. Such issues are rule-making, rate-making, and policy formation.

Some states have independent state agencies or consumer-based groups that represent insurance consumer issues and the consumers themselves as a class. These groups often assess the impact of insurance rates, rules, and policy formation on consumers. They are advocates for insurance consumers. Typically, they are powerful lobbyists, and they monitor insurance legislation. Without these organizations, consumers as a group could not be represented adequately in insurance matters that directly affect them.

Typically, insurers have vast resources. However, individual consumers have traditionally had little say in the issues championed by these consumer groups. These organizations have been involved in areas such as:

- requiring insurers to offer installment payment plans for premiums
- requiring policies to be written in easily understood language
- ensuring that consumers receive full disclosure of all material facts

Other areas of consumer protection covered by such advocate groups are the following:

- public education
- distributing literature on insurance topics
- offering newsletters that inform consumers and legislators
- public speaking to community groups

Rule-making is critical to consumers in the area of claims. For example, rules can prohibit unfair claim settlement practices. They also can create other issues that enhance the ability of the consumer to get a claim paid quickly and fairly. Finally, rules can contain definitions and statutory interpretations that remove any doubt concerning claim coverage.

The most important consideration concerning any claim is the policy itself. A claim must be made within the limitations of the insurance policy contract. Consumers need a strong advocate acting on their behalf with respect to insurance policy contracts. Barring this, only the insurance industry has input concerning which coverages are included in policies. Without this capable representation, there would be a serious disparity of power between the insurance industry and those it serves.

Relief for Consumers

Generally, the intent of the many pieces of consumer protection legislation is to protect consumers against unfair or deceptive practices. The intent is also to provide relief to consumers through efficient and economical procedures to secure this protection.

Typically, to secure this relief, liability must be found on the part of the insurer. If an insurance consumer takes action against an insurer, it must be based upon one of the following theories of recovery:

- breach of contract
- breach of the duty of good faith and fair dealing
- negligence
- fraud

- deceptive trade practices
- unfair insurance practices
- untimely claim payment or claim denial

Breach of Contract

Breach of contract is a fundamental cause of action in contract law. It is the foundation of many disputes. If the policy provides for coverage that is not granted, a suit can be brought for breach of contract. If the insurer does not pay policy benefits, then the insurer is liable for unfair insurance practices.

Sometimes, even in situations where the policy contract does not provide coverage, grounds for a suit could exist. For example, if an insurer misrepresents coverage, this misrepresentation can bind him or her, even if the policy does not cover the loss in question.

The rules for interpreting insurance policy contracts always favor the policyowner. The main principles for construing a policy contract in favor of the policyowner are the following:

- A life insurance policy is a contract of adhesion that is presented to the applicant on a "take it or leave it" basis. Any ambiguous or unclear clauses are always construed in favor of the policyowner.
- Ambiguous policies are always interpreted to provide, rather than to deny, coverage.
- An insurance policy is considered "patently ambiguous" when it can be reasonably interpreted in more than one way.
- When a policy provision is capable of more than one reasonable construction, a court must adopt the construction that favors coverage.
- Once the policyowner offers a reasonable interpretation of the policy, any contrary interpretation is not permitted and is consequently rejected.
- No limitations or exclusions are implied in any policy contract.

The Breach of the Duty of Good Faith and Fair Dealing

Insurers have a duty of good faith and fair dealing in their administration of insurance policies. This duty is breached if the insurer denies or delays payment of a claim without a reasonable basis for doing so. The duty of good faith and fair dealing also is breached if the insurer fails to determine whether the claim has a reasonable basis. An insurance consumer has a cause of action for delay or denial of benefits if the insurer has no reasonable basis for such a delay or denial.

Negligence

The breach of the duty of good faith and fair dealing is often construed as negligence if the insurer fails to perform its duty.

Fraud

Fraud can be used as a theory of recovery. For the element of fraud to be present, a material representation must be false, and the maker of the representation must know it to be false. Or, the maker of the representation must make a material representation recklessly, without any knowledge of the truth. The maker of the representation must also make it with the intention that it should be acted on by the other party. The other party must rely upon it and must suffer some resulting injury.

Deceptive Trade Practices

Deceptive trade practices are frequently used as a theory of recovery. The grounds for recovery under deceptive trade practices include the following:

- false, misleading, or deceptive acts or practices
- the breach of express or implied warranty
- any unconscionable act
- any unfair practice or act

Unfair Insurance Practices

The unfair insurance practices theory of recovery is broad in its scope. Engaging in these practices or acts often falls under the provisions of unfair competition and unfair practices or under the provisions of unfair claim settlement practices.

Failure to Make Timely Claim Payment or Claim Denial

Failing to make timely payment or to deny a claim is clearly grounds for recovery. An insurer must comply with certain time limits when paying or denying a claim. If these deadlines are not met and liability is found, the insurer is typically subjected to a penalty that can include punitive damages and attorneys' fees, in addition to having to pay the amount of the claim.

Remedies

Typically, any remedies provided for by the various state legislative actions are in addition to any other procedures or remedies provided by other laws. So, if a consumer brings an action under some other statute, he or she can still use the various insurance consumer protection laws. Any attempts on the part of an insurer or its agent to bypass these consumer protection acts are usually void.

When a consumer brings an action against an insurer for unfair practices, he or she has various remedies available, such as the following:

- actual (compensatory) damages
- punitive damages
- any orders necessary to restore funds that could have been acquired unlawfully
- court costs
- reasonable and necessary attorneys' fees
- any other relief the Court deems proper

Compensatory Damages

Compensatory damages are those damages awarded for losses the consumer can substantiate as being a result of an unfair practice. In addition, many states provide for an additional award of a multiplier, for example, three times the first $1,000 of compensatory damages. Compensatory damages can include the cost of repair, diminished value, mental anguish, out-of-pocket expense, loss of bargain, interest or finance charges, and consequential economic loss.

Punitive Damages

Many states typically provide for damage awards designed to punish egregious actions. If the violation is committed knowingly, the court can award punitive damages, typically up to three to five times the amount of compensatory damages. Punitive damages usually apply to amounts in excess of $1,000.

Orders to Restore Funds

If it is shown that the insurer acquired money from unfair practices, a state can issue orders requiring that the insurer restore (by means of refund or return) the unfairly acquired money.

Other Relief the Court Deems Proper

In most states, the court can decide to appoint a receiver to supervise the practices of an insurer. Or, the court can decide to revoke the license or certificate authorizing the insurer to do business in the state. The court can also sequester an insurer's assets. These orders are not issued unless a judgment against the insurer has not been satisfied, typically within three months of the final judgment. The cost of this receivership is assessed against the defendant insurer.

Court Costs and Reasonable and Necessary Attorneys' Fees

Court costs incurred by the consumer plaintiff can be recovered in most states, if the plaintiff prevails in his or her lawsuit. In addition, states generally provide for the award of attorneys' fees to the consumer. These fees are usually expressed as a percentage of the recovery.

Defining Unfair Practices and Acts

Exactly what are these unfair practices and acts in which the insurer cannot engage? Of course, the rules vary from state to state. However, certain behavior is expected from those licensed in the insurance industry.

Some acts and trade practices are prohibited by federal legislation under the title of "Deceptive or Unfair Trade Practices" and are regulated by the Federal Trade Commission. In addition, state statutes prohibit certain acts and practices for those licensed to conduct insurance business within the state.

The legislation for regulating unfair or deceptive acts or practices is broad. The rules apply not only to individuals but also to corporations, associations, partnerships, insurers, and any other legal entity that is engaged in the business of insurance. This includes agents, brokers, adjusters, and life insurance counselors.

Legislation creates causes of actions for consumers who are aggrieved.[8] To avoid liability, agents and insurers should not engage in any unfair method of competition or in any unfair or deceptive act or practice while conducting the business of insurance.

In addition to creating causes of actions for consumers, the statutes also dictate punishment for insurance companies who engage in this unfair conduct. Typically, the state insurance commissioner can investigate insurers to ensure compliance.

In most states, if an insurer is thought to be engaging in unfair or deceptive acts or practices, the commissioner must give the insurer a statement of charges if he or she believes the insurer is not in compliance. Next, the commissioner must give notice of a hearing, which in most states is a show cause hearing. In a show cause hearing, the insurer has the burden of showing why a cease and desist order should not be ordered by the appropriate regulatory agency or board.

If the insurer fails to meet this burden, the state commissioner usually issues a formal cease and desist order to the insurer. A cease and desist order directs the insurer to cease and desist from engaging further in the method that was the basis of the complaint.

Any insurer who violates the terms of the cease and desist order is subject to various civil penalties or administrative penalties. Civil penalties are fines. Administrative penalties include injunctions prohibiting an insurer from conducting further business or the suspension or loss of a license.

Although civil penalties vary among the states, they are typically $1,000 per violation, and provisions are usually in place stipulating that the civil penalty not exceed a certain amount, for example, $5,000.

Further, most state insurance commissioners can restrain the insurer by means of a temporary restraining order, a temporary injunction, or a permanent injunction.

State commissioners normally have the authority to order the insurer to make restitution not only to the consumer victim but also to all policyowners who are similarly situated. The insurer can be required to refund all premiums, minus policy benefits, to its policyowners.

The following practices are considered unfair methods of conducting the business of insurance:

- misrepresentation and false advertising of policy contracts
- false information and advertising
- defamation
- boycott, coercion, and intimidation
- false financial statements
- deceptive name or symbol
- stock operations and advisory board contract
- unfair discrimination
- rebates

Each of these practices is described in the following sections.

Misrepresentation and False Advertising of Policy Contracts

Consumers are protected against misstatements and misrepresentation concerning policy contracts. Making an estimate or illustration that portrays the terms of any insurance policy in a false or misleading way violates insurance law. The misrepresentation of the terms of any policy in any way is prohibited, whether that misrepresentation involves policy benefits, advantages, exclusions, or other provisions.

Likewise, misrepresenting the policy dividends is prohibited. This includes dividends previously paid on similar policies, as well as misleading statements with respect to policies being recommended for purchase. Misleading representation concerning the financial condition of any insurer or the legal reserve system upon which the insurer operates is also prohibited.

Likewise, using any name or title of a policy (or class of policies) that can distort the true nature of the policy is prohibited. Insurers are forbidden to misrepresent information to induce a policyowner to lapse, forfeit, or surrender his or her insurance policy. While replacing a life insurance or other policy or recommending that the policy be replaced are not prohibited, insurers and agents must be careful in disclosing any material fact with respect to the proposed replacement, including both its advantages and disadvantages.

The statement of incorrect or misleading comparisons of policy contracts to induce a policyowner to replace a life insurance or other policy with another is called **twisting** in the insurance industry. By twisting, an agent might attempt to convince a policyowner to cancel a policy that he or she currently holds to purchase the policy the agent is selling. Twisting can cause significant losses to a policyowner.

False Information and Advertising

Although the wording of the statutes cannot be the same, states protect insurance consumers by prohibiting false information in advertising. Publishing, disseminating, circulating, or placing before the public in any way, directly or indirectly, circulars, pamphlets, newspapers, magazines, or other publications that contain misleading statements is prohibited. This also applies to brochures, letters, and posters. Furthermore, untrue, deceptive, or misleading statements cannot be made over any radio or television station.

In many states, insurers are prohibited from using, displaying, publishing, circulating, or distributing any name, symbol, slogan, or device that is the same or greatly similar to a name adopted and already in use.

Defamation, Boycott, Coercion, and Intimidation

Defamation violations occur when false statements, made directly or indirectly, are intended to injure anyone engaged in the business of insurance. "Directly or indirectly" refers not only to statements made as verbal assertions but also to pamphlets, circulars, articles, and literature. No false assertions or statements can be made that are maliciously critical or derogatory to the financial condition of the insurer.

Furthermore, it is unlawful to enter into any agreement to commit an act of boycott, coercion, or intimidation that would result in a monopoly or in the unreasonable restraint of the insurance business.

False Financial Statements

Insurers are forbidden to misrepresent the financial condition of any insurer (the insurer itself or another insurer) with the intent to deceive. Filing with any supervisor or public official or making, publishing, disseminating, or circulating a false statement concerning the financial condition with the intent to deceive is prohibited.

These types of misrepresentation include making false entries into any book, report, or statement with the intent to deceive an examiner who has been appointed to examine these affairs. Similarly, purposely omitting such a material fact on any book, report, or statement also is prohibited.

Stock Operations and Advisory Board Contract

It is a violation of most state statutes to deliver company stock, other capital stock, benefit certificates, shares in a corporation, securities, or other special board contracts or to permit agents to issue the same and then to promise returns and profits as an inducement to a potential applicant to purchase insurance. No one can issue these instruments and guarantee the payment of dividends as an incentive.

Unfair Discrimination and Rebates

Insurers discriminate all the time in deciding which risks to assume and which to decline through underwriting. However, *unfair discrimination* in the rates charged for any contract by insurers between individuals of the same class and equal expectation of life is prohibited. This applies to the following:

- the rates charged for life insurance, health insurance, and life annuities
- the payment of dividends and other benefits under these contracts
- any terms and conditions of the insurance contract

It is prohibited in almost all states to pay, offer to pay, or to rebate premiums; to provide bonuses or the abatement of premiums; or to allow special favors or advantages concerning dividends or benefits related to an insurance policy, annuity, or other contract associated with any stock, bond, or security of any insurance company. This applies to all life insurance, annuities, and health insurance.

A rebate is considered as either directly or indirectly giving anything of value other than what is specified in the policy contract as an inducement to purchase insurance. This can include stocks, bonds, securities, or other dividends not specified in the contract.

So an insurance agent is prohibited from returning part of his or her commission or from offering some other form of payment to induce someone to purchase insurance. Further, an agent cannot purchase goods from an insurance applicant as an inducement to the applicant to purchase an insurance policy.

The justification behind these statutes is that if a rebate were given, one policyowner would have an unfair advantage over others in similar situations who do not receive the benefit of the rebate, thereby conducting an act of unfair discrimination.

However, some practices do fall outside the definition of discrimination or rebates, such as the following:

- Paying bonuses to policyowners or otherwise abating their premiums can be done in whole or in part from the surplus accumulated from nonparticipating insurance. This practice is fair, assuming that these bonuses or abatements are fair and equitable to policyowners and that the practice is in the best interest of the company and of the policyowners.
- Making allowances to policyowners who have continuously, for some specified period, made their premium payments directly to an office of the insurer in an amount that is fairly represented as a savings in collection expense is not considered unfair.
- Readjusting the premiums for a group insurance policy based on its loss or expense experience can be done. However, it can be done only at the end of the first or subsequent policy years.

Although these listed practices generally do not constitute either discrimination or rebating, an insurer cannot unfairly discriminate in their administration.

Words Prohibited on Insurance Policies

Most states have provisions making it unlawful for any company engaged in the business of insurance to issue an insurance policy contract containing the words “Approved by the Board of Insurance Commissioners,” “Approved by the State of Vermont,” or similar words.

Language Used in Insurance Transactions

The job of selling an intangible product such as life insurance requires, in many cases, that an agent use language to “paint a picture” of the benefits and terms of the contract; in a sense, he or she is creating “word pictures.” In so doing, however, the agent must ensure that the words paint an *accurate* picture. For that reason, certain words and terms should not be used.

Although some states forbid their use in either a specific or general way, each of the following words or phrases obscures the product and presents an ethical concern:

Never Say	When You Mean
account, plan, private pension, program, or strategy	Policy
contribution, deposit, investment, or payment	Premium
earnings, profit, or return	Dividends
account or savings	cash value
mutual fund	separate account
vanishing premiums	using dividends to pay premiums
tax free	tax deferred

Other Areas of Insurance Consumer Protection

All insurance consumers are consumers first and insurance consumers second. They are protected by the various laws that protect consumers in general. In addition, if they have an insurance-related complaint, consumers are further protected by the insurance codes of the various states.

Government regulation surrounds nearly every consumer product and service. This includes insurance policies or products as well as other services offered by the insurance companies. Under consumer protection laws, the consumer is granted the power to obtain a statutory injunction, and therein lies the power to widely correct the wrong, which protects everyone.

Consumer statutes, including those in the insurance industry, are one-sided in that they are obviously enacted to protect consumers rather than insurers. For example, whenever confusion or ambiguity exists in a contract, the issue is decided against the insurer. Whenever questions regarding coverage exist, the issue is often decided in favor of the policyowner.

The objective of these consumer statutes is to encourage conscientious businesspeople, service providers, sellers, and others to compete more equitably. In the case of the insurance industry, companies are required to conform to certain disclosure practices and specific claim settlement obligations. Further, agents and brokers are required to exhibit certain ethical behavior.

Insurers are subject to the various pieces of legislation enacted within their own states. Often, though not always, these state statutes are modeled after federal legislation. For example, federal laws of the Consumer Protection Act regulate consumer practices. State laws draw from this legislation. The individual states call their statutes by varying names. However, their intent is the same.

Both the federal and the state governments are given considerable powers concerning the inspection and oversight functions of consumer laws. These levels of government have the power to require and standardize disclosures that enable consumers to compare goods, services, securities, and insurance policies.

At the federal level, Congress has declared that the business of insurance and everyone engaged in it are subject to the laws enacted by the states in which the insurer can solicit business. The authority provided here is in addition to any existing powers of the states.

Unfair Competition and Practices by Insurers

States usually have some form of unfair practices act. Sometimes, these statutes refer to deceptive trade practices, unfair trade practices, or unlawful trade practices. The statutes are broad in scope, application, and protection, and they provide for private causes of action for any consumer who is damaged because of another's misrepresentation, breach of warranty, unconscionable conduct, or unfair practice. Even when a state does not have specific legislation on its books with regard to certain acts and practices, insurers are always held to the duty of good faith and fair dealing.

Deceptive trade practices can fall within these broad categories:

- **misrepresentation**—When an insurance agent or broker makes a representation, he or she has the duty to ensure that the statement is true. The consumer is clearly entitled to rely on this representation. Misrepresentation provisions of these acts are intended to ensure the accuracy of descriptions of products and services.
- **failure to disclose**—Allegations of failure to disclose give rise to many causes of action, including lawsuits brought against insurance companies. Agents and brokers are typically trained to extol the virtues of their products, but they are not generally trained to discuss the disadvantages of their products. In addition, many insurance agents are not eager to explain the intricacies of policy exclusions. Any allegation of failure to disclose requires the consumer plaintiff to prove that the defendant intended to induce him or her to participate in a transaction that he or she would not have otherwise entered. Knowledge and intent are the essential elements of the failure to disclose.
- **breach of warranty**—Breach of express or implied warranty is a clear violation of contract law.
- **unconscionable conduct**—An unconscionable act takes advantage of the lack of knowledge, ability, experience, or capacity of a person to a grossly unfair degree. An unconscionable act results in a gross disparity between the value received and the consideration paid for any item, including an insurance policy.[9]
- **insurance code violations**—Each state has its own insurance code. Violations of these insurance codes typically fall under some sort of deceptive trade practices legislation.
- **violations of tie-in statutes**—Tie-in statutes also are known as **linking statutes**. An insurance consumer can be granted the right to bring a cause of action under one law by linking it with another.

Other deceptive practices subject to consumer protection codes involve deceptive acts, including the following:

- passing off services as those of another
- causing confusion or misunderstanding concerning the source, sponsorship, approval, or certification of services offered
- causing confusion or misunderstanding with respect to the affiliation, connection, or association with another
- using deceptive representations or designations of geographic origin in connection with services, for example, if an agent tells a prospective customer that he or she shares the same hometown as a way to build rapport
- representing that services have sponsorship, approval, characteristics, or benefits when, in fact, they do not
- making false or misleading representation with respect to the services or the business of another (slandering the competition)

- advertising services with the intent not to sell the services as advertised
- representing that an agreement confers or involves rights, remedies, or obligations that it does not have or that are prohibited by law
- misrepresenting the authority of a sales person or an agent to negotiate the final terms or execution of a transaction
- concerning services, the failure to disclose information in order to induce the consumer into a transaction that he or she would not have otherwise entered had the information been disclosed
- advertising under the cloak of obtaining sales personnel when, in fact, the purpose is to first sell a product or service to the applicant
- making false or misleading statements concerning the price of services
- employing bait and switch advertising in an effort to sell services other than those advertised
- requiring tie-in sales or other undisclosed conditions that must be met before selling the advertised services
- failing to deliver the advertised products or services or make a refund within a reasonable time
- failing to identify oneself and represent the purpose of the call within an appropriate time after initiating a conversation when soliciting by telephone or door-to-door
- advertising services as guaranteed without clearly disclosing the nature and the limits of the guarantee.

Unauthorized Insurer Advertising

Under these statutes, insurers who are not authorized to transact business in a specific state are prohibited from publishing advertisements that are designed to induce that state's residents to purchase insurance from the unauthorized insurer. These statutes were enacted to protect insurance consumers from insurers not authorized to transact business in the state.

The term "unauthorized insurer" includes any insurance company organized under the laws of another state, as well as any territory of the United States or any foreign country, that has failed to obtain a certificate of authority from the state in which its advertisements are sent or published.

Because anyone who is not so authorized in the first place cannot conduct the business of insurance within a particular state anyway, the purpose of these acts is to protect insurance consumers from misrepresentation. No unauthorized insurer can issue any advertisement, estimate, or illustration that misrepresents its financial condition, the terms of its policy contracts, benefits, advantages, or dividends. This includes newspaper and magazine ads, radio, television, and all circulars, pamphlets, letters, and flyers. In some states, if the insurance commissioner believes that an insurer is engaging in this unlawful advertising, the commissioner must notify the insurance supervisory official in the state of that insurer.

Unfair Claims Settlement Practices

A great amount of legislation has been created to protect insurance consumers from unfair claims settlement practices. No insurer in any state can engage in unfair claims settlement practices. The following acts are prohibited:

- failing to acknowledge, with reasonable promptness, appropriate communications concerning claims
- knowingly misrepresenting to a claimant pertinent facts or policy provisions that relate to his or her coverage

- failing to adopt and implement effective and efficient standards for the prompt investigation of claims
- failing to, in good faith, make a prompt, fair, and equitable settlement of a claim submitted in which liability is reasonably clear
- compelling policyowners to initiate lawsuits to recover amounts due under policy coverage by offering to settle for an amount substantially less than is ultimately recovered by the claimant
- failing to maintain a complete record of all of the complaints received during recent years or since the date of the last examination by the insurance commissioner, whichever is shorter. This record must indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, their disposition, and the time to process each complaint.
- committing any other actions that the state defines as an unfair claim settlement practice

Assignment Protection

In the health insurance industry, benefits are commonly assigned to a physician, clinic, hospital, or other health-care provider. An insurer cannot prohibit or restrict any written assignment of these benefits. The insured can request an assignment of benefits; that is, he or she can request that the benefit payments be made directly to his or her physician or other health care provider. When such payment is authorized by the insured and made to the provider, the insurer is relieved of its obligation to make payment to the insured.

Naturally, the assignment of benefits does not relieve the insured from his or her responsibility for paying deductibles and copayments. Finally, a health-care provider cannot waive a deductible or copayment and accept the assignment as full payment.

Insurer Compliance

Each state has its own guidelines with respect to regulatory intervention in cases of insurer insolvency or financial impairment. The insurance industry in each state is regulated by some type of state board of insurance, typically appointed by the governor. One member is usually selected to act as the chairman. Often, an insurance commissioner is appointed as well. The board and the commissioner are responsible for supervising the Department of Insurance and administering the laws that govern the insurance practices of the state.

Typically, the state board of insurance has the power to examine and investigate the affairs of anyone who is engaged in the business of insurance within the state. This board can determine if any unfair method of competition has occurred, or if any unfair or deceptive act or any unfair claim settlement practice has occurred. Additionally, the state board of insurance usually monitors financial practices and ensures compliance with the laws of the state.

When a state board of insurance believes that an insurer is violating the various insurance consumer protection acts, states generally permit the board to file an application in court to serve a statement of charges against the insurer and to give the insurer notice of a hearing to be held. The purpose of the hearing is for the insurer to show cause why a cease and desist order barring these activities is unnecessary.

At this hearing, the insurer has the opportunity to be heard, and the insurer can be represented by an attorney. In fact, in some states, anyone with something relative to say on the subject is permitted to appear and to be heard. Hearings are typically informal, where no formal rules of pleading or evidence must be followed.

In most states, the board has the power to

- administer oaths
- examine and cross-examine witnesses
- receive evidence
- subpoena witnesses
- require the production of books, papers, records, correspondence, and other relevant documents

If someone refuses to comply with a subpoena or testify as required, the state board can request the district court to have this person comply. The failure to comply with such a request is considered contempt of court.

If, after the hearing, the state board determines that the insurer has engaged in some unfair insurance practice, a cease and desist order must be issued. A cease and desist order requires the insurer to stop engaging in the unfair practice. In most states, if the insurer violates the terms of the cease and desist order, it is then given notice to appear at another hearing and show cause why it should not pay a civil penalty.

Methods of Ensuring Insurer Compliance

Each state can employ various measures for ensuring regulatory compliance by insurers. Insurance department examinations are the method most commonly used for ensuring regulatory compliance by insurers. These exams typically occur every two to four years, usually depending on the size of the insurer. (Smaller insurers are generally examined more frequently than large insurers.) The insurer and the books and records of its agents are examined. The company being examined must bear the expenses of the examination and must usually provide office space, telephones, and computers for the team of examiners. Negative results of an insurance department examination can lead to the insurer's certificate of authority being revoked or modified.

Two pieces of federal legislation are often used as the models for state rehabilitation and liquidation statutes. These two federal acts are the Uniform Insurers Liquidation Act (UILA) and the Insurers' Supervision, Rehabilitation, and Liquidation Model Act.

Although other regulatory measures can be referred to by different names, they come under the broad headings of rehabilitation or liquidation. Rehabilitation allows for the restructuring of the insurer under the supervision of the state board. Liquidation is a most severe situation, where the state board takes title of the insurer's assets and uses them to pay creditors and policyowners.

Typically, rehabilitation measures include the following:

- **administrative oversight**—Generally, administrative oversight is an informal process and is a procedural tool used for insurers who show troubling financial or policyowner trends. The insurer must pay the expenses of administrative oversight. Because this is not confidential, any consumer can call the state board to inquire whether a particular insurance company is under administrative oversight.
- **sanctions**—Sanctions are taken to order an insurer to cease and desist a specified activity or to suspend or revoke the authority of an insurer to do business in the state. An insurer can be ordered to pay restitution to those who have been harmed by a violation. Further, monetary penalties such as fines or tax penalties can be imposed as sanctions on companies that violate provisions of the state's insurance code.

- **injunctions**—Injunctions are used when the state board requests the state attorney general to bring an action in the name of the state against an insurer to restrain the use of unfair practices. This restraint can be in the form of a temporary or a permanent injunction. In addition to requesting the injunction, the state board is typically permitted to request a civil penalty.
- **supervision**—In most states, the state board has the authority to place a company or its agent in a state of supervision, and the insurer must bear the cost of the supervision. Generally, a supervision order contains a list of prohibited transactions. It also specifies remedial actions that the insurer must take to be released from supervision. The supervision order sets a hearing date by which the insurer must correct the items in question.
- **conservation**—Also known as conservatorship, if an insurer cannot prove that it has satisfied the conditions necessary for release from supervision, the state board can order that the insurer be placed in conservation. Conservation is considered a harsh measure and is used when a company is insolvent, when the company's condition is hazardous to the public or to its policyowners, when the company has exceeded its powers, or when the company has failed to comply with the state board's requirements. A conservator can temporarily take over the operation of the company.
- **receivership**—This is the harshest remedy against a licensed insurer. The state board requests the state attorney general to institute a receivership action in which the insurer is alleged to be insolvent.

Generally, the state board has the discretion to accept the assurance of voluntary compliance by an insurer. Conditions are imposed on voluntary compliance; for example, the insurer must restore to all consumers any money that could have been acquired as a result of its unfair practices.

Any civil penalties, premium refunds, judgments, recoveries, orders, awards, costs, damages, or attorneys' fees that are awarded to any consumer as a result of the insurer being found liable must be paid only from the capital or surplus funds of the insurance company.

Avoiding Liability

To avoid liability, insurers are held to certain responsibilities and codes of conduct. Among the most significant is the duty of good faith and fair dealing. The courts have upheld the duty of good faith and fair dealing many times, stating that a "special relationship" is created by the insurer's disproportionately strong bargaining position relative to the beneficiary in the claims-handing process.

In addition to the duty of good faith and fair dealing, insurers also have the duty of care. The duty of care requires that insurers perform their obligations with care, skill, reasonable expedience, and faithfulness. The insurer's standard of care is measured by a determination as to whether a reasonable insurer, under the same or similar circumstances, would have acted in the same way, such as in delaying or denying a claimant's benefits. The measure of the duty of care is defined as "that degree of care and diligence which a man of ordinary care and prudence would exercise in the management of his own business."

However, the duty of care has limits. For example, unlike the duty of care and good faith owed to an insured, the insurer does not owe a fiduciary duty or a duty of good faith and fair dealing to a third-party claimant. This rule applies even if the claimant is one of its own insureds presenting a claim against another of its insureds.

With respect to limitations, although the duty of good faith and fair dealing requires that the parties must "deal fairly" with one another, this duty does not impose the burden of requiring one party to place the interests of the other party before his or her own.

Finally, insurers have the duty to settle. The insurance company must settle valid claims within a reasonable period. Every reasonable settlement demand within policy limits should be accepted. This final duty is associated with the greatest amount of litigation in the insurance industry.

20-Point Checklist for Safe and Effective Claims Handling

Following these measures will enhance the integrity and reputation of any insurance professional.

1. Inform the insured and the claimant of their rights and obligations under the policy contract.
2. Extensively investigate all facts presented by the insured, the claimant, the agent, the witnesses, and the attorney. Formal reports, such as police reports, only aid in the overall investigation. The investigation must be thorough.
3. Never make a deceptive representation to anyone.
4. Never manipulate records, reports, and other documents. Such manipulation is considered to be fraud.
5. Never use the insured's or claimant's financial situation as leverage to devalue his or her bargaining power. Taking advantage of someone who needs money badly by offering less than what the person is fully entitled to recover is a clear example of bad faith.
6. Never make oppressive demands on the insured or on the claimant.
7. Never unreasonably increase reserves on claims.
8. Never tell the insured or the claimant not to retain legal counsel. In most states, this conduct is considered illegal. If not illegal, it can be construed as unfair and unreasonable conduct.
9. Promptly answer letters of inquiry and telephone calls from insureds, claimants, and attorneys. This is more than a professional courtesy. In some states, it is required by statute. Some states specify the number of days in which a response must be made or an action must be taken. Of course, documentation of this is essential.
10. Address coverage issues in a timely fashion. Confirming or denying coverage should be conveyed to the insured or claimant as soon as reasonably possible.
11. Be consistent in paying similar claims.
12. Pay claims in a timely fashion. The unnecessary and unreasonable delay in paying a claim is a prime area of litigation.
13. If a claim is denied, it is wise to get a second opinion. In fact, this step is mandatory in many companies. In some cases, losses that have been considered not to be covered are interpreted differently by the courts.
14. Pay every element of the claim when it becomes reasonably clear that the payment is due. For example, if the insured or the claimant has more than one element to a claim, the payment of one portion cannot be withheld to coerce settlement of the other part.
15. Never compel the insured or claimant to take a case to court to recover benefits if the coverage is reasonably clear. If the insurer or claimant takes his or her case to suit and prevails, the insurer can be held responsible for reasonable attorney fees if the litigation was unnecessary to recover benefits.
16. Promptly honor reasonable requests by the insured, such as disclosing which payments have been made to a third party.

17. Never threaten the insured or claimant with the possibility of taking him or her to court or by appealing the claim.
18. Do not request redundant information. This could be interpreted as harassment, leading to a bad faith action.
19. Give a written explanation of the denial of a claim or the compromise of a claim.
20. Mislead no one about statutes of limitations and when they can run out.

Summary

During the decade of the 1970s, universal and variable life insurance life products were introduced. They quickly gained significant popularity based on their tax-favored status as life insurance coupled with their ability to generate substantial investment gains. To avoid granting the favorable life insurance income tax treatment to products that are really investments with only modest death benefits, Congress created certain tests that a policy is required to meet in order to be deemed "life insurance."

Under the first of those tests, insurance contracts issued after December 31, 1984, must meet the definition of life insurance prescribed in the Internal Revenue Code (Code § 7702) in order for cash values to be tax deferred and for their death benefits to be fully excludable from the beneficiary's income for tax purposes. Meeting that definition of life insurance requires that a policy meet either of the following tests:

- cash value accumulation test (CVAT)
- guideline premium and cash value corridor test

A life insurance policy that does not meet either test loses its favorable income tax treatment.

In 1988, Congress again addressed the income taxability of life insurance policies by creating a special category of life insurance policies known as "modified endowment contracts" as well as an additional test to identify cash-value-rich life insurance contracts. Pursuant to this new congressional tax initiative, any life insurance policy—one that meets the test of IRC § 7702, in other words—that is entered into after June 20, 1988, and fails to meet a "7-pay test" is considered a modified endowment contract (MEC) subject to less favorable income tax treatment of lifetime distributions.

In addition to these changes in tax law affecting certain life insurance contracts, the prevailing commercial philosophy has migrated from "let the buyer beware," a concept known as *caveat emptor*, to one that could be characterized as "let the seller beware." This newer commercial philosophy means considerably greater consumer protections. Due to improved legislation and increased insurance industry regulation resulting from this consumer-oriented philosophy, predatory and unfair insurance sales practices are punished severely.

Two pieces of federal legislation further increased federal control over the insurance industry: Dodd-Frank and the Patient Protection and Affordable Care Act.

Chapter 4 Review Questions

1. Which of the following result(s) from a life insurance policy's failure to meet the statutory definition of life insurance contained in IRC § 7702?
   I. Tax deferral of cash value gain is lost.
   II. Some or all of the policy's death benefits are subject to income taxation.

   A. I only
   B. II only
   C. both I and II
   D. neither I nor II

2. Phil's life insurance policy is considered a modified endowment contract. What can he do to change that characterization?

   A. Nothing; the characterization of a life insurance policy as a MEC cannot be changed.
   B. reduce the policy's death benefit
   C. reduce the policy's cash value
   D. assign the policy

3. What was the commercial philosophy with respect to product liability in the early 20th century?

   A. Caveat vendor.
   B. Let the buyer beware.
   C. Congress imposed strict product liability on all product manufacturers and sellers.
   D. Let the seller beware.

4. If a life insurance policy purports to provide coverage that is not actually provided, a suit can be brought against the insurer for what type of transgression?

   A. negligence
   B. fraud
   C. deceptive trade practices
   D. breach of contract

5. When may an insurer refuse to accept an assignment of health insurance benefits to a health care provider?

   A. only when the provider is part of a competing PPO or HMO
   B. never
   C. when a provider is suspected by the insurer of fraudulent billing
   D. when the insured is age 65 or older

Answers to Chapter 4 Review Questions

1. C. Life insurance contracts issued after December 31, 1984, must meet the definition of life insurance prescribed in IRC § 7702 for policy death benefits to be fully excludable from the beneficiary's income for tax purposes. Furthermore, cash value growth in such contracts failing to meet the definition of life insurance is generally not tax deferred.
2. A. Generally, if a life insurance policy is deemed to be a MEC, nothing can be done to change that status. Once a policy is considered a MEC, it is always a MEC.
3. B. Caveat emptor is a term that encapsulated the judicial approach to product liability in the first half of the 20th century. The term translates to "let the buyer beware." It was a clear acknowledgment that the buyer of goods or services was expected to watch out for himself, and it was the prevailing common law doctrine regarding the transaction between buyers and sellers.
4. D. If a life insurance policy purports to provide for coverage that is not actually provided, a suit can be brought for breach of contract.
5. B. In the health insurance industry, benefits are commonly assigned to a physician, clinic, hospital, or other health care provider. An insurer cannot prohibit or restrict any written assignment of these benefits. The insured can request an assignment of benefits; that is, he or she can request that the benefit payments be made directly to his or her physician or provider. When such payment is authorized by the insured and made to the provider, the insurer is relieved of its obligation to make payment to the insured.

Chapter 5
Issues Affecting Insurer Liability

Insurer liability is sometimes obvious and straightforward; occasionally, it is anything but obvious. Several legal concepts affect liability and can impose it or can allow an insurer to avoid it, depending on the facts involved. An important concept in the insurance industry is the law of agency, which is described in detail in this chapter. Also provided is a discussion of the insurer's defenses to liability.

The Law of Agency

To many, the word "agent" brings to mind the people who sell insurance. However, the concept of agency is far broader than that. An agency relationship can result when one party consents to another person's acting on his or her behalf—irrespective of the activities in which the parties engage. The resulting relationship creates a principal and an agent. In this section we will look at the common law concept of agency and consider its impact on the business of selling insurance.

Parties to Agency

A **principal** is the party on whose behalf the agent acts. An **agent** is the party who acts for another. So, although an insurance agent is clearly an agent in the context of the law of agency, many others who do not sell insurance or any other product or service can also be agents.

The person who is a principal or an agent can be either a natural person—an individual, in other words—or a nonnatural person, such as a corporation. (Interestingly, a partnership cannot be a principal although a partner can be.) Furthermore, under the general law of agency, an agent need not have contractual capacity to be able to bind his or her principal. In simpler terms, that means that a minor, for example, could be an agent for a principal, and the minor's actions could bind the principal.

Although an agent need not have contractual capacity, a principal must have it to appoint an agent. For an insurance agent's agency relationship, the principal is, of course, the insurer.

Authority Conveyed to an Agent

The essence of the agency relationship involves the granting of certain authority to the agent, enabling him or her to act on the principal's behalf. The basic agency rule is that the actions of the agent, when acting within his or her authority, bind the principal.

Definition

Authority—the power to act given by one party to another

In the case of an insurance agent, the document that establishes the agency relationship between the agent and an insurer is the agent's contract. However, it is not only when the agent is performing the activities specifically recited in the agent's contract that he or she can bind the principal; rather, the law of agency expands the agent's authority considerably. Despite that broadening of the agent's authority, it is only the agent's authorized acts that bind the principal. That authority, however, may be granted in various ways.

Because only the agent's *authorized acts* can bind the principal, we need to understand all of the methods by which authority is conferred on the agent. An agent can have three types of authority:

- express authority
- implied authority
- apparent authority

Each of these can cause an insurer to be liable for the actions of its agents. Let's examine each of these types of agent authority.

Express Authority

The authority given to an agent and recited in the contract between the agent and the insurer is known as **express authority**. The agent's contract is specific insofar as it recites the activities the agent is authorized to perform and outlines his or her duties. It should be obvious that, if the agent does only what he or she is given express authority to do, those actions would bind the insurance company. Because the agent's contract is specific, generally few legal problems arise from this kind of authority.

Implied Authority

Anybody who has functioned as an insurance agent knows that a typical agent performs far more activities in doing his or her job than could possibly be recited in the agent's contract. For that reason, the express authority given in the contract implies that the agent is authorized to perform other acts not specifically mentioned. This is the basis of **implied authority**. An agent's authority is implied when it:

- is intended to be given by the insurer
- usually relates to the general customs of the business
- is not contractually provided or specifically delineated

Implied authority, unlike express authority, derives from the powers that the company customarily gives its agents rather than being specified in the contract between the agent and the insurer. It is easy to understand implied authority if we just think about an agent's job. The insurer gives an agent express authority to solicit applications for insurance on its behalf. Because the agent probably could not reasonably solicit insurance applications on behalf of the insurer without arranging sales appointments with prospects, the insurer also gives the agent the implied authority to telephone prospects on its behalf to arrange sales appointments. So, although the agent's authority to telephone prospects to arrange sales meetings is generally not expressly given in the contract, the agent, nonetheless, possesses it.

Implied authority and apparent authority (discussed just below) sometimes cause insurers to give agents authority that was never intended. Consider what kind of authority, if any, might be bestowed in the following situation.

Suppose that an insurer's field managers knowingly or negligently permitted the company's agents to engage in unethical sales practices. Because the insurer failed to stop these practices, an injured plaintiff could successfully maintain that the company gave the agents implied authority to act as they did. To the extent that the insurer authorized that conduct—in this case, through implied authority—it is responsible for it just as though it had specified that activity in the agent's contract and could be held liable for any damages resulting from it. Not surprisingly, perhaps, implied authority has been the legal basis for some successful lawsuits alleging unethical marketing practices.

Apparent Authority

Although implied authority sometimes makes insurers liable for their agents' unlawful or unethical acts, it is **apparent authority** that is more frequently a compliance concern for insurance companies. Apparent authority is authority that:

- is not provided by contract
- is not intended by the insurer
- reasonably appears to the customer to be given to the agent based upon the agent's believable statements

Apparent authority reasonably appears to the client to be given to the agent, and this apparent authority can make the company liable for the agent's unauthorized acts. Not unexpectedly, it is apparent authority that causes the majority of the liability for insurers.

Even if the agent has none of these types of authority, an insurer can still be liable for the agent's acts. That outcome can result from the insurer's ratification of the agent's acts.

Ratification

Insurers can give official sanction to the otherwise unauthorized acts of an agent through a concept known as **ratification**. Ratification involves the principal's confirming or approving an agent's actions. The following four elements are necessary for ratification:

- The agent must have represented himself or herself as an agent acting on behalf of the insurer.
- The customer must have believed the agent's representations.
- The insurer must subsequently have confirmed the agent's actions by ratifying them in some fashion.
- The insurer must have ratified the entire agent transaction.

Although the concepts of express, implied, and apparent authority are fairly straightforward, the insurer's consequent liability is often anything but certain, because several other legal issues can affect liability and afford defenses to that liability.

Defenses to Liability

Although an insurer can mount many specific defenses against a claim of liability, four important concepts can play a part in any insurer's defense. These concepts are the following:

- waiver
- estoppel
- election
- course of conduct and custom

These concepts are generally based on two broadly held beliefs:

- A person should be bound by those things to which he or she agrees.
- A person whose conduct has caused another to act in a certain manner should not be permitted to act in a way that is contrary to the belief or expectation he or she has created.

Let's examine each of these liability-affecting concepts.

Waiver

Definition

Waiver —the intentional and voluntary relinquishment of a right

Waiver is a defense that involves the voluntary and intentional giving up of a right the individual knows he or she has. As an example to clarify the concept, suppose that an agent has handled a client's insurance needs for years. When the date for renewing the coverage approached, the agent routinely informed the client of it. Eventually, the client told the agent that such notification was neither needed nor desired, because he employed risk managers to stay abreast of those matters. When the inevitable happened and the client's building burned to the ground right after the fire insurance policy expired, the client sued the agent, stating that the agent had a duty to inform him of the policy's expiration.

Although the client certainly had a right to be informed that his coverage was about to expire, he voluntarily relinquished that right. At the client's direction the agent informed his staff that policy status notices were not to be sent to the client. The client voluntarily and intentionally gave up the right to receive policy status notices. In other words, the client waived his right to receive cancellation notices.

Estoppel

Definition

Estoppel —the relinquishment of a right because of prior actions that are inconsistent with its retention

Although both waiver and estoppel involve the giving up of a right, they are fundamentally different. With estoppel, the client gives up a right without intending to give it up, and it is that lack of intent that is the main difference between the two concepts. In a sense, we can say that estoppel limits an individual's right to change his or her mind. The test of whether the individual ought to be permitted to change his or her mind depends on whether another party has acted reasonably based on the individual's actions. Simply stated, estoppel involves the legal inability to abandon a decision or action.

Consider the following example. Suppose an insurer believes it is on a particular risk and acts in a manner that lets the client believe coverage is in force. The insurer may subsequently be unable to deny that coverage was in force if the customer's interests would be harmed by that assertion. If the client did not get additional coverage because the insurer's actions indicated the risk was already covered, the insurer could not subsequently deny coverage when a claim was submitted. This would be the case even though the in-force policy did not provide the needed coverage.

Election

The concept known as election works in the following fashion. When a party to an insurance contract has a choice of actions and chooses one, he or she cannot subsequently change his or her choice if the change would be detrimental to the other party. For example, if a client agrees to repairs of damaged property but later attempts to change the choice to a cash settlement after repairs are started, the court might say that the client had elected the repair option, and he or she would be held to that position. To do otherwise would injure the other party—the insurance company.

Course of Conduct and Custom

The legal concept known as the Course of Conduct and Custom Doctrine considers the way that people have done business previously. By looking at the parties' previous method of working together, this doctrine considers the way the parties handled their dealings together over a period of time to determine what is reasonable.

In the example of the insured whose building was destroyed the day following the expiration of coverage, suppose that even though the client had never asked the agent *not* to provide expiration notices, they were, nonetheless, never provided. As each policy expired, the client initiated a meeting with the agent to add new coverage, increase limits, etc., but at no time had the agent ever notified the client when a policy expired.

Although it could be modified by statute or regulation, the court would apply the doctrine of "Course of Conduct and Custom" to the facts. Because it was customary for the agent *not* to inform the client of the expiration of coverage, the court could hold that the agent had no duty to inform the client. Although the prudent client would probably avoid this kind of agent, it illustrates the concept of Course of Conduct and Custom Doctrine.

Applicant Statements

These classic defenses to liability are not the only ones that an insurer can use to legitimately avoid liability under an insurance contract. An insurer also can avoid liability on the basis of statements the applicant makes in his or her application for the insurance.

When an applicant applies for insurance, he or she makes certain statements on the application. It is important to understand that the "status" of those statements as either **warranties** or **representations** can have a significant effect on the coverage if one or more of the statements made in the application are untrue. Let's begin the examination of applicant statements with a definition of warranties and representations.

A **warranty** is a statement that becomes a part of the contract; it is guaranteed by the maker to be true in all respects. A **representation**, in contrast, does not become a part of the contract; rather, it is a statement that is made at the time of the formation of the contract that induces a party to enter into it. The practical effect of a statement being deemed a warranty rather than a representation can be significant.

In simple terms, an insurer can rescind an insurance contract if a statement made in applying for it is considered a warranty and is untrue *in any way*. In contrast, an insurer can rescind an insurance contract if a statement considered a representation is untrue *only if the untrue statement was material* to the formation of the contract. If a statement is a warranty, its lack of materiality is unimportant. (The Patient Protection and Affordable Care Act limits insurers' customary right to rescind a health insurance policy by prohibiting an insurer from rescinding health insurance coverage except for fraud or intentional misrepresentation of a material fact.)

Warranties

To understand the doctrine of warranties we need to return to eighteenth century England and the insuring of commercial shipping. Much of the eighteenth century found European nations at war, and those wars generally wreaked havoc on ships carrying cargo to the United States and other nations. Because of the greater risk to which these ships were exposed, insurers offered their best rates to ships that would be constantly protected by English warships throughout their voyage. Commercial ships that would be traveling unescorted by these warships could expect to face greater danger from pirates and privateers and, as a result, would pay higher insurance premiums—often substantially higher premiums.

To obtain these more favorable insurance rates, commercial shipowners were required to warrant that their ships would travel only in a convoy protected by English warships. The policy issued in response to

those warranties would warrant that these desirable conditions would prevail throughout the voyage. If the shipowner, having made such a warranty, permitted his ship to travel without the warranted protection, the insurance became void. There was no question as to whether that lack of protection was material. In fact, its materiality was assumed. Furthermore, the insurer was not required to present evidence of the shipowner's bad faith or fraud in order to void the contract. All that was required was a showing that the warranty given by the shipowner had been breached.

Representations

Although warranties can still play a role in marine insurance, they have tended to become far less important in other types of insurance, and they play no major role with respect to life and health insurance. Instead, statements an applicant makes for such coverage are generally considered representations and not warranties.

As we noted just above, representations are written or oral statements that are made before or at the time of formation of the insurance contract. Although the representations are not a part of the contract, these statements are deemed to be an inducement to form the contract and need to be *substantially true* at the time they are made. (This distinction is an important one: representations need not be literally true in all respects.)

In more than half the states, laws have been passed known as **entire-contract statutes**, which specify that the insurance contract constitutes the entire contract between the parties, along with an attached application if one exists. In addition, such statutes disallow any oral statements the applicant makes as being a part of the contract.

When we consider representations and their effect on an insurer's ability to avoid liability under an insurance contract, we need to understand that a representation is significant *only* if it:

- is communicated to the insurer
- influences the insurer's decision concerning whether to enter into the contract

In plain terms, the representation must be *material* for it to have any effect on the insurer's ability to avoid liability under the policy. Before misrepresented facts can be deemed material, they must be such that the insurer would have:

- refused to enter into the contract or
- entered into the contract only on different terms

If the insurer cannot show that knowing the truth would have caused it to refuse to enter into the contract or to enter into the contract on different terms, the misrepresented facts would not be deemed material. (In addition to the intentional misrepresentation of a material fact as a basis for rescission, the Patient Protection and Affordable Care Act permits insurers to rescind coverage in cases of fraud.)

Misrepresentation

As we noted earlier, the rule of warranty was developed by the English common law courts, and it is generally adopted by the courts in this country. The warranty rule provides that an insurer can avoid liability under a claim for insurance benefits if it is proven that an applicant submitted incorrect information to the insurer, and this incorrect information was then incorporated into the policy as a warranty.

In most states, however, information submitted as part of an application for insurance coverage must be treated as representations rather than as warranties. In fact, most state legislation addressing this issue declares that "all statements and descriptions in any application for an insurance policy or annuity

contract, by or on behalf of the insured or annuitant, shall be deemed to be representations and not warranties."

Despite the significant protection afforded policyowners by statements in an insurance application generally being considered representations, an insurer may be able to avoid liability in the event of a material misrepresentation. Except in the case of health insurance, an insurer may be entitled to relief from liability under an insurance policy on the basis that an insured provided incorrect information when all three of the following criteria are met:

- It is proven that the information was incorrect.
- It is proven that the incorrect information received was material to the insurer's decision to insure or to the terms of the insurance contract. That is, there must be a causal relationship between the incorrect information submitted and the loss that is the basis of the claim.
- It is proven that the insurer relied on the incorrect information. In some cases, this reliance must be further characterized as "reasonable."

When a party to a contract has acted in reliance on a misrepresentation made by the other party to the contract and has entered into a contract to which he or she would not have otherwise become a party, the deceived party can usually rescind the contract. Legislation passed in 2010 adds an additional limitation on an insurer's right to rescind an individual or group health insurance contract, however, as discussed below.

Health Insurance Rescission

The Patient Protection and Affordable Care Act (PPACA), limits a health plan's or health insurer's right to rescind coverage. The law makes it somewhat more difficult for an insurer to rescind health insurance coverage than to rescind life insurance coverage.

Under this law, a health plan or a health insurer cannot rescind coverage in the absence of fraud or an *intentional* misrepresentation of a material fact. Thus, in order for an insurer to rescind group or individual *health insurance* coverage on the basis of a misrepresentation, the misrepresentation must also be intentional in addition to being incorrect, material, and relied upon.

Note

Rescission involves the termination of the contract with a retroactive effect. When a contract is rescinded, it is declared void because of a misrepresentation of a material fact. In the case of health insurance coverage, the misrepresentation must also be intentional.

Materiality

If any question remains about what is *material* and what is not, remember that a material misrepresentation is one that, had the insurer known the true facts, would have caused it to accept the risk only on other terms or to refuse to accept the risk at all. Over the years, courts have tried to test the materiality of misrepresentations using two approaches:

- by referring to the underwriting practices of the insurer involved in the lawsuit, an approach known as the **individual-insurer standard**
- by referring to industry underwriting practices, an approach known as the **prudent-insurer standard**

Although the prudent-insurer standard of materiality has been adopted as the test of the materiality of misrepresentations in most jurisdictions, both approaches have advantages and disadvantages.

Summary

Whether called “agents,” “producers,” “brokers,” or by some other term, persons who sell insurance are legally considered agents of the insurer. Under the legal concept of agency, the authorized actions of insurance agents are attributable to the insurers they represent. Such actions may be considered “authorized” and, as such, attributable to insurers under express authority, implied authority, or apparent authority. When an agent is given the authority to engage in certain actions in his or her contract, such authority is said to be “express authority.” The authority an agent has is considered “implied authority” when the activity is one that is customarily engaged in by an agent and, while not expressly given in the contract, is intended to be granted by the insurer.

Unlike express and implied authority, “apparent authority” is not intended to be granted by the insurer. Apparent authority, however, is authority that, based upon the agent’s believable statements, reasonably appears to the customer to be given to the agent.

Even though insurers are liable for the authorized actions of their agents, they may defend themselves against liability by asserting various defenses. Four legal concepts often play some role in an insurer’s defense. These concepts are waiver, estoppel, election, and course of conduct and custom.

Chapter 5 Review Questions

1. A material misrepresentation made on an application for a life insurance policy is one that would have caused the insurer, had it known the truth, to decline the risk or to accept the risk only on other terms.

    A. True

    B. False

2. Helen's agent contract states that she is "authorized to solicit applications for insurance on behalf of MegaMutual." What is the type of authority she has been granted by virtue of the contract language?

    A. implied authority

    B. express authority

    C. apparent authority

    D. evident authority

3. What type of agent authority is *not* specifically provided for under a contract but is intended by the insurer to be granted?

    A. express authority

    B. evident authority

    C. apparent authority

    D. implied authority

4. Peter is Audrey's insurance client. After regularly receiving late payment notices indicating his insurance premium was late, Peter informed Audrey that he employed others to monitor his insurance and did not wish to receive further late premium payment notices. When his warehouse was destroyed by fire, it was determined that his policy had lapsed and that he had not received a late payment notice. What defense is the insurer likely to offer for its refusal to pay the claim?

    A. waiver

    B. course of conduct and custom

    C. estoppel

    D. election

5. Which of the following types of statement made by a party to a contract becomes a part of the eventual contract?

    I. a representation
    II. a warranty

    A. I only

    B. II only

    C. both I and II

    D. neither I nor II

Answers to Chapter 5 Review Questions

1. A. A material misrepresentation is one that, had the insurer known the true facts, would have caused it to accept the risk only on other terms or to refuse to accept the risk at all.
2. B. The authority given to an agent and recited in the contract between the agent and the insurer is known as express authority.
3. D. An agent's authority is implied when it is intended to be given by the insurer, usually relates to the general customs of the business, and is not contractually provided or specifically delineated.
4. A. The insurer is likely to claim that Peter waived his right to receive late payment notices. Waiver is a defense that involves the voluntary and intentional giving up of a right the individual knows he or she has.
5. B. A warranty is a statement that becomes a part of the contract; it is guaranteed by the maker to be true in all respects. A representation, in contrast, does not become a part of the contract; rather, it is a statement that is made at the time of the formation of the contract that induces a party to enter into it.

Chapter 6
Issues Affecting Life Insurance Taxation

Life insurance has enjoyed special tax treatment when compared to other financial products, such as stocks, bonds, and savings accounts. As distinctions between products blurred, however, and life insurance, with the advent of universal life and variable universal life insurance, became an "investment" product of choice for many individuals, Congress imposed stricter requirements on life insurance to qualify for traditional life insurance income tax treatment. The previous chapter examined those stricter requirements that include a statutory definition of life insurance and the creation of a new category of life insurance known as a modified endowment contract.

In this chapter, the consequences for life insurance contracts that fail to meet the statutory definition of life insurance or that become modified endowments are examined. In addition, this chapter describes the death benefit tax consequences of an assignment of the policy in return for the policyowner's receipt of valuable consideration. The negative effects of such a transfer for value are examined, and the types of transferees that are exempt from the transfer for value rule are listed. This chapter also discusses the effect of the Pension Protection Act of 2006 (Act) on the tax treatment of certain employer-owned life insurance policies.

Also considered are the special tax rules that apply to life insurance policies purchased in split-dollar plans and those policies that are included in qualified retirement plans.

Consequences of Failure to Meet Life Insurance Definition

The value of life insurance is, unquestionably, enhanced by its receipt of favorable income tax treatment. Favorable tax treatment, however, is conditioned on the life insurance contract's meeting the Internal Revenue Code § 7702 definition of life insurance. A life insurance contract that fails to meet the definition of life insurance is subject to income taxation in a manner similar to other financial products. Specifically, the traditional income tax treatment of cash values and death benefits is lost. Let's briefly consider how these important elements of a life insurance contract are taxed if the contract fails to meet the definition of life insurance.

Cash Values

Life insurance contracts issued after December 31, 1984, that fail to meet the statutory definition of life insurance lose the tax deferral of the inside build-up of cash surrender values. The taxable income resulting from the growth of cash value in a life insurance contract that does not meet the statutory test is determined using the following three steps:

1. Subtract the contract's net surrender value at the end of the current year from the net surrender value at the end of the previous year.[10]
2. Add the increase in surrender value determined in (1) above to the cost of life insurance protection for the year.[11]
3. Subtract the premiums paid during the year from the result calculated in (2) above.[12]

To illustrate the tax on the inside build-up of cash values in a life insurance contract that fails to meet the statutory definition, consider the following values:

Net surrender value this year:	$25,000
Net surrender value last year:	– $20,000
Increase in net surrender value:	$5,000
Deductions from cash value to pay cost of insurance this year:	+ $480
Total	$5,480
Less premiums paid:	– $4,800
Taxable portion of inside build-up	$680

Death Benefits

Death benefits in a life insurance contract that was issued after 1984 and fails to meet the statutory definition of life insurance are similarly subject to income taxation. In the case of death benefits, the excess of the death benefit over the net surrender value is received by the beneficiary income tax free. Furthermore, the beneficiary also receives income tax free any unrecovered basis (including cash value increases previously includible in income) in the contract.

An example of how these death benefits might be taxed is as follows:

Death benefits paid:	$100,000
Less net surrender value at date of death:	– $25,000
Received tax free:	$75,000
Tentatively taxable amount:	$25,000
Less premiums paid:	– $15,000
Less cash value increases included in policyowner's income in prior years:	– $2,500
Beneficiary's taxable income:	$7,500

Consequences of MEC Status

MEC status generally changes the tax treatment of lifetime distributions—that is, distributions of other than death benefit proceeds—from a life insurance policy that has not met the 7-pay test and is, therefore, a modified endowment contract (MEC). Under a life insurance policy that has met the 7-pay test (and is, therefore, not a MEC), lifetime distributions are taxed on a first-in, first-out (FIFO) basis. Because premiums are always deemed to be paid in to a life insurance policy before any earnings are credited, FIFO tax treatment results in distributions being considered a tax-free recovery of the policyowner's basis *before any taxable earnings are distributed*. The net effect of that tax treatment is that withdrawals from

the policy are tax free until they exceed the policyowner's basis in the contract. (Remember, the policyowner's basis in the contract is generally equal to the net premiums paid for the life insurance.)

FIFO Treatment Changed to LIFO

When a life insurance policy fails to meet the 7-pay test (the policy is a MEC, in other words) the tax treatment is reversed. FIFO tax treatment is changed to the less favorable last-in, first-out (LIFO) treatment. Under LIFO, all taxable earnings are deemed to be withdrawn before any tax-free cost basis is recovered. As a result of that treatment, any gain on the contract at the time a withdrawal is made is deemed to be received first. Only after all the gain has been distributed will the remainder of the withdrawal be tax free.

Policy Loans Treated as Distributions

Loans from life insurance policies that meet the 7-pay test are not subject to income tax at the time of the loan, although any loan outstanding at the time of surrender is deemed to be a distribution. Loans from a MEC, however, are treated as distributions for tax purposes. As a result, a loan from a MEC under which the contract has a gain results in taxable income to the policyowner equal to the lesser of the loan and the amount of the gain.

For example, suppose that a MEC policyowner takes a policy loan of $10,000. If the policy has a gain of $7,500, only $2,500 of the policy loan avoids current income taxation; the balance, $7,500 in this case, is taxable income in the year in which the loan is taken.

Certain Dividends Treated as Distributions

Although life insurance dividends are normally received tax free until aggregate dividends exceed the policy's basis, certain dividends paid under policies deemed to be MECs are considered amounts "received under the contract" and can result in taxable income.

Amounts received under the contract in a MEC are considered taxable income to the extent of any gain under the policy. Dividends paid in cash, accumulated under the policy, or retained by the insurer to pay principal or interest on a policy loan are deemed amounts received under the contract. As such, they result in taxable income to the policyowner to the extent of any policy gain under the contract. Dividends retained by the insurer and applied to purchase paid-up additions under a MEC are not considered amounts received under the contract and do not result in taxable income.

Withdrawals Deemed Income First

Consistent with the change of tax treatment from FIFO to LIFO in a MEC, withdrawals from a life insurance policy deemed a MEC constitute taxable income to the policyowner to the extent of any gain under the contract. Under this approach, all of the gain in the life insurance policy is considered to have been received in the withdrawal before *any* basis was deemed withdrawn. An illustration may help to clarify.

Suppose Alan made ten annual premium payments of $5,000 to his life insurance policy. The policy had not met the 7-pay test and was, therefore, deemed a MEC. If the policy has cash value of $70,000, his gain under the contract is $20,000 ($70,000 – $50,000 = $20,000). If Alan withdrew $25,000 from the contract, the first $20,000 withdrawn would constitute taxable income to him; the remaining $5,000 of the withdrawal would be deemed a nontaxable recovery of his basis in the contract.

Premature Distribution Penalty Tax Added

In addition to changing the tax treatment of distributions from MECs from the traditional FIFO to the far less favorable LIFO, Congress imposed a 10 percent penalty tax on certain MEC distributions. The 10 percent MEC penalty tax applies to any amount received from a MEC that is includible in income by an individual before he/she reaches age 59½. Two additional exceptions to imposition of the penalty tax, however, are when the following circumstances occur:

- The distribution is made after the policyowner becomes disabled.
- The distribution is part of a series of substantially equal periodic payments made for the individual's life or life expectancy or for the joint lives or joint life expectancies of the individual and his or her beneficiary.

Death Benefits Unaffected

Death benefits paid under a life insurance policy deemed a MEC are not affected by its MEC status. It is important to remember that a MEC is a contract that meets the definition of life insurance under § 7702 but fails the 7-pay test. Its meeting the statutory definition of life insurance is sufficient to retain the generally income tax-free nature of the death benefit despite its being a MEC.

Charges Against Cash Value for Qualified Long-Term Care Coverage

Certain other distributions from a MEC avoid the usual unfavorable MEC tax treatment. Those distributions are charges against a MEC's cash value for purposes of paying the premium cost for certain qualified long-term care insurance coverage.

Rather than being considered a distribution of gain and subject to income taxation and penalties, charges against a MEC's cash value to pay for qualified long-term care coverage are deemed a distribution of tax-free cost basis. Thus, such a distribution will reduce the policyowner's cost basis in the policy but not to less than zero.

For such charges against the cash value of a MEC to receive this favorable income tax treatment, the following conditions must be met:

- The coverage must be qualified long-term care insurance coverage.
- The coverage must be included in the basic contract or added to the contract by rider.

Transfer for a Valuable Consideration

Transfers of life insurance policies were considered in an earlier chapter in the section dealing with policy assignments. When a policy is absolutely assigned, all of the rights associated with ownership vest in the assignee. When the assignee is a donee—in other words, when the policy is transferred as a *gift* to another party—the donee assumes all the rights of the former policyowner. In such a case, the tax treatment of the death benefits when the insured dies is the same as it would have been had the assignment never taken place: the death benefits are received by the beneficiary income tax free.

Transfer for Value Defined

In some cases, however, the assignment of a life insurance policy is not done as a gift; instead, a *sale* takes place, and the former owner is compensated for the transfer. Generally, although not always, the payment given to the assignor in return for the policy transfer is approximately equal to the policy's cash value. When ownership of a life insurance policy is transferred to another party, and the assignor receives a valuable consideration as compensation for the ownership transfer, the transfer is considered a **transfer for a valuable consideration** and comes under the **transfer for value rule**.

The term "consideration" is a fairly broad one and includes far more than simply money. **Consideration**, when used in connection with the elements required for a valid contract, means something of value that the offeror bargains for and requests and that the offeree gives in exchange for the offeror's promise.

Situations that could easily result in a transfer of a life insurance policy for a valuable consideration include the following:

- retirement of a key executive whose employer had purchased key-person life insurance coverage. In such a case, the life insurance is no longer needed, and the former employer can offer the ownership of the policy to the retired key executive for its cash value
- dissolution of a partnership. In this case, life insurance policies that had been purchased by each partner on the life of the other partner are no longer required. Each partner can choose to offer the insured the opportunity to purchase the policy on his or her life for its cash value.

Many other situations exist in which it can be appropriate to assign a life insurance policy to another party in exchange for payment of its cash value.

Another type of transfer for value that became important beginning in the last decade of the twentieth century involves a **viatical settlement**. A viatical settlement is the sale of a life insurance policy to a third party by an individual who has a life-threatening illness in return for a percentage of the face amount of the policy. A viatical settlement generally involves individuals suffering from a terminal illness who have a life expectancy of up to 48 or 60 months. When the insured subsequently dies, the purchaser of the policy receives a return on his or her investment—the policy's death benefit.

Consequences of a Transfer for Value

The nonincome taxability of life insurance death benefits has long been an important benefit of the purchase of life insurance. That favorable tax treatment is lost, however, when the policy has been assigned to a nonexempt assignee in a transfer for value. When a transfer for value occurs involving a nonexempt transferee, the death benefits are income taxable to the beneficiary to the extent the death benefits exceed the total of the consideration paid for the policy and any subsequent premiums paid by the transferee.

Suppose that Ed and Cindy were married and subsequently divorced. During the marriage, Ed purchased a $100,000 life insurance policy on his life with death benefits payable to Cindy. Following the divorce, Ed felt he had no need for the life insurance and, rather than surrender it, sold it to his brother, George, for its $15,000 cash value.

George continued to pay the policy premiums of $2,000 annually. When Ed died 10 years later, George had paid a total of $20,000 in premiums. The portion of the $100,000 that George would be required to recognize as income in the year in which the death proceeds were received is $65,000, as shown below:

Policy death benefit proceeds:	$100,000
Less: (a) consideration paid by George:	– $15,000
(b) subsequent premiums paid by George:	– $20,000
George's total gain:	$65,000

Exceptions to Transfer for Value Rule

Not every transfer for value results in income-taxable death benefit proceeds; certain parties are considered **exempt transferees**. Even though a life insurance policy is transferred for a valuable consideration, death benefits are not income taxable if the transfer is made to the following exempt transferees:

- the policy insured
- a partner of the insured
- a partnership of which the insured is a partner
- a corporation of which the insured is an officer or shareholder

Split-Dollar Plans

A **split-dollar plan** is an arrangement under which the ownership of a life insurance policy and certain other policy elements are split between an insured, who has a need for life insurance, and another party, usually an employer, who has the funds to pay for the life insurance policy and the desire to do so.

An important consideration with respect to the viability of split-dollar plans is their taxation. Under IRS rules, the tax treatment given to a split-dollar plan depends on who owns the policy—the employer or the insured.

Policy Owned by Employer

If the employer owns the life insurance policy, then the employee has a reportable economic benefit equal to the value of the insurance benefit provided *plus* the dividends applied to his or her benefit.

The principle underlying employee taxation in a split-dollar plan depends on the particular situation. One of three methods for determining the reportable value of the life insurance is generally used:

- If the split-dollar plan involves a contractual agreement between the employee and employer requiring the use of P.S. 58 rates, and the split-dollar plan was entered into before January 28, 2002, P.S. 58 rates can be used.
- Rates known as the Table 2001 rates can be used to measure the value of the current economic benefit.
- The lower of the insurer's published one-year term premium rates or the Table 2001 rates can be used.

P.S. 58 Rates per $1,000 of One-Year Term Insurance			
Age	**Premium**	**Age**	**Premium**
15	$1.27	49	$8.53
16	$1.38	50	$9.22
17	$1.48	51	$9.97
18	$1.52	52	$10.79
19	$1.56	53	$11.69
20	$1.61	54	$12.67
21	$1.67	55	$13.74

P.S. 58 Rates per $1,000 of One-Year Term Insurance			
22	$1.73	56	$14.91
23	$1.79	57	$16.18
24	$1.86	58	$17.56
25	$1.93	59	$19.08
26	$2.02	60	$20.73
27	$2.11	61	$22.53
28	$2.20	62	$24.50
29	$2.31	63	$26.63
30	$2.43	64	$28.98
31	$2.57	65	$31.51
32	$2.70	66	$34.28
33	$2.86	67	$37.31
34	$3.02	68	$40.59
35	$3.21	69	$44.17
36	$3.41	70	$48.06
37	$3.63	71	$52.29
38	$3.87	72	$56.89
39	$4.14	73	$61.89
40	$4.42	74	$67.33
41	$4.73	75	$73.23
42	$5.07	76	$79.63
43	$5.44	77	$86.57
44	$5.85	78	$94.09
45	$6.30	79	$102.23
46	$6.78	80	$111.04
47	$7.32	81	$120.57
48	$7.89		

Table 2001 Table of One-Year Term Insurance Premiums For $1,000 of Life Insurance Protection							
Age	**Premium**	**Age**	**Premium**	**Age**	**Premium**	**Age**	**Premium**
0	$.70	25	$.71	50	$2.30	75	$33.05
1	$.41	26	$.73	51	$2.52	76	$36.33
2	$.27	27	$.76	52	$2.81	77	$40.17
3	$.19	28	$.80	53	$3.20	78	$44.33
4	$.13	29	$.83	54	$3.65	79	$49.23
5	$.13	30	$.87	55	$4.15	80	$54.56
6	$.14	31	$.90	56	$4.68	81	$60.51
7	$.15	32	$.93	57	$5.20	82	$66.74
8	$.16	33	$.96	58	$5.66	83	$73.07
9	$.16	34	$.98	59	$6.06	84	$80.35
10	$.16	35	$.99	60	$6.51	85	$88.76
11	$.19	36	$1.01	61	$7.11	86	$99.16
12	$.24	37	$1.04	62	$7.96	87	$110.40
13	$.28	38	$1.06	63	$9.08	88	$121.85
14	$.33	39	$1.07	64	$10.41	89	$133.40
15	$.38	40	$1.10	65	$11.90	90	$144.30
16	$.52	41	$1.13	66	$13.51	91	$155.80
17	$.57	42	$1.20	67	$15.20	92	$168.75
18	$.59	43	$1.29	68	$16.92	93	$186.44
19	$.61	44	$1.40	69	$18.70	94	$206.70
20	$.62	45	$1.53	70	$20.62	95	$228.35
21	$.62	46	$1.67	71	$22.72	96	$250.01
22	$.64	47	$1.83	72	$25.07	97	$265.09
23	$.66	48	$1.98	73	$27.57	98	$270.11
24	$.68	49	$2.13	74	$30.18	99	$281.05

To determine the imputed value of the life insurance provided to the employee for purposes of income taxation, split-dollar plans can use an insurer's lower one-year term insurance rates instead of the Table 2001 rates if the one-year term insurance is available to all standard risks at those rates. Split-dollar plans that are entered into after January 28, 2002, can use an insurer's one-year term insurance rates only if the insurer meets both of the following conditions:

- The insurer must make the availability of those rates known to anyone who applies for term insurance coverage.
- The insurer must regularly sell term insurance at those lower rates to anyone who applies for term insurance coverage through its normal distribution channels.

Policy Owned by Employee

If the employee owns the life insurance policy in the split-dollar plan instead of the employer, split-dollar taxation is quite different than if the employer owns the policy. In employee-owned policies in split-dollar plans, the IRS distinguishes between split-dollar arrangements under which the employee must repay the employer's premium advances, which is the usual case, and those not requiring repayment.

Policy premiums an employer pays are considered loans on which the employee must pay interest if the employee is required to repay those premium advances. However, an insured employee-policyowner will have received a below-market loan if he or she:

- pays no interest or
- pays interest at a rate that is less than the applicable federal rate (AFR)

Note

The IRS publishes base interest rates each month that are known as the **applicable federal rates** (AFR). They are used for various purposes under the Code, including being used in imputed interest and original issue discount rules. The AFR is normally available during the third or fourth week of the month.

If the insured employee received a below-market loan, the unpaid interest is additional compensation and a simultaneous interest payment from the employee to the employer. Because of that interpretation, the employee has an additional tax liability equal to the interest that should have been paid but was not.

The case in which an employee owns the life insurance policy and is not required to repay the employer's premium advances is an extremely unusual one. In that case, the premium payments are considered additional compensation and are subject to income taxation. Although the insured who owns the policy can have additional compensation or an imputed loan, neither the value of the pure term insurance benefit nor any dividends applied to the insured's benefit result in income tax liability.

The employee's tax treatment of split-dollar plans is summarized in the following chart:

Split-Dollar Insured Employee Tax Treatment Summary				
	Taxability to Insured Employee			
Policy Owned By	**Employer Premium Payments**	**Cash Surrender Value Allocation**	**Value of Pure Term Life Insurance**	**Dividends Applied to Insured's Benefit**
Employee and obligation to repay employer premium payments	Premium payments are not taxable, but interest must be charged at least equal to AFR or imputation of taxable income results.	No	No	No
Employer	No	Yes, the increase in the cash surrender value to which the insured has access each year is subject to tax.	Yes, imputed income based on Table 2001 rates	Yes
Employee but with no obligation to repay employer premium payments	Yes, employer's premium payments are taxable as compensation.	No	No	No

Employer-Owned Life Insurance

Employers use life insurance to satisfy many business objectives. Among those objectives that are often met by an employer's purchase of life insurance are the following:

- providing the cash to fund the employer's stock redemption agreement
- compensating the employer following the death of an important employee
- paying off existing business debt when a key employee dies

Although these are important uses of employer-owned life insurance, the possible applications of life insurance in a business situation are far broader than these.

Traditionally, all employer-owned life insurance enjoyed the favorable income tax treatment given to life insurance death benefits generally. However, the Pension Protection Act of 2006 (act) changed that treatment in certain cases.

Under the law in effect before the act, the termination of an employee who is insured under employer-owned life insurance provided the employer with several options concerning the life insurance policy:

- surrender the policy for its cash value
- transfer the policy to the insured employee
- maintain the policy in force for eventual payment of the death benefit

Pursuant to the provisions of the act, an employer who receives death benefits under a life insurance policy insuring a former employee is required to include those death benefits in its gross income to the extent they exceed the employer's cost basis unless an exception applies.

An exception to the required inclusion of business life insurance death benefits exceeding cost basis in an employer's gross income applies to amounts paid:

- to the former employee's heirs
- with respect to an insured who was employed by the policyowner at any time within 12 months before his or her death
- with respect to an insured who was a director or highly compensated employee or individual when the policy was issued

Therefore, any death benefits paid to an employer upon the death of a former employee are subject to income tax unless one of these three exceptions applies.

The term "highly compensated employee," as used in the act, means any employee who:

- was a 5-percent owner at any time during the year or the preceding year or
- for the preceding year:
    - had compensation from the employer in excess of a specified amount[13]
    - if the employer elects the application of this clause for such preceding year, was in the top-paid group of employees for such preceding year

An employee is a 5-percent owner for any year if at any time during such year such employee was a 5-percent owner of the employer. An employee is in the top-paid group of employees for any year if such employee is in the group consisting of the top 20 percent of the employees when ranked on the basis of compensation paid during such year.

Furthermore, the term "highly compensated individual," as used in the act, means an individual who is:

- one of the 5 highest paid officers
- a shareholder who owns more than 10 percent in value of the stock of the employer
- among the highest paid 35 percent of all employees

Life Insurance Purchased in Qualified Retirement Plans

Up to this point, we have discussed life insurance ownership by the insured or a third party; that third party can be an adult child, a trust, or an employer. An additional entity that can own a life insurance policy on the life of an insured is a qualified retirement plan under which the insured is a participant. The plan can be a pension plan, profit sharing plan, or 401(k) plan. When life insurance is owned in a qualified retirement plan, limitations are placed on the amount owned, and the tax treatment changes somewhat.

Incidental Benefit Limitations

Congress has placed certain limitations on the ownership of life insurance in qualified retirement plans. Because qualified retirement plans receive favorable tax treatment in recognition of their providing *retirement* benefits, life insurance is permitted in them only if the life insurance is incidental to the principal qualified plan function of providing those retirement benefits.

For life insurance to be considered incidental, it must meet one of the following tests:

- The cost of the life insurance must be less than 25 percent of the cost to provide all plan benefits.

- The life insurance death benefit cannot exceed 100 times the monthly retirement income provided by the plan.

Although either of these two tests can be applied to any qualified retirement plan, in actual practice, the first test (*less than 25 percent*) is generally used for life insurance purchased in defined contribution plans. The second test (*not to exceed 100 times*) is generally used for life insurance purchased in defined benefit plans.

Premiums

Premiums paid for life insurance coverage in a qualified retirement plan are deductible by the plan sponsor. However, the plan participant must include the value of the pure death benefit (the net amount at risk, for example) as imputed income in his or her gross income for tax purposes based on the Table 2001 rates or, if lower, on the insurer's one-year term insurance rates.

The net amount at risk in a life insurance policy is equal to the policy's death benefit *minus* the policy's cash value. So, if a life insurance policy with a $100,000 death benefit has a $20,000 cash value, the net amount at risk is $80,000 ($100,000 – $20,000 = $80,000).

To determine the amount of income that a plan participant is required to include in his or her gross income for tax purposes, note the abbreviated following rates in Table 2001. If the plan participant whose life insurance policy had an $80,000 net amount at risk were 45 years old, the amount that he or she is required to include in income is $1.53 × 80 = $122.40. If the plan participant were in a 25-percent income tax bracket, his or her additional tax liability in that year is $30.60 ($122.40 × 25% = $30.60). As the insured becomes older, the one-year term insurance rates increase.

The total amount of income that the plan participant is required to include in income because of the life insurance in the plan *constitutes the plan participant's cost basis* and can be recovered tax free from the life insurance proceeds paid from the plan.

Table 2001 Table of One-Year Term Insurance Premiums for $1,000 of Life Insurance Protection

Age	Premium	Age	Premium	Age	Premium	Age	Premium
0	$.70	25	$.71	50	$2.30	75	$33.05
1	$.41	26	$.73	51	$2.52	76	$36.33
…	…	…	…	…	…	…	…
7	$.15	32	$.93	57	$5.20	82	$66.74
8	$.16	33	$.96	58	$5.66	83	$73.07
9	$.16	34	$.98	59	$6.06	84	$80.35
10	$.16	35	$.99	60	$6.51	85	$88.76
…	…	…	…	…	…	…	…
20	$.62	45	$1.53	70	$20.62	95	$228.35
…	…	…	…	…	…	…	…
24	$.68	49	$2.13	74	$30.18	99	$281.05

Death Benefits

Although a beneficiary usually receives death benefits free of income taxation, the same death benefits received under a life insurance policy in a qualified retirement plan are treated somewhat differently for tax purposes.

Death benefits a beneficiary receives under a life insurance policy in a qualified retirement plan are conceptually divided into two components:

- the net amount at risk
- the policy cash value

The net amount at risk—the difference between the policy's death benefit and its cash value—is received entirely free of income taxation, provided the insured included the value of the life insurance in his gross income each year. The policy cash value minus the plan participant's cost basis is subject to taxation at ordinary income rates.

It was noted earlier that the value of the life insurance included in income by the plan participant each year constitutes the cost basis that the plan participant can recover tax free. That tax-free recovery is also enjoyed by the beneficiary, who can deduct the following amounts from the policy's otherwise taxable cash value:

- the aggregate amount of the term life insurance costs included by the plan participant in his or her income[14]
- any nondeductible contributions made by the plan participant towards the cost of the life insurance included in the plan
- any loans from the plan included in the plan participant's income
- any employer contributions that have been taxed to the plan participant

Summary

Congress's statutory definition of life insurance and its subsequent creation of a category of life insurance policies known as modified endowment contracts (MEC) added more complexity to the issue of life insurance taxation. A life insurance contract failing to meet the definition of life insurance contained in IRC § 7702 loses the traditional income tax treatment of cash values and death benefits.

A life insurance policy that becomes a MEC is subject to less favorable income taxation of distributions occurring during the insured's lifetime. The traditional FIFO tax treatment of distributions is changed to last-in, first-out (LIFO) treatment. Under LIFO, all gain on the contract at the time a withdrawal is made is deemed to be received before any tax-free withdrawal of basis is distributed. In addition, loans from a MEC are considered distributions for tax purposes and subject to LIFO tax treatment. Dividends paid in cash, accumulated under the policy, or retained by the insurer to pay principal or interest on a policy loan, are deemed amounts received under the contract if the policy is a MEC.

In addition to changing the tax treatment of distributions from MECs, the law imposes a 10 percent penalty tax on any distribution received from a MEC that is includible in income by an individual before he/she reaches age 59½. Two exceptions to the penalty tax, however, are the following:

- when the distribution is made after the policyowner becomes disabled
- when the distribution is part of a series of substantially equal periodic payments made for the individual's life or life expectancy or for the joint lives or joint life expectancies of the individual and his or her beneficiary

The unfavorable tax treatment of lifetime distributions from a life insurance policy deemed a MEC do not apply to charges against the cash value of a MEC to pay the premium cost for qualified long-term care insurance coverage that is a part of the basic policy or included by rider. Such charges reduce the policyowner's cost basis in the policy. MEC status does not affect the favorable income tax treatment of death benefits.

Ownership of a life insurance policy may be transferred to another person by assignment. When ownership of a life insurance policy is transferred to another party, and the assignor receives a valuable consideration as compensation for the ownership transfer, the transfer is considered a **transfer for a valuable consideration** and comes under the **transfer for value rule**. When a transfer for value is made to a nonexempt transferee, the death benefits are income taxable to the beneficiary to the extent they exceed the total of the consideration paid for the policy and any subsequent premiums paid by the transferee. However, even though a life insurance policy is transferred for a valuable consideration, death benefits are not income taxable if the transfer is made to an exempt transferee.

A split-dollar arrangement is a popular method of purchasing life insurance in an employer-employee situation. The tax treatment given to such plans depends on what party owns the policy—the employer or the insured. If the employer owns the life insurance policy, the employee will have a reportable economic benefit equal to the value of the insurance benefit provided *plus* the dividends applied to his or her benefit. In the case of an employee-owned policy in a split-dollar plan, the IRS distinguishes between split-dollar arrangements under which the employee must repay the employer's premium advances and those cases not requiring repayment. Policy premiums an employer pays are considered loans on which the employee must pay interest if the employee is required to repay premium advances. If an insured employee owns the life insurance policy in the split-dollar plan and is not required to repay the employer's premium advances, the premium payments are considered additional compensation and are subject to income taxation.

The taxation of employer-owned life insurance on former employees varies, depending on whether an exception applies. Unless such an exception applies, an employer who receives death benefits under a life insurance policy insuring a former employee is required to include those death benefits in its gross income to the extent they exceed the employer's cost basis. An exception to the required inclusion of death benefits in an employer's gross income applies to amounts paid in the following circumstances:

- to the former employee's heirs
- with respect to an insured who was employed by the policyowner at any time within 12 months before his or her death
- with respect to an insured who was a director or highly compensated employee or individual when the policy was issued

The income tax treatment of life insurance in qualified retirement plans varies substantially from the tax treatment of personally owned life insurance. Premiums paid for life insurance coverage in a qualified retirement plan are deductible by the plan sponsor. However, the plan participant must include the value of the pure death benefit as imputed income in his or her gross income for tax purposes. Although a beneficiary usually receives death benefits free from income taxation, the same death benefits received under a life insurance policy in a qualified retirement plan are treated differently. In such a case, the death benefits are conceptually divided into two components: the net amount at risk and the policy cash value. The net amount at risk—the difference between the policy's death benefit and its cash value—is received entirely free from income taxation, provided the insured included the value of the life insurance in his gross income each year. The policy cash value, however, is subject to taxation at ordinary income rates.

Chapter 6 Review Questions

1. Jim's universal life insurance contract does not meet the statutory definition of life insurance contained in IRC § 7702. What would be his taxable income from the contract if last year's cash value was $20,000, this year's cash value was $25,000, $500 was taken from the cash value to pay the cost of insurance, and he paid $5,000 in premiums?

   A. $0

   B. $500

   C. $4,500

   D. $5,500

2. Carol's universal life contract does not meet the statutory definition of life insurance. How much income must her beneficiary recognize from the death benefit if the policy values are as follows at the time of Carol's death?

Death benefits paid:	$100,000
Net surrender value at date of death:	$25,000
Total net premiums paid:	$15,000
Cash value increases includible in policyowner's income:	$2,500

   A. $0

   B. $7,500

   C. $75,000

   D. $85,000

3. Audrey's life insurance policy is a modified endowment contract. How much income, if any, would she need to recognize if she took a $5,000 withdrawal from the policy when the policy's values were as follows?

Current cash value	$8,000
Cost of insurance deductions this year	$250
Total net premiums paid	$6,000

   A. $0

   B. $1,750

   C. $2,000

   D. $5,000

4. Peter's universal life insurance policy is a modified endowment contract with values as shown below. If he took a $10,000 loan from the policy, how much, if any, income would he be required to recognize?

Current cash value	$75,000
Cost of insurance deductions this year	$1,000
Total net premiums paid	$50,000

A. $0

B. $1,000

C. $9,000

D. $10,000

4. Sharon's life insurance policy's death benefit is $100,000, and her cash value is $40,000. What is the net amount at risk under her policy?

A. $100,000

B. $40,000

C. $60,000

D. $20,000

Answers to Chapter 6 Review Questions

1. B. The taxable income is $500. This is determined by (1) subtracting the current year cash value from the prior year's cash value ($25,000 – $20,000 = $5,000); (2) adding that amount to the cash value deduction for the cost of insurance ($5,000 + $500 = $5,500); and (3) subtracting from that amount the premium paid ($5,500 – $5,000 = $500).

2. B. Death benefits received under a policy that does not meet the statutory definition of life insurance are income tax free in an amount equal to the net amount at risk plus the policyowner's unrecovered cost basis (including cash value increases previously includible in income). In this case, Carol's beneficiary must recognize $7,500 in income as follows: The death benefit ($100,000) less surrender value ($25,000) equals the net amount at risk ($75,000). This amount is received tax free, as is Carol's unrecovered cost basis ($15,000 premiums paid) and amounts that were previously included in Carol's income ($2,500). [($100,000 – $25,000) + ($15,000) + ($2,500)] = $92,500 received tax free. The remainder of the death benefit ($7,500) is taxable.

3. C. Distributions from a modified endowment contract are includible in income in an amount equal to the lesser of the policy gain or the distribution. Because the policy gain is $2,000 and the distribution is $5,000, the policyowner must include $2,000 in her income. The cost of insurance deductions plays no part in the calculation of gain to be included in income.

4. D. Loans from a modified endowment contract are considered distributions. Distributions from a modified endowment contract are includible in income in an amount equal to the lesser of the policy gain or the distribution. Because the policy gain is $25,000 and the distribution is $10,000, the policyowner must include $10,000 in his income. The costs of insurance deductions play no part in the calculation of gain to be included in income.

5. C. The net amount at risk in a life insurance policy is equal to the difference between the policy's death benefit and its cash value. Because Sharon's death benefit is $100,000 and her cash value is $40,000, her policy's net amount at risk is $60,000 ($100,000 – $40,000 = $60,000).

Chapter 7
Health Insurance

The insurance landscape with respect to health care plans—insured and self-insured plans providing benefits for an insured's hospitalization and utilization of health care provider services—changed significantly in 2010 with the passage of the Patient Protection and Affordable Care Act (PPACA). Although the PPACA and its accompanying regulations are complex and voluminous, covering several thousand pages, an overview of the more important elements of the law is provided in this chapter.

Those elements can be categorized as:

- basic coverage provisions
- individual tax provisions
- employer tax provisions

Basic PPACA Coverage Provisions

The basic PPACA coverage provisions require the following:

- All non-exempt individuals must maintain health care coverage that provides at least minimum essential coverage or face a tax penalty. The penalty is scheduled to be reduced to zero after December 31, 2018.
- Large employers must offer affordable minimum essential coverage to their employees and their employees' dependents or face a potential tax penalty.
- Insurers:
    - must provide health care coverage to all individuals who apply for it through an insurance exchange during open enrollment periods, irrespective of their medical history
    - may charge varying premiums only based on age and tobacco use
    - are generally prohibited from:
        - imposing pre-existing condition exclusions
        - imposing annual or lifetime benefit limitations
        - rescinding health care except for fraud or intentional misrepresentation of a material fact when applying for coverage
- Individuals who purchase minimum essential coverage through an insurance exchange and whose household income places them between 100 percent and 400 percent of the federal poverty guidelines are eligible to receive a federal tax credit or subsidy to assist them in purchasing coverage.

Requirement to Maintain Coverage

Every non-exempt individual must maintain health care coverage that is considered minimum essential coverage. The following are all deemed to provide such minimum essential coverage:

- any health plan bought through the Health Insurance Marketplace, either state or federal
- individual health plans bought outside the Health Insurance Marketplace, if they meet the standards for qualified health plans
- any grandfathered individual insurance plan the individual has had since March 23, 2010
- any job-based plan, including retiree plans and COBRA coverage
- Medicare Part A or Part C (but Part B coverage by itself doesn't qualify)
- most Medicaid coverage, except for limited coverage plans
- the Children's Health Insurance Program (CHIP)
- coverage under a parent's plan
- most student health plans
- health coverage for Peace Corps volunteers
- certain types of veterans health coverage through the Department of Veterans Affairs
- most TRICARE plans
- Department of Defense Nonappropriated Fund Health Benefits Program
- Refugee Medical Assistance
- state high-risk pools for plan or policy years that started on or before December 31, 2014

Exemptions from the Requirement to Maintain Coverage

Certain individuals are exempt from the requirement to maintain minimum essential coverage. Those exemptions apply to individuals who:

- are members of a recognized religious sect[1] in existence since December 31, 1950, that is conscientiously opposed to acceptance of benefits from any private or public insurance that makes payments in the event of death, disability, old-age, or retirement or makes payments toward the cost of (or provides services for) medical care
- suffered a hardship with respect to the ability to obtain coverage
- are members of a health care sharing ministry in existence since December 31, 1999
- are members of an Indian tribe recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians
- are incarcerated, except for incarceration pending disposition of charges
- cannot afford self-only coverage because its cost exceeds 8.05 percent of household income
- are not lawfully present in the United States (i.e., they are unlawful residents)
- are without coverage for less than two consecutive months (Note: This exemption applies only to the first short coverage gap in a calendar year.)
- have a household income less than the federal income tax filing threshold

- live abroad for at least 330 days in a 12-month period or are bona fide residents of a U.S. possession
- had a member of their tax household be born, be adopted, or die during the year

Penalty for Failure to Maintain Health Care Coverage

If a non-exempt person fails to maintain the required minimum essential coverage, a tax penalty is imposed. The tax penalty for each month during which a non-exempt person fails to maintain required coverage in 2018 is 1/12 of the greater of:

- $695 for each household member age 18 or older and $347.50 per child (up to three household members)
- 2.5 percent of household income for the taxable year in excess of the threshold amount for filing a tax return

Again, the penalty for failure to maintain individual coverage is set to reduce to zero after December 31, 2018.

Individual Tax Credits

Individuals who meet specified income, coverage, and other criteria are eligible to receive refundable tax credits to help them purchase a qualified health plan. Persons eligible for a refundable tax credit to assist in purchasing a qualified health plan are those who meet the following requirements:

- have household income between 100 percent and 400 percent of the federal poverty level
- are enrolled in a qualified health plan through a health insurance exchange
- are legally present in the United States and not incarcerated
- are not eligible for other affordable qualifying health care coverage

Large Employers Required to Offer Coverage or Face Tax Penalty

The PPACA categorizes employers as either (1) small employers or (2) large employers. Large employers must offer affordable qualifying health care coverage to all full-time employees and dependents or be liable for a potential tax penalty. In contrast, small employers are not required to offer coverage and, depending on meeting various criteria, may be eligible to receive a tax credit for purchasing it.

A large employer is an employer who employed an average of at least 50 full-time employees on business days during the preceding calendar year. A full-time employee means an employee who is employed on average at least 30 hours per week or 130 hours per month.

The PPACA-imposed requirement on large employers to offer coverage has two important requirements. The coverage must:

1. meet the criteria to be considered minimum essential coverage
2. be affordable

Large Employers Not Offering Coverage

A penalty is imposed on a large employer who does not offer qualifying coverage if one or more of its full-time employees enrolls in health insurance coverage through an exchange and receives a premium tax credit or cost-sharing reduction. The tax penalty for any month in 2018 for which such an employer is liable is an amount equal to the number of its full-time employees in excess of 30 multiplied by 1/12 of $2,320.

Large Employers Offering Unaffordable Coverage

In some cases, a large employer who offers qualifying coverage may, nonetheless, be liable for a penalty if the coverage fails to provide minimum value or the employee's cost for employer-offered coverage exceeds 9.56 percent of the employee's household income in 2018 and the employee receives a premium tax credit. For each full-time employee receiving a credit or subsidy through an exchange in 2018, the large employer penalty is equal to 1/12 of $3,480 multiplied by the number of employees receiving the credit or subsidy. However, the penalty for the month for which a large employer offering coverage to its full-time employees would be liable is limited to no more than the employer would have been liable if it had failed to offer coverage.

Small Employers Eligible for Tax Credit

In contrast to the penalties for which large employers may be liable under the PPACA for failing to offer affordable health care coverage, small employers may be eligible for a tax credit for providing such coverage. The maximum small employer health insurance premium credit available to eligible small employers is 50 percent of employees' health care premiums. (For small *tax-exempt* employers, the maximum credit is 35 percent of employee health care premiums.)

The credit is available to employers who meet all of the following requirements:

1. paid premiums for employee health insurance coverage under a qualifying arrangement
2. had fewer than 25 full-time equivalent employees for the tax year
3. paid average annual wages of less than $53,200 (2018) per full-time equivalent employee

Summary

The PPACA, law that became effective in 2010, has changed much of the health care marketplace dramatically. It requires all individuals to maintain qualifying health care coverage unless they are exempt. Applicants for such coverage may be eligible for tax credits to assist them in purchasing coverage if their household income places them between 100 percent and 400 percent of federal poverty guidelines.

Insurers are required to provide coverage to all individuals who apply for it through an insurance exchange during open enrollment period, regardless of their medical history and are forbidden to impose any pre-existing condition exclusions or benefit limitations on essential health benefits. In addition, insurers may not rescind health care coverage except for fraud or intentional misrepresentation of a material fact.

Large employers are required to offer affordable health insurance to all full-time employees and their dependents or face a tax penalty. Penalties vary depending on whether it is imposed due to a failure of the employer to offer coverage or due to its being unaffordable for some employees.

Eligible small employers who provide employee health care coverage may receive a tax credit equal to 50 percent of the employer's contribution for employee health care coverage (35 percent for tax-exempt small employers).

Chapter 7 Review Questions

1. Individuals whose household income places them between 100 percent and ___ percent of the federal poverty guidelines may receive a federal tax credit or subsidy to enable them to purchase health care coverage.

    A. 200

    B. 300

    C. 400

    D. 500

2. Joe's Food Shack, a for-profit employer, employed ten full-time employees in 2018. What is the maximum health insurance premium credit for which it may be eligible?

    A. 0 percent

    B. 25 percent

    C. 35 percent

    D. 50 percent

3. Arthur purchased health care coverage through an insurance exchange during an open enrollment period. For which of the following may the insurer charge Arthur a higher premium than other enrollees who are the same age?

    A. smoking

    B. a history of heart disease

    C. diabetes

    D. Premiums may not be increased for any one person for any reason.

4. A full-time employee means an employee who is employed on average at least _____ hours per week or ____ hours per month.

    A. 20, 80

    B. 30, 130

    C. 37, 195

    D. 40, 160

5. In order for a small employer to be eligible for the small employer premium credit, the employer must employ fewer than _____ full-time employees.

    A. 10

    B. 25

    C. 35

    D. 50

Answers to Chapter 7 Review Questions

1. C. Individuals who purchase minimum essential coverage through an insurance exchange and whose household income places them between 100 percent and 400 percent of the federal poverty guidelines are eligible to receive a federal tax credit or subsidy.
2. D. The maximum small employer health insurance premium credit available to eligible small employers for 2018 is 50 percent of employees' health care premiums. For small tax-exempt employers, the maximum credit is 35 percent of employee health care premiums.
3. A. Insurers must provide health care coverage to all individuals who apply for it through an insurance exchange during open enrollment periods, irrespective of their medical history. However, they may charge increased premiums based only on the insured's age and tobacco use.
4. B. A full-time employee, for purposes of the PPACA, means an employee who is employed on average at least 30 hours per week or 130 hours per month.
5. B. The credit is available to small employers who paid premiums for employee health insurance coverage under a qualifying arrangement, had fewer than 25 full-time equivalent employees for the tax year and paid average annual wages of less than $53,200 (2018) per full-time equivalent employee.

Chapter 8
Unauthorized Entities

The insurance department in each state looks closely at insurers before they grant them the authority to sell their products in their respective states. Increasingly, however, insurance entities that are not authorized to do business in the state have begun marketing their products there. In this chapter we examine the issue of unauthorized insurers, the factors that contribute to their growth, and some of the problems they cause to clients, insurers, agents, and health-care providers.

The problem of unauthorized insurers is not a new one, but it has become a greater problem since ERISA became law. Unauthorized insurers, as this chapter describes, can wreak havoc in the industry and with clients. They cause substantial loss to health-care providers and can expose insurance agents and brokers to enormous liability.

Defining an Unauthorized Entity

Before addressing the subject of *un*authorized insurers, it is helpful to understand what an **authorized insurer** is. Keeping in mind that the definition of an authorized insurer and the requirements to become an authorized insurer can vary depending on the legislation in that state, an authorized insurer can normally be defined as an insurer duly authorized by a certificate of authority issued by the department of insurance to transact insurance in the state.

Not unexpectedly, an unauthorized insurer is an insurer that is not authorized by such a certificate of authority.

But, what does it mean to *transact insurance*? Does it mean issuing insurance policies? Giving a sales presentation? Providing policyowner service? The answer to all of those questions is "yes"; all of those activities and more are included under "transacting insurance." The following activities are generally included in the definition of transacting insurance:

- soliciting the purchase of insurance
- doing preliminary negotiations for an insurance purchase
- issuing an insurance contract
- providing service to a policyowner

It should be obvious that insurance agents and brokers perform daily nearly all of the activities included in this definition.

Because of that broad definition of transacting insurance, an agent can be guilty of transacting insurance for an unauthorized insurer if he or she:

- solicits applications for insurance
- engages in negotiations intended to result in an insurance purchase
- sells an insurance policy
- provides claims or other policyowner service

Obtaining a Certificate of Authority

The process of gaining authorization to transact insurance is governed by state laws as administered by the state insurance department. A certificate of authority is granted only when the insurance department is confident that the insurer:

- maintains adequate reserves
- has operated for a specified minimum period of time
- has sufficient capital and surplus
- has competent and experienced managers

Furthermore, the insurer is not ordinarily granted a certificate of authority if any manager who has the ability to exercise effective control has been guilty of a felony or is associated with any entity guilty of a felony.

To ensure that an insurer meets the statutory criteria, insurance regulators normally review the following:

- the insurer's financial status, including its assets, capital, surplus, and reserves to ascertain that it is able to meet its financial obligations under the insurance contracts it enters
- the identity and background of the insurance company's principal officers to determine their knowledge, experience, honesty, and integrity

Uniform Certificate of Authority Application

Completing a satisfactory Uniform Certificate of Authority Application (UCAA) is normally required before an insurer is admitted to do business. The UCAA consists of the following:

- primary application
- certificate of compliance
- questionnaire
- biographical affidavit
- financial statements

In the primary application, the insurer certifies that the classes of insurance shown are (1) currently authorized, (2) currently transacted, and (3) those the insurer is applying to transact in the state. The primary application must indicate the date of the insurer's most recent financial examination and the value of issued stock.

The Certificate of Compliance requires that the insurance regulator of the applicant's domiciliary state certify that the insurer:

- is organized under the laws of the state of domicile
- is authorized to transact certain lines of insurance (the lines must be indicated)
- possesses at least the minimum required level of admitted assets
- has a stated level of surplus

The Questionnaire portion of the UCAA enables regulators to determine whether the organization and its principals are fit to transact insurance in the state. The Questionnaire asks whether the insurer:

- has ever changed its name
- has had a change of management or control since its last annual statement and whether such a change is contemplated in the foreseeable future

- is owned by a holding company
    - If so owned, the principal owners of the holding company must be listed.
    - If not so owned, an organizational depiction must be provided that includes charts showing positions, names, titles, etc.
- has had its certificate of authority in any state suspended or revoked in the last ten years
- is currently engaged in a dispute with any state or federal regulatory agency
- is involved in a lawsuit arising out of a policy claim

With respect to the insurer's managers, the Questionnaire asks if any present officer or director has been convicted of or pleaded guilty or nolo contendere to a felony for theft, larceny, or mail fraud or for violating any securities or insurance statute.

The biographical affidavit that is part of the UCAA provides biographical information concerning the following:

- officers and directors listed in the insurer's most recent financial statement
- key managerial personnel
- individuals with a 10 percent or more beneficial ownership in the company or its ultimate controlling organization

Finally, the UCAA concludes with the following financial statements:

- a balance sheet
- a cash flow statement
- a profit and loss (P&L) statement
- a nationwide premium income by line of business
- an analysis of operations by line of business

Even though the process of obtaining a certificate of authority is lengthy, expensive, and invasive, the granting of a certificate of authority only starts the regulators' oversight of the insurer. Regulators continue to supervise the operations of the insurer through the administration of licensing and continuing education requirements, and through periodic insurance department examinations. These measures help to ensure that the agents and brokers are competent, honest, and compliant with the rules concerning sales conduct and that the insurer continues to be solvent.

Background of the Unauthorized Insurer Problem

The Employee Retirement Income Security Act of 1974, better known simply as ERISA, has been hailed as the watershed pension legislation of the twentieth century. While ERISA significantly improved the level of security enjoyed by pension participants, providing greater participant security was not all that it did. It also created confusion with respect to regulatory oversight; in simple terms, it made less clear whether the states or the federal government regulated certain entities.

In addition to retirement plans, ERISA also addresses certain issues involving employer-sponsored health plans. An objective of ERISA was to encourage employers to sponsor employee health plans.

Democratic governments often encourage corporate and individual citizens to take particular actions by making these actions financially attractive, usually through tax incentives. Employer-sponsored health plan premiums, however, were already tax deductible at the time of ERISA's passage and were not includible in the employees' wages. Because the principal governmental incentives, i.e., tax breaks, were

not readily available, ERISA helped permit employers to maintain employee health plans at potentially lower cost by allowing them to self-insure. Under this legislation, a single employer can self-insure a health plan for its employees and dependents while avoiding certain health insurance costs and some of the conditions placed on health insurers.

Through self-insurance, an employer can avoid the additional costs incurred by insurers to maintain statutory reserves and to meet regulatory compliance requirements. In addition, employers can avoid the insurer profit that is normally a part of the insurer's premiums. These self-insured employer health plans are subject to regulation under ERISA through the U.S. Department of Labor (DOL) rather than through the individual states.

Although ERISA prohibits the states from regulating private-sector employer and union-sponsored health plans, it permits the states to regulate the insurers who serve these plans. For that reason, a plan that avoids state regulation entirely as an ERISA plan must be completely self-insured. These self-insured plans are regulated by the DOL rather than the state insurance departments, and the state insurance laws that regulate other health insurance plans do not protect the participating employees of ERISA plans.

ERISA Pre-emption

The central issue in the problem of unauthorized health insurers is that a particular health plan is not subject to state insurance regulation. Much of this contention arises out of Section 514(a) of ERISA, which states that ERISA "supersedes any and all state laws insofar as they . . . relate to any employee benefit plan. . . ."

This concept is known as the ERISA "pre-emption."[16]

Taken alone, this language clearly exempts employee health plans from regulation by the individual states. For that reason, it forms the basis of unauthorized insurers' claims that their plans are not subject to state regulation. However, ERISA contains another provision, known as the "savings clause," that specifically excludes certain industries from its pre-emption and limits its scope.[17]

Section 514(b)(2)(A) of ERISA significantly narrows the scope of the pre-emption provided by Section 514(a) by providing that nothing in ERISA . . .shall be construed to exempt or relieve any person from any law of any state which regulates insurance, banking, or securities. . .

When both sections are read together, it becomes clearer that Section 514 of ERISA does not pre-empt any state law that regulates insurance. So, the question is whether a health plan is insurance as that term is used in the legislation. If it is, the states regulate it; if it is not, the federal government regulates it. ERISA contains a provision known as a "deemer clause" that helps resolve the issue. This clause provides that no employee benefit plan or trust . . . shall be deemed to be an insurance company or other insurer. . .or to be engaged in the business of insurance. . .[18]

The deemer clause clarifies that, while ERISA preserves state authority over insurance, its exclusion of insurance from the pre-emption does not mean that a legitimate ERISA plan providing health benefits can be deemed to be insurance. In other words, a health plan that meets the criteria of a legitimate ERISA plan is not "insurance," nor is it subject to state regulation, even though the benefits provided by the plan are similar to those provided by a health insurer. A genuine single-employer ERISA plan is not subject to direct state insurance regulation.

The effect of combining the pre-emption clause, the savings clause, and the deemer clause in ERISA is a determination that its jurisdiction is not exclusive and that state regulatory jurisdiction applies to any insurer that is financially responsible for claims payment in an *insured* ERISA plan.

Multiple Employer Welfare Arrangements

Unauthorized entity issues have also surfaced with respect to multiple employer welfare arrangements (MEWAs). A MEWA is an arrangement under which group benefits are provided to employers with a small number of employees. A MEWA is generally defined as an employee welfare benefit plan or other arrangement that is established or maintained to provide one or more insurance benefits to the employees of two or more employers.

MEWAs are usually created as a way to provide group benefits to employers within specific industries, and three types exist:

- MEWAs that are fully insured and administered by insurance companies, commonly known as multiple-employer trusts (METs)
- MEWAs that are insured but administered by third parties
- MEWAs that are self-funded

The most significant concern with respect to regulation is centered on the self-funded version of MEWAs.

Because insured MEWAs are clearly subject to state insurance regulations because of their insured status, the regulatory problem with respect to MEWAs involves only the third category: self-funded MEWAs. These plans have tended to exist in a regulatory limbo, receiving little oversight from the federal government. Because no insurance contracts are involved, the states have generally been hampered in their attempts to regulate them.

Because a MEWA is normally defined in applicable state laws as providing benefits for the employees of *two or more employers*, it is not exempt from regulation by the individual states under ERISA.

Union and Association Plans

Union plans can be exceptions to the definition of a MEWA. Because of that, a union plan cannot be subject to the concurrent state and federal regulation that is characteristic of a MEWA. For a union plan to be an exception to the MEWA definition and thereby to avoid state regulation, the DOL must make an express finding that the employer-union collective bargaining agreements are bona fide. In such a case, the union plan is not subject to state regulation.

Association plans are popular among professional associations and can offer a wide range of benefits. These plans are unable to avoid state insurance regulation on two counts:

- Because no employer-employee relationship exists in an association plan, an ERISA pre-emption is not possible.
- Because association plans must be fully insured, the ERISA pre-emption is not available.

Effect of Insurance Market Cycles

Like many industries, the insurance industry experiences market cycles, sometimes referred to as “hard” or “soft” markets. A “soft” insurance market is one in which premiums are generally modest. This cycle is often followed by a “hard” insurance market that is characterized by steeply increasing premiums. Although this hard/soft phenomenon is principally characteristic of the property and casualty insurance market, it is clear that the health insurance market is very “hard” and that the cost of health insurance continues to increase at a rate that is often in excess of the inflation rate.

It is no secret that this kind of a market causes employees and employers to experience higher health insurance premiums. Because of their generally more limited resources, smaller firms and their employees are often the most seriously affected. Because of that, these smaller employers are more likely to be attracted by fraudulent and unauthorized insurance entities that offer low rates—sometimes as low

as 50 percent below usual rates—for health insurance plans. Often, however, they get far less than they expected.

Unauthorized insurers usually attempt to recruit independent insurance agents to market their products and often assert that they do not require a certificate of authority from the state to market them because they are exempt from state regulation as a MEWA. Sometimes these "insurers" market their products through legitimate-sounding though bogus trade groups and can imply they have the financial backing of a well-known and respected insurer. The large insurer relationship usually does not exist.

Apparently high-quality health insurance at unbelievably low prices was not the only attraction of these arrangements: coverage was usually offered at little or no underwriting. Because no underwriting was normally involved, people with significant medical histories were often attracted to it. Unfortunately, these individuals were convinced to forgo legitimate health insurance coverage to lower their health insurance coverage costs. It often takes several months before the individual realizes that substantial claims will not be paid.

Usually, a fraudulent and unauthorized insurance entity pays some of the earlier claims to gain a reputation for fast and reliable claims service. Insurance agents who were reluctant to offer these products can be duped into marketing them and then find that subsequent larger claims remain unpaid because premiums were diverted into the owners' pockets. Usually, when that occurs, the fraudulent and unauthorized entity has disappeared.

The Affordable Care Act has taken some of the attraction away from the health insurance products offered by these bogus insurers by prohibiting insurers from excluding coverage on the basis of pre-existing conditions and by permitting them to vary health insurance premiums for a particular level of coverage only on the bases of the insured's age and use of tobacco.

Cause for Regulatory Concern

Unauthorized insurance entities have been marketing their products for a long time. The following have caused concern for insurance regulators and the industry at large:

- illicit unauthorized insurance entity activity
- potential for criminal activity in the industry
- financial damage to users and providers of health care

Fraudulent and unauthorized insurance entities cause damage to consumers, legitimate insurers, and health-care providers.

Consequences of Representing an Unauthorized Insurer

Considering the serious financial and other problems caused by fraudulent and unauthorized insurers, it should not be surprising that states are becoming stricter with agents who represent them. Depending on the state, agents or brokers who transact insurance for an unauthorized insurance entity face severe penalties that can include the following:

- criminal prosecution
- imprisonment
- revocation of insurance licenses

In addition, they can find themselves financially responsible for payment of any unpaid claim under the contract. To more fully understand the personal consequences of representing an unauthorized insurer, consider the following cases.

An investigation of a life and health agent found that he sold consumers health insurance plans from certain unauthorized insurers. When the consumers had medical claims, they were informed there was no coverage, causing them significant financial harm.

The agent was fined $1,000 and investigative costs of $1,000. He was also ordered to return all commissions received from any of the contract plans or policies he sold. More costly for the agent was the order that he must satisfy all unpaid claims or losses for all persons entitled to coverage under the policies he sold.

In another case, an investigation of a life, health, and variable annuity agent found that he represented an unauthorized insurer with respect to the sale of health insurance. The punishment for such activity imposed on the agent included:

- license suspension for six months
- probation for 12 months if and when he applies for reinstatement
- payment of a $5,500 fine
- requirement that he make restitution of $660.50

Although many of the unauthorized insurer problems involve the sale of health insurance, the problem of unauthorized insurers is not confined to health insurance. In a recent case involving property and casualty coverage, an investigation of an insurance agency, its officers, agents, and customer representative determined they had sold boat insurance policies issued by an unauthorized entity. The transactions included providing quotes, accepting premium payments, and receiving commissions. Additionally, some of the individuals at the agency were not licensed and appointed when the bogus insurance was transacted.

Punishment in that case included the following:

- The agent in charge (also an officer of the agency) was fined $12,000 and placed on two years of probation.
- The other agent and officer were fined $10,000 and placed on two years of probation.
- The agency was fined $7,500 and placed on one year of probation.
- The customer representative was fined $7,500 and placed on one year of probation.

Summary

Becoming an authorized insurer in any state involves that state's insurance regulators looking closely at the insurance organization—including its history and financial soundness—and its management. Such an investigation before granting the insurer a certificate of authority helps ensure that consumers, agents, and others are protected when buying or selling insurance or when relying on the insurer. An unauthorized insurer is an insurer that has not received a certificate of authority from state regulators that permits it to do business in the state.

ERISA, the dominant retirement legislation of the twentieth century, created confusion with respect to regulatory oversight, making less clear whether the individual states or the federal government regulated certain entities. It contains a provision stating that ERISA supersedes state laws as they relate to "employee benefit plans." Unauthorized insurers tend to rely on this ERISA provision—known as the ERISA pre-emption—in claiming that the plans they attempt to sell to consumers are not subject to state insurance regulatory oversight.

Although the ERISA pre-emption clause clearly appears to support unauthorized insurers' contention that certain benefit plans are not subject to state insurance regulation, another ERISA provision, known as the savings clause, narrows the ERISA pre-emption. The savings clause contained in ERISA states that

nothing in ERISA exempts any person from a state law that regulates insurance. Thus, when the pre-emption clause is examined in the context of the savings clause, it becomes clear that insurance plans are not exempt from state insurance laws.

Fraudulent and unauthorized organizations market bogus health and other insurance products that they maintain are exempt from state insurance regulation. By offering such products at remarkably low premiums relative to otherwise comparable legitimate insurance policies, they dupe unaware consumers into purchasing products that are often nothing more than scams.

These organizations attempt to recruit insurance agents to market their products and often assert that they do not require a certificate of authority from the state to market them because they are exempt from state regulation. Unsuspecting agents, eager to offer their clients insurance coverage at low rates, may be willing to sell these products. Clients may replace existing insurance policies for these fraudulent products only to find that their claims are unpaid. When the insurance product offered by an unauthorized insurer is a health insurance policy, health care providers—physicians, hospitals, etc.—typically find that their bills are not paid and eventually write off the account or pursue collection efforts.

Agents or brokers who become involved with an unauthorized insurance entity face severe penalties that may include criminal prosecution, imprisonment, and revocation of their insurance licenses. Furthermore, they may be financially responsible for payment of any unpaid claim under the contract they sold to an unsuspecting consumer.

Chapter 8 Review Questions

1. Which of the following is deemed to constitute transacting insurance?
   I. soliciting the purchase of insurance
   II. issuing an insurance contract
   III. providing service to a policyowner

   A. I and II only
   B. I and III only
   C. II and III only
   D. I, II and III

2. The problem of unauthorized insurance entities has resulted, in part, from the "pre-emption" clause. In which of the following does the pre-emption clause appear?

   A. ERISA
   B. TAMRA
   C. TEFRA
   D. ERTA

3. How did ERISA enable employers to establish health plans at potentially lower cost?

   A. by providing additional tax incentives
   B. by limiting premiums that insurers could charge
   C. by permitting employers to self-insure
   D. by permitting employers to join multiple employer trusts

4. What regulatory agency oversees ERISA-authorized self-insured employer plans?

   A. each state
   B. FINRA
   C. PBGC
   D. Department of Labor

5. Which of the following is correctly characterized as an arrangement under which group benefits are provided to employers with a small number of employees?

   A. cafeteria plan
   B. VEBA
   C. multiple employer welfare arrangement
   D. self-insured plan

Answers to Chapter 8 Review Questions

1. D. The definition of "transacting insurance" is broad and includes its solicitation, the issuance of an insurance contract, and providing insurance-related services to a policyowner.
2. A. ERISA contains a pre-emption clause that states that ERISA supersedes any and all state laws insofar as they relate to any employee benefit plan. Unauthorized insurance entities often attempt to rely on that clause when marketing their unauthorized insurance products.
3. C. ERISA helped permit employers to maintain employee health plans at potentially lower cost by allowing them to self-insure. Under this legislation, a single employer can self-insure a health plan for its employees and dependents while avoiding the additional costs incurred by insurers to maintain statutory reserves and to meet regulatory compliance requirements.
4. D. Self-insured employer health plans are subject to regulation under ERISA through the U.S. Department of Labor (DOL) rather than through the individual states.
5. C. A MEWA is an arrangement under which group benefits are provided to employers with a small number of employees. It is generally defined as an employee welfare benefit plan or other arrangement that is established or maintained to provide one or more insurance benefits to the employees of two or more employers.

Glossary

absolute assignment—A complete transfer of the policyowner's right, title and interest to the assignee; the former policyowner retains no rights to the policy. As such, the assignee stands in the shoes of the former policyowner with respect to any rights in the policy and becomes, in fact, a party to the contract with the insurer.

adhesion, contract of—A contract drafted by one party and offered on a take-it-or-leave-it basis, with little opportunity for the other party to bargain terms, price, or other elements.

agent—The party who acts for another.

aleatory contract—A contract in which one party can receive a benefit that is completely out of proportion to what he or she is giving. Receipt of the disproportionately large benefit, however, is contingent on the occurrence of a chance event.

apparent authority—Authority that is not provided by contract nor intended by the insurer but which appears to the client to be given to the agent based upon the agent's believable statements.

assignee—The party to whom an insurance policy is transferred.

assignment—The transfer of some right in an insurance policy to another party known as an assignee.

assignor—The party who transfers an insurance policy to an assignee.

collateral assignment—The transfer of a life insurance policy's death benefit to another, i.e. the assignee, to the extent of his or her interest. It is designed to enable the life insurance policy's death benefit to act as collateral and, thereby, secure a debt.

common law—That body of English law and concepts that grew out of the English judicial system. It was this law—based principally on the decisions and opinions of law courts—that became the law in the English colonies. Augmented by legislation, that common law constitutes much of our current system of laws.

consideration—When used in connection with the elements required for a valid contract, something of value that is bargained for and requested by the offeror and given by the offeree in exchange for the offeror's promise.

contingent beneficiary—Sometimes called a *secondary* beneficiary, this beneficiary has a claim against the life insurance policy's death benefit proceeds only upon the death or removal of the primary beneficiary.

course of conduct and custom doctrine—The doctrine that considers the way that people have previously done business. It takes into account the manner in which the parties to the transaction had handled their dealings together over a period of time to determine whether conduct is reasonable.

estoppel—When the client gives up a right as a result of his or her actions without intending to give it up.

express authority—Contractual-given authority. It is given to the agent through his or her contract with the insurer and any amendments made by the company to that contract.

implied authority—Authority that comes from the powers that the company customarily gives its agents rather than from the contract between the agent and the insurer. An example of implied authority can be seen in the insurer's giving the agent the express authority to solicit applications for life insurance on its behalf; by giving the agent that express authority, it also gave the agent the implied authority to telephone prospects on its behalf to arrange sales appointments.

incontestable clause—A provision in a life insurance policy that limits an insurer's right to dispute its validity after the passage of a certain period of time following the formation of the contract.

indemnity, contract of—A contract under which the benefit payable cannot be greater than the actual loss incurred by the contract owner or the face amount of the policy, whichever is less. In simple terms, the insured's recovery under the policy is limited to his or her actual loss.

insurable interest (life insurance)—In the case of life insurance, a relationship between the person applying for insurance and the person whose life is to be insured in which there is a reasonable expectation of benefit or advantage to the applicant from continuation of the life of the insured or an expectation of loss or detriment from the cessation of that life.

insurance law—A system of rules of conduct for those operating within the business of insurance. It includes rights and privileges that are formally recognized by our society and mandated by our federal or state governments. While much of the body of law that has come to be known as insurance law is codified in statute, many of the concepts and rules are not.

Modified Endowment Contract (MEC)—A life insurance contract that:

- was entered into after June 20, 1988 and
- meets the statutory definition of life insurance but
- fails to meet the 7-pay test

offer—Can be written or verbal but must be conveyed to the other party to the agreement. To be a valid offer, it must express a willingness to enter into an agreement in such a way that the other party understands that his or her assenting to the offer will result in an agreement.

parties to insurance contract—The insurer and contract owner.

per capita—A Latin expression that literally means "by the head" and would restrict allocation of the death benefit to the remaining members of the beneficiary class rather than to the deceased beneficiary's issue or lineal descendants.

per stirpes—A Latin expression that literally means "by the trunk" and, in terms of beneficiaries, means that the deceased person's issue or lineal descendants take the share of the death benefit that the beneficiary would have taken had he or she lived.

primary beneficiary—The beneficiary with the first claim to the life insurance policy's death benefits.

principal—The party on whose behalf the agent acts.

ratification—The confirmation or approval of an agent's actions by the principal.

representation—A statement that is made at the time of the formation of the contract that induces a party to enter into it but does not become a part of the contract.

rescission—Involves the termination of the contract with a retroactive effect. When a contract is rescinded, it is declared void because of a material misrepresentation by one party. Health insurance rescissions may be made only in the presence of fraud or an intentional misrepresentation of a material fact.

Section 7702 (IRC)—The section of the Internal Revenue Code that provides the statutory definition of life insurance.

subrogation—A term that means "to substitute." So, subrogation substitutes one person for another with respect to a claim or right that the second person has against a third party. Under this doctrine, an insurer, upon payment of a covered loss, acquires the insured's right to bring a lawsuit against a negligent third party whose actions caused or contributed to the loss.

transfer for value—When ownership of a life insurance policy is transferred to another party and the assignor receives a valuable consideration as compensation for the ownership transfer, the transfer is considered a transfer for a valuable consideration and comes under the transfer for value rule.

unilateral contract—A contract in which only one party to it makes an enforceable promise.

waiver—A defense that involves the voluntary and intentional giving up of a right the individual knows he or she has.

warranty—A statement that becomes a part of the contract; it is guaranteed by the maker to be true in all respects.

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End Notes

[1] It should be noted that the Dodd-Frank Act and the Patient Protection and Affordable Care Act have given the federal government a more prominent role in these areas of the insurance business that have traditionally been governed by the states.

[2] Model legislation is sample law that is furnished to state legislatures that they may choose to pass as presented, amend and pass, or reject.

[3] Under "several liability," the insurer is only liable for that part of the overall risk it assumed.

[4] Under the Uniform Commercial Code (UCC), certain common law concepts have been modified.

[5] Universal life insurance is not considered permanent life insurance for purposes of its inclusion in qualified plans. Instead, it is covered by the rules that cover term insurance for that purpose.

[6] Key-person life insurance is life insurance owned by an employer on the life of a key employee that is designed to pay the employer a death benefit to compensate the employer for the loss of profits it can experience at the death of the employee.

[7] An insurance consumer has a cause of action if there is no reasonable basis for denying benefits or delaying payment of a claim. A cause of action is a specific legal claim—such as for negligence, breach of contract or medical malpractice—for which a plaintiff seeks compensation.

[8] In the law, a cause of action is a recognized kind of legal claim that a plaintiff pleads or alleges in a complaint to start a lawsuit. It includes both the legal theory of what legal wrong the plaintiff claims to have suffered, and the requested remedy to compensate the plaintiff for that wrong.

[9] Consideration—when used in connection with the elements required for a valid contract—means something of value that is bargained for and requested by the offeror and given by the offeree in exchange for the offeror's promise.

[10] The net surrender value is the cash value less any surrender charges.

[11] The cost of life insurance protection is the lesser of the cost of individual insurance on the insured's life determined on the basis of uniform premiums or the mortality charge stated in the contract.

[12] "Premiums paid" are reduced by any dividends received that are excludable from income.

[13] As a point of reference, this amount was $120,000 in 2018. It is subject to periodic change.

[14] If the plan participant was a self-employed owner-employee, the beneficiary cannot deduct the aggregate amount of the term life insurance costs.

[15] The sect must be as described in IRC §1402(g)(1).

[16] **ERISA and Federal Pre-emption**

Congress intended to make welfare and pension plan legislation and regulation an exclusively federal matter. ERISA, 29 USC § 1144(a) states, in pertinent part:

"Except as provided in subsection (b) of this section, the provisions of this title and title IV shall supersede any and all State laws insofar as they can now or hereafter be related to any employee benefit plan described in section 4(a) [29 USC § 1003(a)] and not exempt under § 4(b) [29 USC § 1003(b)]."

This means that states cannot regulate welfare plans and pension plans, through statute or otherwise, except as specifically provided in ERISA ("Federal Pre-emption"). This does not mean that Congress intended to take away the power of the states to regulate the insurance industry within their borders. Remember that ERISA pertains to plans established by employers or employee organizations. Two relevant ERISA clauses give power to the states to regulate the insurance industry, within certain parameters, and a third clause brings MEWAs within state regulatory control.

[17] **The Savings Clause**

The Savings Clause, 29 USC § 1144(b)(2)(A), makes it clear that the states continue to regulate insurance, banking, and securities activities within their borders. This clause provides:

"Except as provided in subparagraph (B), nothing in this title shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities."

[18] **The Deemer Clause**

The Deemer Clause, 29 USC § 1144(b)(2)(B), was added to ERISA to restrict the states from simply designating welfare and pension plans as part of the insurance industry and thus subject to their regulation. It provides:

"Neither an employee benefit plan described in section 4(a) [29 USC § 1003(a)], which is not exempt under section 4(b) [29 USC § 1003(b)] (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies."

LONG-TERM CARE: PROGRAMS, POLICIES, AND PARTNERSHIPS

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Long-Term Care: Programs, Policies, and Partnerships
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Introduction

Few issues are more compelling than the need for long-term care. As our population ages, and as more and more people live longer in their retirement years, it's likely that a larger number will be forced to confront this issue. In fact, more than half of all individuals will require some type of long-term care in their lifetimes. The question is, will they be prepared? Are you, as a producer or financial advisor, ready and able to counsel your clients and prospects on long-term care and the options available for funding and delivering that care?

Those who work the senior market and those who provide retirement planning services and products must understand that the needs of the retiree extend well beyond asset accumulation, income distribution, and estate planning. Today, meeting the needs of the senior market (as well as those who are preparing for their retirement years) requires knowledge of long-term care—when it is needed, how it is delivered, and how it can be funded.

Course Objectives

The purpose of this course is to provide a thorough orientation to long-term care and the sources, providers, and levels of care available. We will focus on the funding of LTC services from social programs, self-pay options, and long-term care insurance (LTCI). We will examine long-term care partnership programs, which encourage consumers to purchase affordable long-term care insurance policies and reduce the burden on state Medicaid programs. The course also explores alternatives to long-term care insurance. The course concludes with a discussion of the ethical issues that must be considered in the sale of long-term care insurance products.

Upon conclusion of this course, you should be able to:

- describe the conditions that have led to the growing need for long-term care
- describe the types of LTC providers and the services they offer
- demonstrate an understanding of the options and limitations of Medicare and Medicaid for paying for long-term care
- define other options for funding long-term care
- outline and define the purpose, function, and application of long-term care insurance
- identify the provisions and features found in long-term care insurance policies
- explain the fundamentals of LTC partnership programs and the requirements for policies that are sold with these programs
- demonstrate an understanding of the ethics and suitability issues that surround the sale of LTC insurance

Chapter 1
The Need for Long-Term Care

Overview

Our study of the need for long-term care encompasses a wide array of medical, social, personal, supportive, and specialized services required by individuals who have lost some capacity for self-care because of a disabling condition or a chronic illness. While many approach the subject of long-term care with fear and anxiety, it is really just a problem in need of a solution. It is a challenge that requires a thoughtful mix of education, planning, and an efficient system of delivering services to those in need.

Chapter Objectives

Upon completion of this chapter, you should be able to:

- define long-term care and how it differs from traditional medical care
- explain the distinctions between medical and nonmedical LTC services
- identify activities of daily living (ADLs)
- understand the basic social issues associated with long-term care
- describe the physical, mental, and social conditions that have given rise to long-term care

Aspects of Long-Term Care

The term **long-term care (LTC)** has been in use for a very long time, although its implication has changed over the years. At one time, the elderly and infirm were shipped off to old age homes or rest homes for their care. Now we seldom hear these terms. Today, long-term care is defined more broadly, yet it has become very specialized. The modern definition of long-term care is not one service; rather, it encompasses a wide range of assistance and support services provided over an extended period, which are designed to meet the medical, personal, and social needs of those who cannot fully support themselves. As such, some refer to it as "long-term services and supports," or LTSS. The primary goal of long-term care is to maintain a patient's maximum functional independence.

A report prepared by the U.S. Senate Special Committee on Aging (February 2000) described long-term care as ". . . differ[ing] from other types of health care in that the goal of long-term care is not to cure an illness, but to allow an individual to attain and maintain an optimal level of functioning."

Long-term care pertains to the organization, financing, and delivery of sustained medical and human services to people in need. It is expected to grow dramatically, given the aging population.

Settings for Long-Term Care

Long-term care comprises many different services aimed at helping people with chronic conditions compensate for restrictions they have in their ability to function independently. Those who need long-term care have diverse physical and mental disabilities that require different types and levels of care. Accordingly, long-term care can take place in a variety of settings, including:

- in an individual's home
- at sites in the community
- in an assisted living facility (ALF)
- in a skilled nursing facility (SNF)

Receiving care and services at home or in a community setting allows an individual to continue to live at home rather than be placed in a nursing facility or other type of residence. Central to managing long-term care is enabling those who prefer to remain in their homes to be able to do so and to maintain their independence as long as possible.

Types of Long-Term Care

Long-term care encompasses many levels of assistance and support. These include both **medical** and **nonmedical** care. In other words, long-term care helps to meet both health and personal needs. Though long-term care may include advanced and sophisticated medical care, it often consists simply of hands-on assistance by others. For example, those with mental disabilities may not need medical care but do require supervision and direction. Types of LTC services, therefore, vary from helping a robust 50-year-old stroke victim relearn grooming skills to providing 24-hour skilled nursing care for a 90-year-old suffering kidney failure.

Medical Long-Term Care

In absolute medical terms, long-term care is **chronic care** with the aim of management, control of symptoms, and maintenance of function. Chronic care differs from **acute care**, which is medical care aimed at treating physical problems directly in an attempt to permanently cure or control them.

From a medical perspective, **long-term medical care** includes treatment for or application of the following:

- falls, fractures, and injuries
- pulmonary and cardiovascular disorders
- psychiatric disorders
- kidney and liver malfunction
- prescription drug treatment
- lab work
- surgeries
- similar medical issues

Medical LTC might include medical support services for people with degenerative conditions such as Parkinson's disease or stroke; those with prolonged illnesses such as cancer or heart disease; or people with cognitive disorders like Alzheimer's disease.

Nonmedical Long-Term Care

Long-term care also has a nonmedical scope. Many individuals requiring long-term care are not, in fact, ill. Long-term care on the nonmedical front is more like **custodial care**. Its purpose is to assist people with support services for daily tasks such as bathing, grooming, eating, dressing, and similar activities. This form of LTC may involve the most private and intimate aspects of a person's life—personal hygiene, dressing, and toileting. These primarily "low-tech" services are designed to minimize, rehabilitate, or compensate for loss of independent physical or mental functioning.

Other, less personal long-term custodial care needs may involve tasks such as preparing meals, running errands, and performing household chores. Custodial care may be provided by persons without special professional skills or training. Custodial care is intended to maintain and support an existing level of well-being and to preserve health and prevent its further decline. Its primary focus is on providing assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs).

Activities of Daily Living (ADLs)

Most people take for granted routine daily activities such as getting into or out of bed, taking a shower, getting dressed, and eating breakfast. But for someone with limited mobility or cognitive impairment, these pursuits can be hardships. These ordinary activities are called **activities of daily living** or ADLs. ADLs are the basics of self-care. The extent to which one is able or unable to perform ADLs is considered one of the most reliable ways to assess the need for long-term care services. ADLs are a measure of functional or physical capacity.

ADL Examples

Representing a broad range of functional and physical abilities, the following are considered fundamental self-care ADLs:

- bathing
- maintaining continence
- eating
- toileting

- dressing
- transferring (getting out of a bed or chair)

Residents in LTC facilities need help with an average of four ADLs. Individuals receiving health care in their homes need help with an average of two and a half ADLs.

Private insurance policies and Medicaid rely on ADL measures as **triggers** for benefits. An insurance policy or Medicaid guidelines will specify the number of ADLs for which assistance is required—typically two out of six—for LTC benefits or payments to begin. All insurance policies must list the ADLs that trigger benefits. Cognitive impairment also triggers long-term care, often involving loss of functional or physical abilities.

Instrumental Activities of Daily Living (IADLs)

Normal aging and illness can hamper the ability to perform the tasks necessary to live independently. Therefore, individual function levels must be assessed as a means of planning for specific services or providing personalized rehabilitation. Such assessments can also establish baseline functionality, and changes may show the need for additional resources or medical treatment.

When measuring levels of functioning, **instrumental activities of daily living** (or **IADL**s) are used. Patients are scored on whether they can perform IADLs independently, if they require some help, or if they are entirely dependent on assistance. IADLs typically involve some kind of interaction with a person's environment, whether in the home or in the community. The following tasks are typically considered IADLs:

- **using the telephone**—Is the patient able to look up numbers, dial, receive, and make calls without help? Is the patient able to answer the phone or dial the operator in an emergency, or does he or she require a special telephone or help in getting the number and dialing? Is the patient unable to use the telephone?
- **traveling**—Is the patient able to drive a car or travel alone on buses or taxis; able to travel with a companion; or unable to travel?
- **shopping**—Is the patient able to select and purchase food and clothing; unable to shop without assistance; or unable to shop at all?
- **preparing meals**—Is the patient able to plan and cook full meals; able to prepare light foods but unable to cook full meals alone; or unable to prepare any meals?
- **housework**—Is the patient able to do heavy housework, for example, scrubbing floors; able to perform light housework while requiring help with heavy tasks; or unable to do any housework?
- **taking medicine**—Is the patient able to prepare and take medications in the right dose at the right time; able to take medications but only with reminding or with someone to prepare the medications; or unable to take medications without supervision?
- **managing money**—Is the patient able to manage finances, for example, paying bills or balancing a checkbook; able to manage daily purchasing but needs help paying bills and managing the checkbook; or unable to handle money at all?

A person's level of IADL abilities is used as a *measurement* of functionality. Unlike activities of daily living, which represent the fundamentals of self-care, IADLs are not considered absolutely necessary for basic functioning.

Long-Term Care Risks and Statistics

The statistics associated with the risk of needing and utilizing long-term care services are sobering. As the population ages and as lifespans increase, the at-risk numbers are also sure to rise.

First, there is the growing population of elderly. By 2030, it is projected that the number of individuals age 65 and older will be more than 73 million, almost one and one-half times the number today.[1] Second, according to the U.S. Department of Health and Human Services, about 70 percent of individuals over age 65 will require at least some type of long-term care services during their lifetimes. Over 40 percent will need care in a nursing home for some period.[2]

The following factors increase one's risk of needing long-term care:

- **age**—The risk generally increases as one gets older. Age is the most significant risk factor leading to long-term care.
- **marital status**—Single people are more likely to need care from a paid provider.
- **gender**—Women are at a higher risk than men, primarily because they tend to live longer.
- **lifestyle**—Poor diet and exercise habits can increase one's risk.
- **health and family history**—These factors also impact one's risk.

In addition, studies have revealed certain other individual-level factors that are statistically associated with the risk of needing care in a nursing home or an assisted living facility. These include the following:

- **income**—Persons with lower current income have a higher risk of moving to a care facility than do persons with higher incomes.
- **education**—Those with lower levels of education face a higher risk of transition to a care facility.
- **family structure**—The presence of potential caregivers has a strong and significant effect on the risk of transitioning to a nursing home or assisted living facility. Those who are single and have no living children are almost three times more at risk of being admitted to a facility than married individuals with children.
- **geography**—Those who live in the Midwest are more at risk of having to transition to a care facility than in other parts of the country, as are those who live in a rural area compared to a metropolitan area.[3]

Who Is at Risk?

Understandably, most people associate the need for long-term care with the elderly, and statistically, the risk of needing long-term care increases with age. However, this need is not confined solely to the aged. According to an article written for Georgetown University Long-Term Care Financing Project, nearly 43 percent of those who need long-term care are between the ages of 18 and 64. At younger ages, congenital defects and accidents are the primary causes leading to the need for long-term care. At middle ages (45 to 55), congenital diseases contribute to the risk. After age 70, individuals are subject to the same congenital diseases, as well as to multiple health conditions and frailty.[4]

Other facts and statistics regarding long-term care point to its growing prevalence:

- More than 6 million elderly Americans need assistance from family or friends if they are to live at home.[5]
- At least two-thirds of all home-care assistance is provided free by family members and friends.[6]
- By the year 2020, one of six Americans will be 65 or older.[7]
- Of people turning 65, 69 percent will need some long-term care before they die.[8]
- More than half of the U.S. population will require some type of long-term care during their lives (nursing home care, home health care, assisted living, or rehabilitative facility care).[9]
- Of men turning 65, 58 percent will need some long-term care.[10]
- Women are more at risk than men—once they turn 65, 79 percent of women will need some long-term care at some point before death.[11]
- Among those turning 65, 52 percent will need long-term care for at least one year before they die, and 20 percent will need more than five years of care.[12]
- The average nursing home stay is approximately two and a half years.[13]
- After 2021, the population in nursing homes is expected to increase substantially. This is the year the oldest baby boomers will turn 75.[14] As the population ages, research has predicted the nursing home population to grow to three to four million residents.[15]

Long-Term Care Is a Social Issue

Long-term care is a social issue because it is one of public welfare. We find ourselves facing a complexity of concerns related to long-term care—everything from accessibility to how to pay for it. Our aging population and its increased longevity combine to make LTC a challenging social issue. We are faced with responding to the emerging needs of an increasingly elderly population. Adding to the complexity is that the LTC population is not a single, homogeneous group. Members of this group are diverse in race, education, health, and economic status. No single strategy is suited to meet the needs of the many.

Advances in Medical Technology

Medical advances have increased the number of years we live and have decreased the number of early sudden deaths. Identifying asymptomatic diseases through screening—for example, for colon cancer, breast cancer, hypertension, high cholesterol, and osteoporosis—has helped to reduce their incidence and severity.

The overall results of medical advances are that:

- People are living longer and requiring additional years of care.
- Hospital stays are shorter because more services are available at home.
- People are surviving more accidents but not always experiencing full recovery, creating a new group of LTC patients.

Some researchers argue that medical advances have increased life expectancy but have not delayed the onset of illness, predicting that declining death rates may actually increase LTC needs. That is, more people are living long enough to develop age-related conditions such as dementia, or they are living longer with existing disabilities and chronic conditions.

Advances in pharmacology and pharmaceuticals also impact the need for long-term care. These advances have not only reduced the symptoms of diseases but also have slowed their progression, thereby increasing longevity. However, increased longevity may necessitate periods of longer care.

The irony is that as medical advances help people live longer, the likelihood increases that long-term care will be necessary.

Family Members as Caregivers

At the turn of the twentieth century, families remained intact. In fact, it was common for three generations to live under one roof. Elders were cared for by younger generations. The community was supportive, and neighbors often pitched in when necessary. But with the arrival of the automobile and the advent of air travel, families began to scatter. Today, we are more mobile than ever, and, unfortunately, elders are frequently left behind to care for themselves.

The swiftly expanding elderly population has produced a great demand for personalized care and medical services. Clearly, this enormous need is placing financial strains on the elderly and their families, government programs, private health insurance companies, and LTC facilities. In spite of private funds, LTCI policies, and government funding for long-term care, family members who provide unpaid long-term care for their loved ones face a considerable financial and emotional impact.

This type of care is referred to as **noninstitutional care**. According to the Family Caregiver Alliance, most caregivers are employed and among those age 50 to 64, an estimated 60 percent work full or part time.[16] Note that employed caregivers spend no less time on elder care than those who are not employed outside the home. Workers who provide elder care spend approximately four hours a day on caregiving in addition to their other responsibilities.

The Toll of Elder Care in the Workplace

As employees' elder-care obligations swell, the cost to employers also increases. A study from the MetLife Mature Market Institute documented that the cost to U.S. business of working caregivers is estimated, conservatively, at slightly more than $13 billion per year in added health costs. Other effects include lost productivity, absenteeism, workday interruptions, and employee turnover. The total estimated aggregate loss of wages, pensions, and Social Security benefits to these working caregivers is $3 trillion.[17] While many employers realize that these costs can be reduced by providing elder-care programs designed to curb productivity losses and employee stress, others are concerned about the costs of offering elder-care assistance and maintaining equitable benefits for those employees who do not have elder-care responsibilities.

Work-Related Issues Associated with Elder Care

In addition to lost productivity, absenteeism, workday interruptions, and employee turnover, other work-related issues associated with caring for elderly parents and other relatives include:

- tardiness
- stress
- excessive phone calls
- unavailability for overtime
- reduced hours
- health problems
- diminished quality of work
- increased risk of work-related accidents and injury

Those with elder-care responsibilities are typically at the height of their careers at 50 to 60 years of age. Their elderly parents need assistance, but often, the resources are not there: they have no LTC insurance policy or surplus income to help with care. They can't afford to scale back on their hours or jeopardize their careers.

Consumer Attitudes and Understanding

Another social factor associated with the growing long-term care need is consumer awareness and attitude. Generally, the public at large does not have a good understanding of the long-term care need, including why and how to plan for long-term care. Many simply deny that they will need long-term care; others believe, incorrectly, that Social Security, Medicare, or their existing health insurance will cover the costs. They do not see long-term care as something one needs to plan for in advance, such as they would retirement.

This attitudinal "disconnect" also explains one of the reasons why people may not consider the purchase of long-term care insurance. According to a report issued by the U.S. Department of Health and Human Services, coverage purchased to cover acute care far surpasses the coverage purchased to cover long-term care.[18] Whereas almost all older individuals are protected from high acute care costs through Medicare and private Medigap insurance, a very small percentage have purchased long-term care insurance. This report cited the following, among others, as key factors limiting demand for long-term care insurance:

- **lack of information**—Many underestimate the likelihood of requiring LTC services and the potential costs of those services.
- **misperception of public and private programs**—Many people believe that Medicare, retiree health plans, or Medicare supplement insurance covers LTC services. This is not the case.
- **delayed preparation for/denial of long-term care needs**—Many do not think about preparing for long-term care needs until the need arises. At that point, they may be too old or disabled to purchase insurance.
- **long lag time between purchase and benefit payment**—Long-term care insurance must be purchased before it is needed; often, this means a period of many years between purchase and when benefits are likely to be paid. Consumers prefer to spend their current dollars on coverage that provides a more near-term benefit, such as Medigap policies.
- **affordability**—Long-term care insurance can be expensive. Many of today's older consumers with middle to low incomes cannot afford the premiums.
- **perception of need**—Some consumers decide they do not need long-term care insurance because they have too few assets to protect or have family and friends available to provide care.[19]

Consumer attitudes and perceptions notwithstanding, long-term care is a growing reality. It is also a very expensive reality.

The Cost of Long-Term Care

The medical, personal, and social services necessary because of an accident, a chronic illness, a disability, or simply the phenomenon of aging—services associated with long-term care—are among the most expensive of health care costs, especially considering the great numbers of people affected. The actual cost of long-term care depends on where the care is received, what type of provider administers the care, and how long the care is required. Some people require minimal assistance with only a few ADLs for a limited time. Others require skilled nursing facility care for an extended period. Unfortunately, no one can predict who will be stricken with the need for long-term care, what type of care will be needed, or how long the care will be necessary.

LTC Costs Compared

The following chart shows how these LTC costs generally compare with each other. These types of providers and services will be discussed in detail in the following chapter.

LTC Costs Compared				
Facility	**Help with ADLs**	**Help with Additional Services**	**Help with Care Needs**	**Range of Costs**
Community-based services	Yes	Yes	No	Low to medium
Home health care	Yes	Yes	Yes	Low to high
Board and care homes	Yes	Yes	Yes	Low to high
Assisted living	Yes	Yes	Yes	Medium to high
Continuing care retirement communities	Yes	Yes	Yes	High
Skilled nursing facilities	Yes	Yes	Yes	High

In more specific terms, the following are current costs for various types and levels of care, as reported in the *Genworth Cost of Care Survey*, reflecting median costs as of 2019.

Home-Based Care

- **homemaker services**—Nationally, the median daily rate charged by a noncertified but licensed home-care agency for homemaker services is $141. Homemaker services include housekeeping, cooking, and running errands.
- **home health aide services**—Nationally, the median daily rate charged by a noncertified but licensed home-care provider for home health aide services is $144. Home health aides provide assistance with ADLs, not medical care.

Community-Based Care

- **adult day health care**—Nationally, the median daily rate charged for adult day health care (which provides therapeutic, social, and other support services in a community-based setting) is $75.

Facility-Based Care

- **assisted living facilities**—Nationally, the monthly median rate for a private one-bedroom unit in an assisted living facility is $4,050 (implying an average annual cost of about $48,600). These rates exclude one-time community or entrance fees.
- **nursing homes**—Nationally, the median rate for a single-occupant private room is $102,200 per year ($8,517 per month). The median rate for a semi-private room is $90,155 per year ($7,513 per month). Considering that the average length of stay in a nursing home is two and a half years, the total cost of an average stay today would be about $225,000 to $255,500. For many, this expense could easily consume a lifetime of savings. Others may not be able to cover the cost at all.

The Genworth study also tracks the historical trends in these costs which, in general, tend to increase each year. Based on these historical trends, it's possible that the cost of the most expensive levels of LTC will, in 15 years or so, be one and a half times what it is today.

Planning for Long-Term Care

Given the likelihood of needing long-term care and the tremendous cost that this care entails, it is important that individuals plan for it—and the sooner the better. Certainly, there are barriers. For example, people tend not to think about becoming older and needing care, or they don't anticipate that they will ever need care themselves; they resist the idea of becoming dependent. They may believe (erroneously) that Medicare or their current health insurance will cover the cost of this type of sustained, ongoing care. They may find it difficult to raise this issue with their loved ones. Or they may underestimate the time and toll that future caregiving will demand of their family or friends. Some are not aware of the tremendous costs of this care or how it is paid for. Some may think of long-term care simply as nursing home care and assume that the "government" will cover the cost. Some are confronted with conflicting financial priorities. And some people may simply not know where or how to begin the planning.

Reasons to Plan for LTC

But for every reason why people do not plan in advance for long-term care, there is a reason why they should:

- Advanced planning for future care needs will allow for greater independence and choice as to where and how the care is delivered.
- Advanced planning can mean greater financial security, not only for those who may need care but also for their family and loved ones.
- Advanced planning can ease the financial and emotional toll on one's family and release them from the burden of providing the care, if and when it is needed.
- Advanced planning will avoid the uncertainty, confusion, and mistakes that could arise in the event of a health care need.
- Advanced planning will promote a continued quality of life, as the person defines it, when care is needed.

Insurance producers and financial planners who serve the senior market and represent products for retirement and late-life needs will find that they have an important role to play in helping individuals and their families address the need for long-term care. First, they can illuminate the need to plan for this risk and the importance of doing so. They can also provide education and guidance on how to meet this need, which may include purchasing long-term care insurance as well as other alternatives.

A Look Ahead

The remainder of this course focuses on LTC services and providers and the levels of care they offer. We will explore the roles of federal and state programs in providing LTC and their eligibility requirements and restrictions. Long-term care insurance is a practical and viable means of paying for the costs associated with LTC, and policy design and options will be discussed in detail. Making LTCI policies even more attractive are state-based long-term care partnership programs. Of course, alternatives do exist to LTCI, and these will be discussed as well. Also, producers who offer LTCI policies will be made aware of the ethical considerations of selling to seniors.

Summary

- Long-term care includes a wide range of medical, social, personal, supportive, and specialized housing services required by people who have lost some capacity for self-care because of a disabling condition or a chronic illness.
- Long-term care has as its goals the management and control of symptoms and maintenance of function. Types of LTC assistance include both medical and nonmedical care.
- Due to our expanding aging population, we are faced with complex issues related to long-term care, such as accessibility, choices in care and facilities, and ways to meet the costs.
- The growing numbers of older individuals and their increased longevity make long-term care a very challenging social and economic issue.
- The time to begin planning for this need is when one is younger and has the advantages of time, options, and choice.

Chapter 1 Review Questions

1. What is a primary goal of long-term care?
    A. to maintain functionality
    B. to find a permanent cure for the affliction
    C. to prolong life
    D. to prevent the spread of disease
2. Which of the following most precisely defines the fundamentals of self-care and the basic tasks of everyday life?
    A. instrumental activities of daily living
    B. activities of daily living
    C. self-awareness
    D. mental acuity
3. Long-term care occurs only in nursing facilities.
    A. True
    B. False
4. On what basis are benefits payable under a long-term care insurance policy typically triggered?
    A. the diagnosis of an acute medical condition
    B. the number and types of medications prescribed
    C. the inability to perform defined ADLs
    D. all of the above
5. What kind of care is intended to assist people with support services for daily tasks such as bathing, grooming, eating, dressing, and similar activities?
    A. acute care
    B. diagnostic care
    C. custodial care
    D. emergency care

Answers to Chapter 1 Review Questions

1. A. Long-term care is chronic care with the aim of management and control of symptoms and maintenance of function.
2. B. Activities of daily living are the fundamentals of self-care. They are the basic tasks of everyday life, which include eating, bathing, dressing, toileting, and transferring. Instrumental activities are those that are associated with interacting with one's community or home.
3. B. Long-term care can occur in a variety of places, including in an individual's home, at community sites and centers, and in care facilities.
4. C. Benefits payable under a long-term care policy are typically based on (or "triggered" by) the inability to perform a certain number of activities of daily living (ADLs) as specified in the policy. Another common benefit trigger is cognitive impairment.
5. C. Care that is intended to assist people with support services for daily tasks such as bathing, grooming, eating, dressing, and similar activities (ADLs) or for help with interacting with their environment (IADLs) is custodial care.

Chapter 2
Long-Term Care Services and Providers

Overview

For the elderly and their families, finding appropriate long-term care services can be a frustrating and overwhelming experience. While many individuals with lower incomes may qualify for publicly funded LTC services, they may be unaware of the extent of their state's programs or program eligibility requirements. Those whose higher incomes do not meet Medicaid or other publicly funded program eligibility requirements may not know how to find quality, yet affordable, private LTC services and providers suitable for their needs.

In this chapter, we survey the kinds of long-term care services that are available and who provides them, the home and community-based resources that facilitate care for the elderly or disabled, and those services that include housing options offered by various types of residence facilities.

Chapter Objectives

Upon completion of this chapter, you should be able to:

- understand the evolution, changes, and improvements in LTC services and providers
- understand the various levels of care and assistance typically required by seniors
- explain the differences between formal and informal caregivers
- distinguish between home- or community-based care and facility-based services and understand the ways in which each can meet the needs of those requiring LTC
- identify the basic housing options and levels of care typically associated with each type of facility

The Evolution of Long-Term Care

Long-term care has changed dramatically over the years. At the turn of the twentieth century, almshouses, poor farms for elderly inmates, and homes for the aged were common, often sponsored by religious and ethnic groups. Later these facilities were known as "rest homes" and "convalescent homes." They provided medical care to the extent it was available at the time. In 1935, the Social Security Act was passed, which established a federal/state public assistance program for the elderly called Old Age Assistance (OAA). Because at the time it was against public policy to use public poorhouses to care for the elderly poor, the act prohibited the payment of OAA funds to residents of public institutions. So began the growth of voluntary and proprietary nursing homes.

Hill-Burton Act

During World War II, construction and development was virtually nonexistent. By the end of the war, much of our country's infrastructure, especially health care infrastructure, was badly in need of replacement or renovation. In 1946, the Hospital Survey and Construction Act, commonly known as the **Hill-Burton Act**, was introduced. Hill-Burton created a system to provide federal financing for construction of new hospitals in rural and poor areas that did not already have such facilities and to modernize hospitals in urban areas. The bill ordered states to develop agencies charged with organizing health care planning. It was up to each state to determine where new state hospitals should be built. In exchange for this funding, states agreed to provide services to individuals unable to pay for their medical care and to make their services available to all individuals residing in the facility's area.

Nursing Home Construction and Modernization Takes Off

Hill-Burton led to a sudden increase in public and nonprofit hospital construction. An unintentional result of the Hill-Burton legislation was that many of the old hospitals that were being replaced were converted to nursing homes, as were hotels, homes, and buildings of all types. Suddenly, formal care of the aged and infirm was accessible to many.

With the availability and modernization of nursing homes, patients and their families began to look to these facilities, rather than home care, as the favored means for receiving care. However, no federal standards existed for their design or operation. Hospitals were licensed, but no licensing was in effect for nursing homes. Buildings were not safe, and numerous allegations arose of abuse and neglect. In 1950,

federal law required that states receiving federal matching funds had to devise systems to license nursing homes. If a state plan for old age assistance, aid to the blind, or aid to the permanently and totally disabled provided for payment to individuals in private or public institutions, the state was required to establish and maintain standards for such institutions. However, the law did not specify what the standards or enforcement procedures should be.

Nursing Homes Become Health Care, Not Welfare

In 1954, the Hill-Burton Act was amended. For the first time, legislation specifically included nursing homes as part of the health care system rather than the welfare system. This legislation provided the first federal standards for the design and construction of nursing home facilities. Hill-Burton also placed nursing homes under the jurisdiction of the National Health Service, thus ensuring medical regulatory oversight.

The Government Takes on a Greater Role in Funding Nursing Homes

In 1956, amendments to the Social Security Act lifted the ban on providing benefits to residents of public LTC institutions and permitted direct government vendor payments to providers. These amendments also created a matching program for medical services, including nursing home services. In 1958, federal grants to the states for public assistance were more generous. Until this time, all block grants of matching funds were split equally between state and federal government. In 1958, the **federal medical assistance percentage (FMAP)** was introduced, and the amount provided by the federal government was based on the average per capita income in the state. Under the FMAP formula, federal participation could not be lower than 50 percent or higher than 83 percent. In effect, the federal government paid more than half of the cost for nursing home services in poorer states and continued to pay half of the cost in wealthier states.

By 1960, the government was absorbed in the business of providing and paying for nursing home care. Approximately half of the residents in private nursing homes were public assistance recipients, and federal, state, and local governments were paying about half of the total cost of all nursing home care. Of course, federal and state reimbursement for the cost of nursing home care continued to increase and is still growing today.

Medicare and Medicaid

In 1965, Congress enacted Titles XVIII and XIX, **Medicare** and **Medicaid** respectively, of the Social Security Act. Both of these programs included coverage for nursing home care and, for the first time, coverage for home health services, although Medicare coverage for both nursing home and home health services was (and remains) limited to short-term, post-acute, convalescent, and rehabilitative skilled nursing care with certain restrictions. Federal legislation had again inspired the growth of the nursing home industry. Further, the ban on Medicaid payments to institutions for mental illness strengthened support for deinstitutionalizing patients in state mental facilities by giving states the financial incentive to transfer elderly people with dementia or psychiatric disorders from state mental hospitals to private nursing homes to access federal matching funds.

The 1970s saw large increases in Medicaid expenditures for nursing home care, creating concern over the feasibility of a long-term care system so reliant on institutional care. Accordingly, in 1981, Congress created the **home and community-based waiver option (HCBS waiver)**, allowing states to offer home and community-based services and cover them under the same financial and clinical eligibility provisions as nursing home benefits.[20]

Affordable Care Act

In 2010, the **Affordable Care Act (ACA)** was enacted, bringing massive changes to the health insurance industry and introducing the nation to health care exchanges. Also included in the original law was the expansion of state Medicaid programs under a national standard. Rather than the maze of eligibility rules and requirements that exist under individual state laws, Medicaid would be available to anyone whose income was lower than 138 percent of the national poverty level. Thus, the expectation was that the uninsured population would gain access to health care, either through an exchange or through Medicaid.

In a challenge to the constitutionality of the ACA, the Supreme Court, while upholding the law in general, ruled that each state could determine whether or not to expand its Medicaid program. As of late 2019, 37 states (including the District of Columbia) had elected expansion.

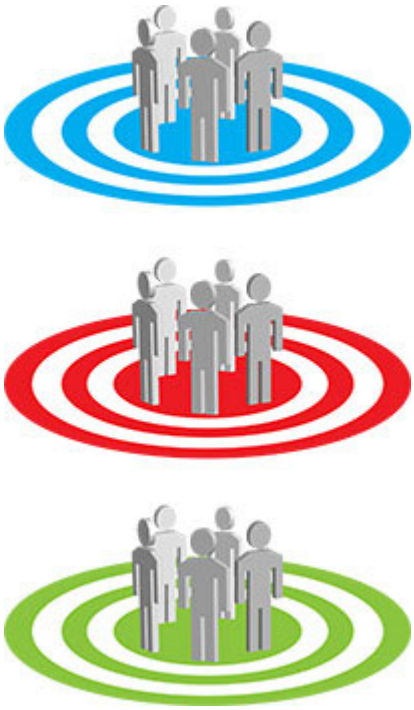
The CLASS Act

Another provision of the ACA, aimed specifically at the issue of long-term care, was the **Community**

Living Assistance Services and Supports (CLASS) program. A national voluntary program, its purpose was to provide cash benefits to middle-class individuals with functional and cognitive limitations to help them purchase long-term care services and supports. The program was to be funded by working individuals who have paid into the program for at least five years and met certain eligibility criteria in order to receive benefits. However, the financing of the CLASS program was never solid—the law required that the program be self-sustaining through premiums and without federal tax dollar support—and the provision was repealed only a few years after it was enacted.

With this background in mind, let's turn to a discussion of today's long-term care environment.

Levels of Long-Term Care



Crucial to any discussion of long-term care is an understanding of the distinction between the three primary levels of care. These are:

- custodial care
- intermediate care
- skilled care

Custodial Care

The primary purpose of **custodial care** is to provide assistance with activities of daily living (ADLs). Custodial care is aimed at meeting the *personal needs* as opposed to the medical needs of the recipient. In other words, custodial care is not skilled medical care or therapy and does not require the ongoing supervision of trained medical personnel.

In addition to assisting with ADLs, custodial care can include other services, such as changing dressings for chronic conditions or helping with braces or similar devices. Custodial care may be performed in the home or in residence facilities and may be delivered in conjunction with an overall program of skilled treatment. In the home, custodial care is provided primarily by family members or friends but can also be provided by other unlicensed individuals or licensed health aides.

Custodial care facilities (CCFs) are sometimes referred to by other terms, such as "rest homes" or even "nursing homes." Of course, the levels of care provided by various kinds of facilities do overlap somewhat. By far, the majority of LTC patients receive custodial care.

Intermediate Care

Intermediate care is provided under a doctor's supervision but is not considered to be continuously medically necessary. It is nursing and rehabilitative care that is required only occasionally or part-time and is performed by skilled practitioners. An example of intermediate care is a woman recovering from bilateral knee replacement. She will require some intermittent skilled care from licensed therapists. An individual with a degenerative condition may first require intermediate care, but as his or her condition worsens, he or she may require full-time skilled care.

Intermediate care may be given at home or in a facility, depending on the particular condition and the patient's overall health. Facilities that are set up specifically to provide this level of care usually exist within a larger skilled nursing facility rather than as stand-alone facilities. Such **intermediate care facilities (ICFs)** are for residents with conditions that are not as acute as those found in skilled nursing facilities, and they generally provide less nursing care than would an SNF. They are geared just as much toward personal services as toward nursing care.

Skilled Care

Skilled care is provided by non-hospital-based skilled nursing facilities. It is care that is continuously medically necessary. That is, it is care requiring the availability of round-the-clock nursing by RNs, LVNs, or LPNs and the presence on duty at all times of at least one supervising RN. Skilled care encompasses nursing care, therapy, and rehabilitation. This is a relatively high level of nursing and medical care for those whose conditions require close monitoring. SNFs also provide other prescribed medical services as well as custodial care for the patients in residence.

The following table compares the characteristics of each level of care.

Levels of Long-Term Care			
	Custodial Care	**Intermediate Care**	**Skilled Care**
Purpose	Assistance with ADLs to maintain current status and to meet current needs	Rehabilitative or restorative services	Medically necessary nursing care, therapy, or rehabilitation
Frequency	Periodically or daily	Intermittently or periodically	Daily
Delivered by	Family, friends, health aides	Physicians, nurses, licensed therapists	Physicians, nurses, licensed therapists
Provided in	Home, community care centers, skilled nursing facilities	Home, intermediate care facilities, skilled nursing facilities	Skilled nursing facilities
Duration	Usually long-term	Usually short- to mid-term	Usually short-term

Informal vs. Formal Care

Another way to distinguish levels of care that are provided in the LTC arena is to differentiate between informal and formal care.

Informal Care

Informal care is unpaid care that is typically provided by family members or friends—usually spouses and adult children. It has long been the most common source of long-term care for the elderly. Informal care can also be provided by neighbors or volunteer groups. It is offered because of love and respect for the disabled or elderly individual, or perhaps out of a sense of obligation on the part of a family member. Cost seems to play a major role in the decision to devote a high number of hours per week to informal caregiving and to minimize the use of formal care resources wherever possible. However, caregiving can exact a heavy toll upon the caregiver in terms of stress and an increase in health problems.

Research has found that the majority of informal caregivers are age 55 or older. Often, the caregiver lives with the care recipient. Many informal caregivers continue to work while caring for older family members. The following data offers a profile of caregivers providing care to those living outside a nursing home:

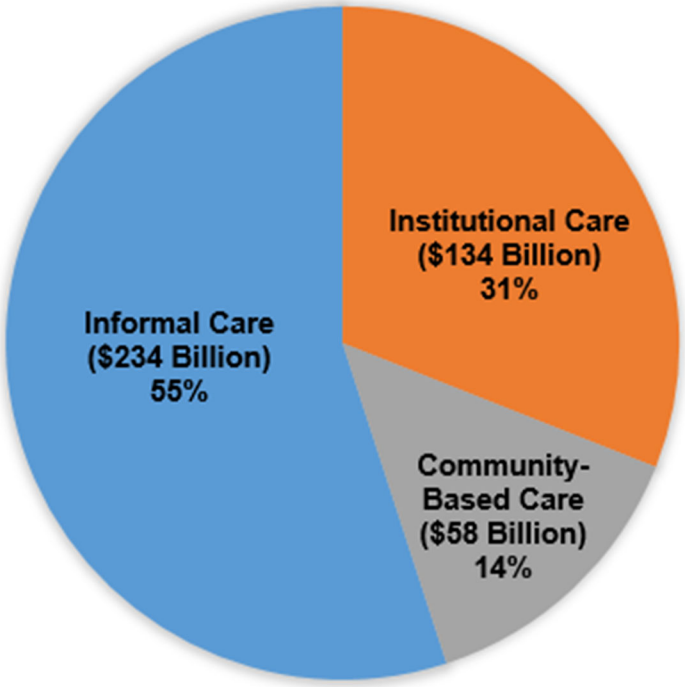
Relationship to Recipient	Percent of Caregivers
Spouse	21.2%
Child	47.6%
Other relative	22.3%
Other non-relative	8.0%
Age of Caregiver	
<45	16.8%
45–54	23.9%
55–64	27.1%
65–74	18.7%
75+	13.5%
Type of Care	
Household/other activities only	31.1%
Self-care or mobility	68.9%
"Informal Caregiving for Older Americans: An Analysis of the 2011 National Study of Caregiving," U.S. Department of Health and Human Services, 2014.	

Formal Care

Formal care is associated with a service system. Formal caregivers may be either paid workers or volunteers, and the organizations they work for may be for profit or nonprofit. Examples of agencies or groups that provide formal care include senior centers, adult day care, charitable groups, home health agencies, assisted living facilities, intermediate care facilities, skilled nursing facilities, state aging services, and hospice care. Typically, formal care workers are trained and can provide services that informal caregivers cannot.

Though the number and types of formal care providers have increased, by far the vast majority of long-term care still remains in the hands of informal caregivers. Often, formal care is selected only to the extent that a patient requires a level of care that is beyond the capacity or expertise of the informal caregiver or when no willing informal caregiver is available.

Estimated Economic Value of Formal and Informal LTC Services for the Elderly



"Financial Risks Due to Long-Term Care," Deloitte Advanced Analytical Consulting Group, August 2016 (citing Congressional Budget Office data from June 2013).

Home and Community-Based Care

Though for many the subject of long-term care conjures up images of institutional living and nursing homes, in actuality, only a portion of LTC recipients reside in such facilities. The majority receive their care at home—either their own home or that of their caregiver. **Home and community-based services** are provided by a range of caregivers—from family caregivers to community organizations, local and state agencies, and medical facilities. Thus, long-term care can be broadly categorized as being either of the following:

- home and community-based
- facility-based

The goal of home and community-based LTC services is to allow recipients to maintain as much independence as possible and to do so in familiar surroundings while maximizing available resources—personal, familial, financial, and community. An increasing number of options exist in most communities with providers that range from volunteer groups to state agencies.

Home-Based Services

Home-based services include many types of in-home personal services, which are described in the following sections.

In-Home Services

In-home LTC services encompass a wide range of assistance with personal care and homemaker services. They include programs that provide for the daily needs of the elderly or disabled at home and those that supplement the efforts of the primary caregivers.

Personal care services are nonmedical help with ADLs: bathing, continence, grooming, eating, toileting, dressing, ambulating, and transferring. **Homemaker services** cover a wide range of tasks that help ensure an individual can remain in the home. They might include the following:

- food management, including meal planning, shopping, and meal preparation
- light chores, such as laundry and housekeeping
- heavy chores, such as washing windows and shoveling snow
- financial assistance, including budgeting and bill paying
- meal delivery programs

- errands
- transportation services
- home repair, upgrade, and maintenance services

In addition to family and friends, in-home LTC services are provided by a variety of care support groups and agencies.

Home Health Care Services

State and federal laws regulate **home health care services agencies**. Many are Medicare- and/or Medicaid-approved. Services may be covered for the period during which home health care achieves the level of care ordered by a physician for a specific condition; services are provided by licensed professionals.

Home health care services provide health services that enable individuals and their families to successfully manage health care at home. The goal is to promote, maintain, or restore health. Care is very personalized and typically includes the services of the following:

- registered nurses and licensed practical nurses
- home health aides
- medical social workers
- case managers/geriatric care managers
- physical therapists
- occupational therapists
- speech therapists
- hospice organizations

Registered Nurses/Licensed Practical Nurses

Registered and **licensed practical nurses** provide care that patients' physicians have ordered. Such care may include performing prescribed medical treatment, administering prescribed medications, assessing chronic illnesses, administering injections, and caring for wounds.

Home Health Aides

Home health aides do not provide skilled care as do licensed nurses. They do provide personal care (help with ADLs), exercises, light housekeeping, and other daily living support. Though they do not deliver skilled care, they may have various health-related training that goes beyond simple personal care. In most states, home health aides must be licensed. Home health aides may or may not work for a social service agency or under the supervision of a nurse. Their objective is to help support and maintain the functioning of individuals in their own homes.

Case Managers/Geriatric Care Managers

Case managers, or **geriatric care managers**, are professionals who assess the mental, physical, environmental, and financial conditions of those potentially in need of long-term care. From the information gathered, the case manager creates a care plan and manages housing, medical, social, and other services.

Case managers are typically social workers or health care professionals who specialize in assisting caregivers and their families with long-term care needs. Case/geriatric managers commonly provide the following services:

- developing a plan of care
- managing, coordinating, and assisting with LTC services
- monitoring LTC needs over time

Hospice Organizations

Hospice care may be provided at home or in other settings. Hospice offers professionally coordinated support services, including counseling, medical care, pain and symptom management, social services, and emotional and spiritual support for the terminally ill and their families.

Community-Based Services

Community-based services take place in the community and outside the home. They provide temporary or periodic care for recipients during times when the primary caregiver is unavailable, or they offer social contact and outlets for the elderly with their peers.

Adult Day Service Programs

Also referred to as "adult day care," **adult day service programs** are local centers providing structured, comprehensive programs, including a variety of health, social, and other related support services in a protective setting during any part of the day for an older person who needs supervised assistance. Services may include health care, recreation, meals, and rehabilitative therapy in a group setting.

Adult day service programs are designed to meet the needs of people with mental or physical limitations, adults with cognitive or functional impairments, or those needing social interaction and a place to go when their family caregivers are at work or just need a break. Adult day centers typically operate during normal business hours five days a week, although some have evening and weekend hours. They do not provide 24-hour care but are designed to provide care and companionship for seniors who need assistance or supervision during the day. These programs offer much-needed relief to family members and caregivers and allow them to go to work or even just relax knowing their elderly relative is safe and well cared for.

While some adult day care centers are in stand-alone facilities, many are in senior centers, nursing facilities, churches or synagogues, hospitals, or schools. These programs aim to achieve the following goals:

- delaying or preventing institutionalization by providing alternative care
- enhancing self-esteem
- encouraging socialization

Senior Centers

Many communities offer a variety of activities in centers designed for older adults. While **senior centers** normally do not provide the level of supervision that adult day service programs do, they do offer a variety of services, including the following:

- nutrition counseling
- meals
- health screenings
- recreational, social, and educational programs
- referrals to other resources for care and services

Care for the Caregiver

Often the burden of caring for an aging parent or grandparent becomes the responsibility of a single individual. The stress, expense, and time-demands in such cases can become intolerable and frequently contribute to increased health problems for the caregiver, because he or she deals with both the practical and emotional aspects of caring.

Caring for an older person can be even more difficult and stressful when the elder is mentally or physically impaired, when the caregiver is not equipped for the task, or when financial resources are lacking. It is frequently necessary for primary caregivers to augment their efforts with services provided by local community organizations or volunteer groups or through private or government agencies. The cost for such assistance ranges from free to expensive.

Care for the caregiver options include:

- **Respite care centers** provide temporary relief for persons caring for someone who is ill, injured, or frail. The services, which can be offered in an adult day care center, the home of the care recipient, or even in a residential setting such as an assisted living facility or nursing home, provide the caregiver with some time to rest or to attend to personal matters.
- **Caregiver and community support groups** provide emotional support and information-sharing for those who are caregivers. They can be either community support groups or Internet support groups and often offer the opportunity for caregivers who live near each other to meet and interact. There, they share experiences and information about local resources and challenges as well as interact socially and form friendships.

Facility-Based Services

Whereas home and community-based care options may be the preferred choice for most and appropriate for many, other elderly or disabled individuals have health issues severe enough to require the level of care offered by a **skilled nursing facility** or **nursing home**. These facilities are designed to provide long-term care to people who need extensive and continuous care, particularly those requiring ongoing nursing care or 24-hour supervision in addition to their personal care needs.

Other forms of residential-care options are available to individuals who do not need the level of care delivered by a skilled nursing facility but are still unable to live entirely on their own. They require some level of ongoing assistance that cannot be received in their homes, usually because of a lack of available caregivers. For those who fall into this category, a variety of residential care settings are available, such as **assisted living**, **board and care homes**, and **continuing care retirement communities (CCRCs)**. Some facilities provide only housing and the associated housekeeping, but many also provide help in managing medications and assisting with personal care along with supervision and special programs for individuals with such conditions as Alzheimer's disease.

Let's take a closer look at these common facility-based long-term care arrangements.

Board and Care Homes

A **board and care home**, sometimes called a "residential care home," is an arrangement wherein a residence provides a room, meals, and assistance with everyday activities. Board and care homes are an option for those who require some assistance. Many board and care residents prefer the group living arrangement found here.

Board and care facilities are staffed by the families or individuals who live there. They offer a home-like environment for small or large groups of elderly or disabled residents. While they generally provide help with the activities of daily living, they encourage residents to make as many choices as possible about their daily lives and health care and to act independently.

Board and care homes do not offer nursing or medical care. Typically, they do not offer planned activities or transportation services. They are simply group residences. Some board and care homes specialize in populations with specific needs, such as people with Alzheimer's disease or those with developmental disabilities.

Such residences are frequently unlicensed. This means that they are not subject to inspection or regulation. A board and care home can be a converted single-family home with up to six or eight residents or may be a large building similar to an apartment building with over 100 residents.

Assisted Living Facilities

Assisted living facilities are residences that provide housing and a range of services for those who are unable to live independently but do not require skilled nursing care. They are nonmedical residential settings that provide or coordinate personal and health care services, 24-hour supervision, and assistance for the care of adults who are aged, infirm, or disabled. Assisted living facilities are intended to be a less costly alternative to more restrictive, institutional settings for individuals who require 24-hour nursing supervision. Residents typically live in apartment-like accommodations, with lockable doors and private bathrooms.

The cost for living in such facilities varies considerably depending primarily on what services are offered or needed. The types of available services in assisted living facilities also vary from state to state and residence to residence.

Residents in an assisted living facility can receive assistance with ADLs as well as assistance with self-administering medication. Meals, housekeeping, transportation, laundry, and clerical services are typically available. Generally, residents arrange with outside agencies or individuals to receive health care services.

Some assisted living residences are part of larger organizations, such as a skilled nursing facility, senior housing complex, or retirement community. Others are stand-alone facilities. These facilities encourage residents to bring their own furniture and keepsakes to make their units feel like their homes.

The following are common services found at assisted living residences:

- help with medications (or medication reminders)
- health care management/monitoring
- help with activities of daily living
- housekeeping and laundry
- recreational activities
- transportation
- security

Continuing Care Retirement Communities (CCRCs)

Continuing care retirement communities (CCRCs) are usually very large compounds. They include many types of LTC facilities so that residents can have any housing and LTC option that their health and

activity levels might require. CCRCs are sometimes called **life care communities**, which reflect the concept of the community being flexible enough to offer advancing care as patients' needs change.

Typically set on a large campus, all of the basic housing arrangements are represented. Some residents require no special assistance and live very independently in separate housing. For those requiring a greater degree of support are assisted living facilities. Skilled nursing facilities are also available for residents who need skilled nursing care.

Some CCRCs, while expensive, offer long-term contracts that guarantee care and shelter for life. Residents may move from facility to facility within the community as they get older and their health needs change. For example, a particular resident may move to the community fully independent. A few years later when requiring assisted living, he or she will move to another part of the campus. If and when skilled nursing care is required, these services will be available, also.

Depending on the housing choice, usually a wide range of living accommodations are available for the choosing, from single family homes to large and small apartments to furnished one-room units in the skilled nursing facilities. In some CCRCs, residents may even own their own living space.

Relative to the other housing choices we have discussed, CCRCs are very expensive and beyond the means of those with low to moderate income and assets. To join, an individual must be able to afford both an entry fee and monthly charges. Entry fees can range from $20,000 to over $400,000 or more, with monthly charges of $200 to $2,500 or more. In addition, there may be separate fees associated with various services, such as daily rates for long-term skilled nursing care.

At some CCRCs, membership may be refused even for those with the financial means to join. Most require a medical exam as part of the application process to ascertain the applicant's physical and mental health. These CCRCs reserve the right to decline applicants based on the results. Other CCRCs are affiliated with particular ethnic or religious groups or fraternal orders, and some require members to be eligible for both Medicare Part A and Part B.

Skilled Nursing Facilities

The once familiar term "nursing home" has been largely supplanted by **skilled nursing facility**, or **SNF**, though the older term is still used by many. Whatever term is used, skilled nursing facilities represent a level of care that requires the daily involvement of physicians and a skilled nursing or rehabilitation staff.

Many elderly or disabled patients need skilled nursing care and substantial, long-term assistance. Skilled nursing facilities can also provide them with rehabilitation, other medical services, personal care, meals, and recreation in a supervised and protected setting. Other examples of SNF services include the following:

- clinical oversight
- venipuncture or blood draws
- intravenous injections
- wound care and monitoring of skin conditions
- diabetic management
- catheter care
- physical, occupational, and speech therapy
- observation and assessment of patients' changing conditions
- a change in treatment and care based on changes in condition
- tube feedings

- ongoing assessment of rehabilitation needs and potential
- therapeutic exercises or activities
- ambulation (walking) programs

The need for custodial care (such as assistance with ADLs) cannot in itself qualify someone for care in a skilled nursing facility. However, if an individual does qualify for coverage based on the need for skilled nursing or rehabilitation, the patient's custodial and personal care needs will be taken care of.

Paying for Skilled Nursing Facility Care

Some SNF residents pay privately and have the option of private rooms. Others must share a room and bath. Either way, skilled nursing facility care is very expensive.

The average cost today for a private room is about $100,000 per year, and this figure continues to rise. As noted earlier, because the average stay in an SNF is about two and a half years, a person entering a nursing home today could expect to pay about $250,000 for the full term of his or her care. In only ten years, assuming an annual 3 percent increase in the cost of such care, a two-and-a-half-year stay will cost about $346,000.

Note

The cost of SNF care can vary greatly, depending on where the facility is located.

Comparing LTC Options

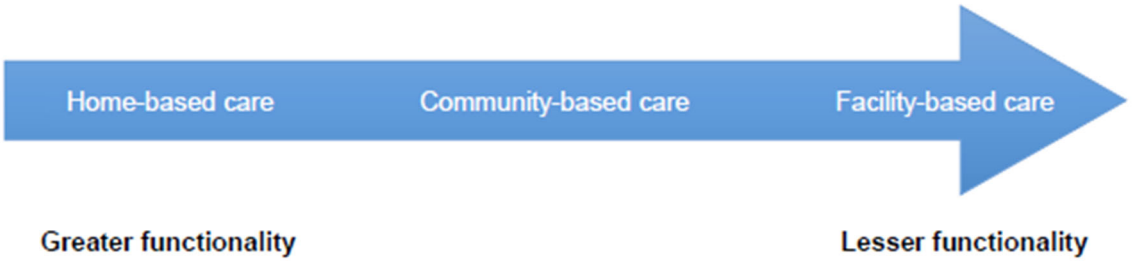
The following table summarizes the types of care available through home-based, community-based, and facility-based care.

Comparison of Long-Term Care Options

Home-Based Care and Support	Community-Based Care and Support	Facility-Based Care and Support
• personal care services • homemaker services • telephone reassurance/friendly visitor/companion services • meal delivery services • transportation services • home health aides • case managers/geriatric care managers • hospice support	• adult day services programs • senior centers • respite care • caregiver support groups	• board and care homes • assisted living • adult foster care • congregate housing/senior retirement communities • continuing care retirement communities (CCRCs) • skilled nursing facilities (SNFs)

This table also illustrates the concept of long-term care as an interlocking set of medical, personal, and support services delivered in the home and through the community as well as in institutions designed for this purpose. This makes possible the coordination of care and services through a variety of options. In addition, this table also shows the common progression of long-term care. Long-term care can be

considered as a continuum of evolving care needs and services, from low-intensity services to highly involved, 24-hour care. As the following graphic shows, individuals tend to move along this continuum: as their functionality lessens, ever higher levels of care are needed.



The Long-Term Care Ombudsman

As the need for long-term care grows and as more living arrangements become available, so too do services related to LTC facilities. Among these emerging services are those provided by an LTC ombudsman. An **LTC ombudsman** is specially trained and represents people in a given geographical area who live in assisted living residences or skilled nursing facilities. Ombudsmen make regular visits to facilities and investigate problems and complaints. They are usually a good source of information about the different facilities in the area, particularly about a facility's specific strengths and weaknesses. Although ombudsmen are prohibited from recommending one facility over another, they may offer advice on what to look for when visiting and evaluating facilities. They may also be able to supply such things as the latest state inspection reports or information about the number and types of complaints a facility may have received.

Summary

- In terms of available services and the providers of those services, LTC can be broadly categorized as home-based, community-based, or facility-based.
- For a number of reasons, including cost, comfort and familiarity with surroundings, social and family ties, and the wishes of those being cared for, many elderly persons and their families prefer that care be provided at home for as long as possible.
- Primary caregivers are usually family members who often find that they must augment their efforts with outside resources to meet all of the needs of those they are caring for. Whether to opt for a facility-based solution is determined by a number of factors, including, but not limited to, the following:
    - the nature and degree of the LTC recipient's needs
    - the availability of a caregiver or caregivers willing and able to meet those needs
    - the financial resources of the senior and his or her family

Chapter 2 Review Questions

1. Which of the following is *not* an example of home or community-based long-term care?
    A. adult day care
    B. CCRCs
    C. respite care
    D. hospice care
2. A long-term care ombudsman represents people in a given geographical area who live in assisted living residences or skilled nursing facilities.
    A. True
    B. False
3. All of the following are services commonly offered by assisted living residences EXCEPT:
    A. health care management
    B. help with medications
    C. housekeeping
    D. continuous post-operative monitoring
4. All of the following are examples of formal caregiving EXCEPT:
    A. home health aides
    B. intermediate care facilities
    C. volunteer charitable groups
    D. daily transportation to a senior center provided by a neighbor
5. Which level of care has as its chief characteristic assistance with ADLs?
    A. custodial
    B. intermediate
    C. skilled
    D. managed
6. What kind of care do the majority of long-term care recipients receive?
    A. skilled nursing care
    B. intermediate care
    C. custodial care
    D. respite care

Answers to Chapter 2 Review Questions

1. B. Continuing care retirement communities, or CCRCs, are large, campus-like facilities that house residents and provide a complete range of long-term care.
2. A. A long-term care ombudsman, as a local representative for those in assisted living facilities or SNFs, can be a valuable source of information about various local facilities for those seeking housing for the elderly.
3. D. Assisted living residences generally provide most personal and health care services except for skilled nursing care, such as continuous post-operative monitoring, which can only be offered by a skilled nursing facility.
4. D. Formal caregiving is paid, or volunteer care is provided through a service system. Informal care is delivered by family or friends.
5. A. Custodial care, the primary characteristic of which is to provide assistance with the activities of daily living, helps meet personal rather than medical needs.
6. C. The majority of long-term care recipients receive custodial care, which is characterized as assistance with ADLs and IADLs.

Chapter 3
Medicare and Medigap

Overview

Officially known as Title XVIII of the Social Security Act, Medicare is the federal government's health insurance program. It was implemented in 1965 to provide health insurance coverage for people age 65 and older. Many changes have been made to the Medicare program over the years, and coverage now extends to include the legally blind, people with end-stage kidney disease, and younger people who are disabled and meet the criteria to collect Social Security disability benefits. The Centers for Medicare and Medicaid Services (CMS) administers Medicare, which covers over 45 million Americans.

Many people mistakenly believe that Medicare pays for long-term care, but this is not the case. In this chapter, we will examine the various parts of the Medicare system and what is covered under each. Also explained are Medigap policies, which are sold by private insurance companies and are designed to fill the gaps where Medicare coverage is lacking.

Chapter Objectives

Upon completion of this chapter, you should:

- be able to explain the four parts of Medicare
- know the purpose of standardized Medigap insurance and how it covers some of the gaps that Medicare does not pay
- understand the very limited role Medicare and Medigap serve in covering extended long-term care services

What Is Medicare?

Medicare is our country's health insurance program for people age 65 or older. Certain people younger than age 65 can qualify for Medicare, too, including those who have disabilities and those who have permanent kidney failure or amyotrophic lateral sclerosis (Lou Gehrig's disease). The program helps with the cost of health care, but it does not cover all medical expenses or the cost of long-term care. Medicare is financed in part by payroll taxes paid by workers and their employers. For every $100 an employee earns, the employer and employee each pay $1.45 in payroll (FICA) taxes to fund the Medicare program.[21] The program is also financed by monthly premiums deducted from Medicare enrollees' Social Security checks.

Today's Medicare Program

Today's Medicare program has four parts:

1. **Part A—Hospital Insurance**—Part A helps pay for inpatient care in a hospital or in a skilled nursing facility (following a hospital stay). It also covers some home health care and hospice care.
2. **Part B—Medical Insurance**—Part B helps pay for doctors' services and many other medical services and supplies that are not covered by Part A.
3. **Part C—Medicare Advantage**—Part C (**Medicare Advantage** or **MA**) is a managed care approach to delivering Medicare-covered services and is available in many areas. People with Medicare Parts A and B can choose to receive all of their health care services through a Medicare Advantage provider organization under Part C.
4. **Part D—Prescription Drug Coverage**—Part D is the prescription drug benefit that helps pay for medications that doctors prescribe for treatment.

Medicare recipients (or beneficiaries, as they're often called) can choose the **Original Medicare plan**, which consists of Part A and Part B, or they can opt to enroll in a **Medicare Advantage (MA)** plan, if one is available in their area, for the delivery of their Part A and B services.

Original Medicare

The Original Medicare plan is a fee-for-service plan managed by the federal government. **Fee-for-service** means that participants are usually charged a fee for each health care service or supply they receive. In addition, for some services, they pay a deductible before Medicare pays its share of the cost. Then, when a Medicare-covered supply or service is provided, Medicare pays its share, and the participant pays his or her share—the **coinsurance** or **co-payment**. Under the Original Medicare plan, participants may use any doctor, supplier, hospital, or other facility that accepts Medicare.

Medicare Advantage

Medicare Advantage, or MA, is a way in which Medicare-covered services are delivered. These plans combine all of the benefits of Part A and Part B and may, depending on the plan, include the coverage provided by Part D. MA plans are offered and administered by private companies and have been approved by Medicare. Compared to Medicare's traditional fee-for-service approach, MA plans are characterized by greater flexibility and the ability to offer enhanced care management services. Most Medicare Advantage plans take the form of a **health maintenance organization (HMO)** or **preferred provider organization (PPO)**. With HMOs, beneficiaries are required to seek care and services from providers who are part of the HMO network; with PPOs, beneficiaries are also served by a provider network, though they may seek care (at a higher cost) outside the network.

Part D

Lastly, as mentioned, **Medicare Part D** provides coverage for prescription drugs. Those enrolled in the Original Medicare plan may choose to enroll in a separate Part D plan; those in a Medicare Advantage plan may have, as part of their plan, coverage for Part D.

With that brief background, let's examine in more detail the specifics of Medicare Parts A, B, C, and D.

Part A—Hospital Insurance

Most people age 65 and older who are citizens or permanent residents of the United States are eligible for free Medicare **Part A Hospital Insurance**.

Part A covers most inpatient hospital care, some inpatient skilled nursing care, some home health care, and hospice care. A monthly Part A premium is not required for people who have 40 or more quarters of Social Security credits, which equates to about ten years of full-time work. Those with 30 to 39 Social Security quarters may buy Part A but will have to pay a monthly premium. People with fewer than 30 Social Security quarters may purchase Part A also but will have to pay a larger monthly premium.

Part A benefits are paid once the beneficiary has met a deductible ($1,408 in 2020). The Part A deductible applies to each **benefit period**. A benefit period starts when an individual enters the hospital and ends when there has been a break of at least 60 consecutive days since inpatient hospital or SNF care was provided. Hospital stays longer than 60 days require the beneficiary to meet a daily co-payment.

Part B—Medical Insurance

Anyone who is eligible for the free Medicare Part A can enroll in Part B Medical Insurance by paying a monthly premium. Even those who are not eligible for the free Medicare Part A can purchase Part B if they are age 65 or older and are U.S. citizens or lawfully admitted noncitizens who have lived in the U.S. for at least five years.

Part B covers a portion of the Medicare-approved costs for the following:

- doctors' services
- outpatient hospital care
- laboratory tests
- outpatient physical and speech therapy
- some home health care
- ambulance services
- some medical equipment and supplies
- certain preventive care (some of which is covered at 100 percent)

Part B coverage is optional. Some people with other medical coverage do not require this part of Medicare until they are no longer covered under other programs, such as their employer's health care plan. Part B requires the payment of a monthly premium, which is automatically deducted from a beneficiary's Social Security check. Those who do not receive Social Security will be billed quarterly for their Part B premiums. (High-income wage earners are charged more for their monthly Part B premiums.)

In addition to the monthly premium, Part B coverage requires the payment of an annual deductible ($198 in 2020). After the deductible is met, Medicare pays for 80 percent of covered and approved charges; the beneficiary is responsible for the balance. In addition, if the charge is greater than the amount allowed by Medicare—referred to as the **excess charge**—the beneficiary is responsible for the difference.

Note

Medicare is not a complete system of health care. Even though it pays for many preventive services and covers most medically necessary services, Medicare pays for less than half of what seniors typically spend for their total health care expenses. Medicare does not pay for routine dental or eye care, or hearing aids. More significantly, it does not pay for long-term care at home or in a nursing home when this care is primarily personal care services or custodial care.

Part C—Medicare Advantage

As an alternative to Original Medicare, **Medicare Advantage (MA)** plans are offered through private health insurance companies and private health care provider organizations and combine into one plan all of the coverages and benefits of Medicare Part A Hospital Insurance and Part B Medical Insurance. Many MA plans offer additional benefits; some may also provide the Part D Prescription Drug coverage. To join an MA plan, participants must have both Medicare Part A and Part B and live in the plan's service area.

The plan may have special rules, such as requiring beneficiaries to see doctors who belong to the plan or requiring them to go to certain hospitals to receive services. While Medicare pays a set amount of money for beneficiaries' care each month to these health plans, beneficiaries may have to pay from their own pockets a monthly premium for extra benefits.

Types of MA plans include the following:

- Medicare preferred provider organization (PPO) plans
- Medicare health maintenance organization (HMO) plans
- Medicare private fee-for-service (PFFS) plans
- Medicare special needs plans
- Medicare medical savings account (MSA) plans

Part D—Medicare Prescription Drug Coverage

Part D Prescription Drug coverage arose from the passage of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, otherwise known as the **Medicare Modernization Act**, or **MMA**. Anyone who has Medicare Part A, Part B, or a Medicare Advantage plan is eligible for prescription drug coverage under Part D. Joining a Medicare Prescription Drug plan is voluntary, and an additional monthly premium is required for the coverage. In 2006, the prescription drug benefit began. Everyone covered by Medicare must make choices with respect to Part D. Beneficiaries are eligible to:

- remain in the traditional Medicare program without participating in the drug benefit
- remain in the traditional Medicare program and enroll in a stand-alone Part D drug plan
- enroll in a private Medicare Advantage plan that offers both Medicare health services and prescription drug coverage

Medigap Insurance

Medigap is the term that applies to private health care insurance policies designed to cover the "gaps," or out-of-pocket expenses, that Original Medicare does not pay for. Also known as **Medicare supplement insurance**, Medigap covers the many deductibles, coinsurance amounts, co-pays, and other limitations and services that Medicare does not pay. For example, a Medigap policy might cover Part B excess charges and emergency health care while the beneficiary is traveling outside the United States.

Clearly, Medigap policies are purchased because Medicare does not pay for total health care. And while a Medigap policy will cover some of these gaps, it doesn't pay for all. A Medigap policy can help lower out-of-pocket costs and expand coverage.

A Medigap policy only works in conjunction with the Original Medicare plan. So, if an individual decides to join a Medicare Advantage plan, Medigap coverage is unnecessary. Those who enroll in Original Medicare may benefit by purchasing a Medigap policy.

Standardized Medigap Policies

A Medigap policy must meet the statutory definition of a Medicare supplement policy as specified in Title XVIII of the Social Security Act. Since 1992, Medigap policies have been standardized. Each plan design provides for a specified set of benefits and is titled simply as a letter of the alphabet. For each plan design, the benefits are the same among all insurers.

The line-up of standardized Medigap plans has been subject to change over the past decade to reflect changes in the Medicare market. The most recent change took effect as of January 1, 2020. There are now eight standard plans available to all Medigap applicants and two plans (Plans C and F) that are available to those who became Medicare-eligible prior to 2020. Plans sold after January 1, 2020, must conform to these changes.

Standardized Plan Benefits

Every Medigap policy must provide for a minimum level of "basic" or "core" benefits. These are represented by Plan A. Every other plan must provide these basic benefits, but they also have additional benefits. The following chart summarizes the benefits that the current series of Medigap policies provide:

Benefits	Plans Available to All Applicants								Medicare first eligible before 2020 only	
	A	B	D	G[1]	K	L	M	N	C	F[1]
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Medicare Part B coinsurance or copayment	✔	✔	✔	✔	50%	75%	✔	✔ copays apply[3]	✔	✔
Blood (first three pints)	✔	✔	✔	✔	50%	75%	✔	✔	✔	✔
Part A hospice care coinsurance or copayment	✔	✔	✔	✔	50%	75%	✔	✔	✔	✔
Skilled nursing facility coinsurance			✔	✔	50%	75%	✔	✔	✔	✔
Medicare Part A deductible		✔	✔	✔	50%	75%	50%	✔	✔	✔
Medicare Part B deductible									✔	✔
Medicare Part B excess charges				✔						✔
Foreign travel emergency (up to plan limits)			✔	✔			✔	✔	✔	✔
Out-of-pocket limit in 2020[2]					$5,980[2]	$2,940[2]				

[1] Plans F and G also have a high-deductible option which requires first paying a plan deductible of $2,340 (2020) before the plan begins to pay. Once the plan deductible is met, the plan pays 100 percent of covered services for the rest of the calendar year. High-deductible Plan G does not cover the Medicare Part B deductible. However, high-deductible Plans F and G count the insured's payment of the Medicare Part B deductible toward meeting the plan deductible.

[2] Plans K and L pay 100 percent of the covered services for the rest of the calendar year once the out-of-pocket yearly limit is reached.

[3] Plan N pays 100 percent of the Part B coinsurance, except for a co-payment of up to $20 for some office visits and up to a $50 co-payment for emergency room visits that do not result in an inpatient admission.

Note: A ✔ means 100 percent of the benefit is paid.

Source: NAIC

Medicare and Long-Term Care

Many people mistakenly believe that Medicare pays for long-term care. The truth is that Medicare does *not* pay for long-term care. Medicare is designed to cover medical expenses for acute conditions. For example, if a person suffers a stroke or cancer, Medicare will pay for hospitalization and treatment. However, as soon as the beneficiary no longer requires a bed in an acute care facility, Medicare benefits cease, and the beneficiary is on his or her own.

Medicare does pay for medically necessary skilled nursing facility care for very short periods; however, beneficiaries must meet certain criteria. To qualify for this type of Medicare coverage, the following is required:

- The individual must have had a prior hospital stay as an admitted patient of at least three full days.
- The individual must be admitted to the skilled care facility within 30 days of discharge from the hospital.
- A doctor must certify that skilled care is required.
- The services or care must be delivered by a Medicare-certified facility.

Medicare will not pay for personal care services or custodial care outside a nursing facility. However, if an individual qualifies for coverage based on the need for skilled nursing or rehabilitation as described, Medicare will cover all of his or her needs in the facility, including assistance with activities of daily living.

SNF Coverage Restrictions

Even when an individual meets the requirements of having spent at least three full days in the hospital, needs skilled nursing care, and a physician has ordered the care, Medicare limits the number of days it will pay for care in a skilled nursing facility. Medicare covers SNF care as follows:

- **days 1 through 20**—Medicare pays 100 percent of the approved cost.
- **days 21 through 100**—The beneficiary is responsible for a daily co-payment ($176 in 2020); Medicare pays the balance.
- **days 101 and beyond**—Medicare pays nothing.

The supplemental coverage provided through a Medicare Advantage plan or a Medigap plan may cover part or all of the beneficiary's share of the SNF cost for days 21 through 100 when Medicare coverage requires a daily co-payment. However, when the underlying Medicare benefit ceases, the supplemental coverage also stops.

After 100 days, Medicare pays nothing for skilled nursing facility care. Once these limited Medicare benefits are exhausted, other options for payment are personal funds, a long-term care insurance policy (if the beneficiary had the forethought to pre-plan), or Medicaid, the subject of our next chapter.

Medicare's Home Health Care Coverage

Medicare covers the costs of having an agency provide part-time or intermittent health care services in the patient's home, but again, this coverage is limited, and the patient must need skilled care. To qualify for Medicare's home health care benefit, the following conditions must be met:

- The care must be certified as medically necessary.
- The care must be ordered by a physician.
- The level of intermittent care needed and provided must be skilled care.
- The care must be provided by a Medicare-certified home health agency.
- The patient must be homebound, meaning that leaving the home requires a great deal of effort and is done only infrequently.

In addition, for qualifying patients, Medicare will pay for medical social services, home health aide services, medical supplies, and durable medical equipment used in the home. However, Medicare does *not* cover custodial home health care.

Note

Beginning in 2019, Medicare Advantage plans can, if they choose, offer supplemental benefits that are often associated with long-term care needs and long-term care services. These supplemental benefits can include, among others, services provided by adult day care facilities, home-based (non-skilled) palliative care, transportation for health care needs, and home safety devices and modifications.

Medigap and Long-Term Care

Just as Medicare provides only limited coverage for long-term care services, so, too, do Medigap policies. Medigap policies are designed to cover the "gaps" in Medicare associated with the program's many deductibles, coinsurance, co-payments, and other similar limits. These policies pick up where Medicare leaves off. They are not intended to provide coverage or benefits for conditions that Medicare itself does not cover. Consequently, because Medicare does not cover long-term custodial care and does not cover long-term stays in skilled nursing facilities, Medigap does not cover these needs either. Other than coverage for the daily coinsurance amount for post-hospital care in a skilled nursing facility—a benefit that ends after 100 days—Medigap policies provide no benefits or payments for long-term care.

Summary

- The Original Medicare plan is a fee-for-service plan managed by the federal government and includes Part A Hospital Insurance and Part B Medical Insurance.
- Part C Medicare Advantage comprises plans obtained through private health insurance companies to expand benefits.
- Medicare Part D Prescription Drug coverage was added as a benefit as of 2006.
- Neither Medigap, a system of standardized private insurance policies designed to provide additional coverage and benefits where Medicare leaves off, nor the very comprehensive Medicare health insurance program provides LTC benefits as many people believe.

Chapter 3 Review Questions

1. Which of the following is a correct statement about Medicare?
    A. Medicare is available only to those 65 and older.
    B. Medicare pays all of the costs of health care for those 65 and older.
    C. Medicare does not cover long-term care.
    D. Medicare covers custodial care in the home whenever help with ADLs is needed.
2. Which of the following only covers inpatient hospital care and hospice?
    A. Medicare Part A
    B. Medicare Part B
    C. Medicare Part C
    D. Medicare Part D
3. With regard to Medicare and long-term care, which of the following statements is true?
    A. Medicare covers long-term care for as long as necessary, but only if the individual requires skilled nursing care in an institution.
    B. Medicare covers long-term care for as long as necessary, but only if the care is delivered in the individual's home.
    C. Medicare covers care in a skilled nursing facility for a limited time, but only if the care follows an admitted hospital stay and is ordered by a physician.
    D. Medicare covers custodial care for up to one year regardless of whether the custodial care is delivered in a facility or in the individual's home.
4. Which of the following is a correct statement about Medicare Part D Prescription Drug coverage?
    A. Enrollment in Part D is mandatory.
    B. All prescriptions are paid in full under Part D.
    C. No additional premium is required for this coverage.
    D. Enrollment in Part D is voluntary.
5. Medicare covers the cost of long-term custodial care in the home when it is delivered by a Medicare-certified agency.
    A. True
    B. False

Answers to Chapter 3 Review Questions

1. C. Medicare helps with the cost of health care, but it does not cover all medical expenses or the cost of long-term care.
2. A. Part A helps pay for inpatient care in a hospital or skilled nursing facility (following a hospital stay), some home health care, and hospice care.
3. C. Medicare covers care in a skilled nursing facility if it is preceded by a hospital stay of at least three days and if the care is ordered by a physician. This benefit extends for only 100 days.
4. D. Medicare Part D provides coverage for prescription drugs, but it does not cover all prescription drug costs. The cost of a stand-alone Part D plan requires a premium payment. (Those who enroll in a Medicare Part C plan may have prescription drug coverage as part of the plan, and the plan's premium would likely include this coverage.) Enrollment in Part D is voluntary.
5. B. Medicare does not cover the cost of long-term custodial care, regardless of where it is delivered or who delivers the care.

Chapter 4
Medicaid

Overview

Medicaid was established as Title XIX of the 1965 Amendment to the Social Security Act, while Medicare was established at the same time as Title XVIII of the act. Medicaid is a public insurance program funded jointly by states and the federal government that pays for some health services for certain low-income people.

In addition, Medicaid pays for nursing home care for older people with low incomes and limited assets and pays for long-term care services at home and in the community. Who is eligible and what services are covered vary from state to state.

This chapter examines Medicaid as the largest public source of funding for long-term care in the United States. Though funded and administered through federal and state efforts, Medicaid is not available to everyone who needs LTC services. It is available only to certain low-income individuals and families who fit into particular eligibility groups. Those who apply to Medicaid for payment of LTC services must meet both financial and functional eligibility criteria to qualify. The financial criteria often require recipients to spend down their assets to become sufficiently needy to qualify.

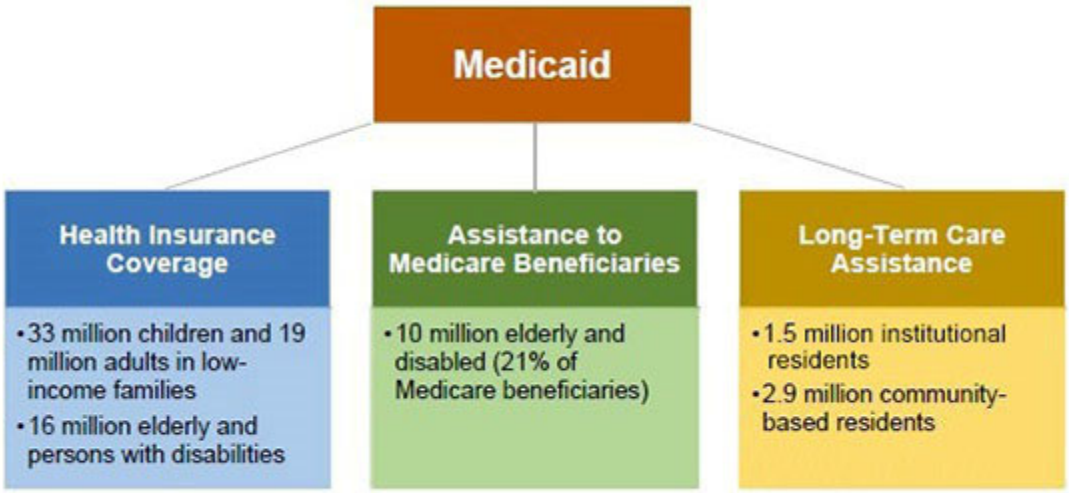
Chapter Objectives

Upon completion of this chapter, you should:

- understand the workings of Medicaid as a federal and state partnership
- be able to explain the basics of Medicaid eligibility requirements
- know the restrictions on spending down assets to qualify for Medicaid
- be aware of the rules prohibiting transferring assets to qualify for Medicaid benefits
- be able to explain the rules that allow preserving assets for healthy spouses to prevent spousal impoverishment
- be able to describe the Medicaid Estate Recovery Program

Dollars and Cents

Medicaid provides health and long-term care coverage for over 70 million low-income people. This includes acute and long-term care coverage for over 20 million elderly and persons with disabilities, in addition to 10 million Medicare beneficiaries. Those who receive both Medicare and Medicaid are called **dual eligibles**. Medicaid pays for nearly one in five health care dollars and one in two nursing home dollars. Medicaid has become the primary payor of LTC services, essentially by default. In the LTC arena, Medicaid is far more significant than Medicare. Total Medicaid spending is in the hundreds of billions of dollars, and a significant portion of those dollars are for long-term care.



"Medicaid Moving Forward," Issue Brief, Henry J. Kaiser Foundation, March 2015.

How Medicaid Emerges as a Primary LTC Payor

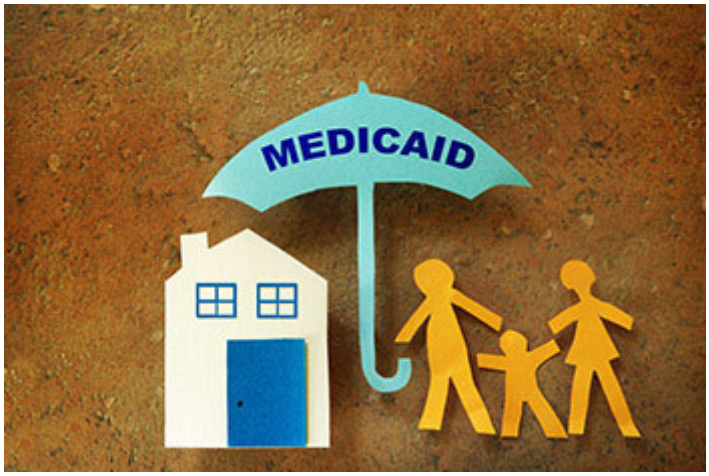
Many elderly people who find themselves needing long-term care and who do not have LTC insurance begin paying for their services themselves when they learn Medicare will not be coming to their rescue. Unfortunately, most quickly discover that their financial resources are not sufficient to cover home health care services or lengthy stays in nursing home facilities for an extended period.

Traditionally, a person needing long-term care would turn to family members to provide unpaid, informal services. However, with a higher incidence of divorce, dual-career families, and a mobile society, it is less likely that an extended family will be available to provide care. If a person has substantial savings, he or she could use them to pay directly for the full cost of care. However, few have such infinite resources.

Although many people who need long-term care can rely on unpaid help from family and friends for *some* period, this type of voluntary care typically and eventually runs its course. Well-meaning family and friends find they are not able to keep up with the physical and emotional demands of providing LTC in addition to their many other responsibilities and obligations. Many are simply not equipped to provide the necessary level of care, and others do not have the financial resources to sustain the commitment. Furthermore, as these individuals learn, Medicare is not a true option for the payment of LTC services.

So, for those without insurance coverage and without significant financial or family care resources, the only recourse to long-term care is Medicaid or a similar government-sponsored program.

The Basics of Medicaid



As discussed, Medicaid is available only to certain low-income individuals and families who fit into an eligibility group that is recognized by federal and state law. Medicaid does not pay money to beneficiaries. Instead, it sends payments directly to health care providers. Depending on state rules, beneficiaries may also be asked to pay a part of the cost in the form of a co-payment for some medical services. Most states have additional state-only programs to provide medical assistance for specified poor persons who do not qualify for the Medicaid program. No federal funds are provided for these state-only programs.

Basic Medicaid Coverages

Medicaid is funded and administered through combined **federal** and **state** programs. Both federal and state laws determine who is eligible and what benefits will be provided. Although wide-ranging federal requirements exist for Medicaid, states have a considerable degree of flexibility in designing and implementing their own programs. States set eligibility standards, determine what benefits and services to cover, and establish payment rates. All states, however, must cover the following basic services:

- inpatient and outpatient hospital services
- laboratory and X-ray services
- skilled nursing care and nursing facility services
- home health services

- physician and certified nurse practitioner visits
- family planning
- periodic health check-ups
- transportation to medical care
- diagnosis and treatment for children

Medicaid may also pay for services such as prescription drugs, clinic visits, prosthetic devices, hearing aids, dental care, eye exams, glasses, and medical services not covered by Medicare. It can also help pay Medicare costs.

FMAP

States determine reimbursement rules for Medicaid-covered services under federal guidelines and make payments to providers. Federal funding comes in the form of federal reimbursement as block grants to individual states. A determination is made each year using a formula that compares a particular state's average per capita income with the national average. The formula is the **federal medical assistance percentage (FMAP)**. Federal Medicaid funding cannot be lower than 50 percent.

States with lower per capita incomes receive larger federal matching funds than states with higher per capita incomes. For example, Connecticut typically has the highest per capita income in any given year. Federal matching funds for Connecticut's Medicaid program are typically 50 percent, and the state budget will make up the other 50 percent. Mississippi, on the other hand, typically has among the lowest per capita income. The federal Medicaid grant for Mississippi is about 77 percent, with the state making up the remaining 23 percent. FMAP levels for other states fall somewhere between these two points. Overall, the federal government's total portion of Medicaid funding is approximately 57 percent.

Basic Medicaid Eligibility Groups

Medicaid does not provide medical assistance for all poor persons. Even under the broadest provisions of the federal statute (except for emergency services for certain persons), the Medicaid program does not provide health care services, even for the very poor, unless they are in a designated **eligibility group**. Among the main Medicaid eligibility groups are the following:[22]

1. **Those who are mandated by the federal government (the "categorically needy")**. A few examples of federally mandated Medicaid-eligible groups include:
    - limited-income families with children who qualify for a state's Aid to Families with Dependent Children program
    - those who are receiving Supplemental Security Income, or SSI (a group that is primarily composed of low income aged, blind, and disabled)
    - infants born to Medicaid-eligible women
    - recipients of adoption assistance and foster care under Title IV-E of the Social Security Act
2. **Those whom states may include at their option (the "optionally categorically needy").** States have the option of establishing and covering other "categorically needy" groups under their Medicaid program and receiving federal matching funds. Virtually all states have identified and include the following optional groups in their Medicaid programs:
    - the aged (65 and older), blind, or disabled whose incomes are below the federal poverty level
    - institutionalized individuals with limited income and resources

3. **Those who are deemed "medically needy."** Individuals in this group are members of a categorically needy group who have high medical expenses but whose incomes or assets exceed Medicaid's limits. If their state has a medically needy Medicaid option, their medical expenses are deducted from their income to determine eligibility. The majority of states have a medically needy option for seniors and the disabled and have established separate income and asset criteria for this group.

Medicaid and Long-Term Care

Medicaid is the nation's major source of financing for LTC services, covering both the elderly and nonelderly in institutional settings as well as in their homes and other community-based settings. However, as noted, the program is limited to those with low incomes or those who incur catastrophic medical expenditures. It is designed to give medical care to those with minimal assets. This means that to be eligible to receive Medicaid benefits for LTC, recipients must first spend down the assets they have. (See an explanation of "spend down" later in this section.)

Eligibility for Medicaid Long-Term Care

Although the federal government sets general guidelines, Medicaid program requirements are actually established by each state. Whether a person is eligible for Medicaid depends on the state in which he or she lives and the rules that specific state imposes.

Most recipients of Medicaid long-term care assistance come from the low-income aged, blind, and disabled group of eligible beneficiaries. Even when Medicaid does pay for long-term care, the conditions may not be the most favorable. Assisted living facilities, which allow residents some privacy and independence, often do not accept Medicaid patients. Most nursing homes do accept Medicaid but limit how many Medicaid patients they will accept. Applicants can face long waits for the homes they prefer, or they may have to settle for a facility far from home and family. The placement process differs from state to state, but in some states, patients must take the first bed that opens up, no matter where it is located. Though not as common today as in the past, a few states may require that care be provided only in nursing homes and not in the home or community. (However, most state Medicaid plans include **waiver programs**, which enable a state to provide a broad array of home and community-based services for certain targeted groups or individuals as alternatives to institutionalization.)

LTC Eligibility Criteria

Notwithstanding the different state rules and requirements, those who apply to Medicaid for payment of LTC services must generally meet three criteria:

- They must belong to a group that their state has defined as a *Medicaid-eligible group* (categorically needy or medically needy, for example).
- They must have a *medical or functional need*—some kind of impairment that limits their ability to perform activities of daily living (ADLs)—thus requiring institutionalized care. Those who need the level of care given in an institution but are able to receive it in the home or in the community may also qualify. Medicaid case management agencies evaluate individuals to determine if their medical or functional needs require long-term care services.
- Their *income and assets must be at or below specified levels*. These levels vary depending on which eligibility group they are in and where the long-term care is received (in the home or community or in a nursing facility, for example).

Regardless of these variables, however, the financial requirements that apply to Medicaid coverage for long-term care services are strict and may subject individuals to a *spend-down*, where they must divert the bulk of their income to the cost of their care and must sell off the majority of their assets. This amounts to self-impoverishment.

Let's take a closer look at the income and asset rules for Medicaid long-term care.

Income Requirements

Because Medicaid is intended to assist those with limited financial resources, it restricts the amount of income an individual can receive to qualify for long-term care services. As a general rule, income limits for Medicaid LTC eligibility are typically set at a percentage of the federal poverty level or are based on income standards for other programs, such as Supplemental Security Income (SSI). In most states, an individual's income must be at or lower than 300 percent of the SSI income limit to qualify for nursing home Medicaid.

Once an individual becomes eligible for Medicaid long-term care, he or she will generally have to contribute almost all of his or her available income toward the cost of care. Medicaid covers the balance. Each recipient is permitted to retain only a nominal amount, such as $30 or $50 each month, for personal use. Those who receive LTC services in their home are given a higher income allowance to allow them to maintain their home.

Spouse's Sole Income Does Not Count

The Medicaid rules do *not* require that the income of the community spouse (i.e., the spouse of a Medicaid recipient who remains in the home or in the community) be spent on the Medicaid recipient's care. Also, if the community spouse has a low monthly income, it is possible for the community spouse to receive an allowance from the income of the Medicaid-recipient spouse. (See the "Spousal Impoverishment Protection" section later in this chapter.)

Income Counted Toward Eligibility

When determining Medicaid eligibility, an individual's income is categorized as **countable** or **not countable**. Examples of income counted in determining Medicaid eligibility include the following:

- wages (certain deductions are allowed)
- interest
- dividends

- Social Security benefits
- veterans' benefits
- pensions

Income Not Counted Toward Eligibility

Examples of income *not* counted when determining Medicaid eligibility include the following:

- temporary aid to needy families (the program that replaces Aid to Families with Dependent Children)
- supplemental security income (SSI)
- food stamps
- Low Income Home Energy Assistance Program benefits (a program that helps pay the heating and cooling bills of low-income and elderly people)
- foster care payments
- certain housing or utility subsidies

In some states, residents whose countable incomes exceed the state's income limit may still qualify for Medicaid payment of nursing home costs if they establish a **Miller Trust**, which is designed specifically for this purpose. The amount of the applicant's income that exceeds the Medicaid limit is assigned as payable to the trust. In turn, the trust pays out monthly to the nursing home facility.

Asset/Resource Requirements

Eligibility for Medicaid LTC is also based on the amount of assets or resources the applicant owns. As a general rule, an individual may have no more than $2,000 or $3,000 in countable assets to be eligible for assistance. To this end, an applicant's assets are deemed either **countable (nonexempt)** or **noncountable (exempt)**.

Countable (Nonexempt) Assets

All **countable assets** are considered in determining Medicaid eligibility—that is, they can be "counted" in determining the amount of property an individual owns. Countable assets include:

- cash
- checking and savings accounts
- certificates of deposit and money market accounts
- stocks, mutual funds, bonds, and other investment holdings
- IRAs, Keoghs, and other retirement funds
- nonresident property

With some minor exceptions, any money and any property that can be valued and turned into cash is a countable asset unless it is specifically exempt. If the value of total countable assets exceeds the Medicaid eligibility limit, the applicant must spend down these assets to the limit before Medicaid assistance is available. Certain allowances are made for married couples that enable a community spouse to retain countable assets up to a certain limit. (This concept is explained later in the "Spousal Impoverishment Protection" section of this chapter.)

Noncountable (Exempt) Assets

Noncountable assets are *not* counted in determining Medicaid eligibility. Noncountable assets include:

- **primary residence**—A Medicaid LTC applicant's principal home is exempt as long as the equity value in the home is less than $500,000 (or up to $750,000 at the state's option).[23] The exempt value of the primary residence is unlimited if the applicant has certain family members living there, such as:
    - a spouse
    - a child under age 21
    - a blind or permanently disabled child
- **automobile**—One automobile of any value is exempt if it is used by a household member.
- **household belongings**—Includes furniture, appliances, and similar items.
- **personal possessions**—Includes jewelry, clothing, and similar items.
- **burial contracts**—Includes both irrevocable and revocable burial contracts up to state-specific limits (such as $5,500 for an irrevocable contract and $1,500 for a revocable contract). In many states, the value of the burial contract must be reduced by the cash value of any life insurance policies.
- **burial plot**—This exemption is for the applicant and his or her immediate family. It includes the purchase or prepayment of the following items:
    - gravesite
    - opening and closing of a gravesite
    - cremation urn
    - casket
    - outer burial container
    - headstone or marker
- **cash value of life insurance**—The cash value of any life insurance owned is exempt as long as the value of all such policies does not exceed a certain amount. For this purpose, some states define "value" as cash value; other states define "value" as face value. Regardless, the value limit is typically very low, such as $1,500 or $3,000.

The fact that property or assets are exempt or noncountable for purposes of determining Medicaid LTC eligibility does not necessarily protect them in the future. To the extent that any noncountable property is held by the Medicaid recipient at his or her death and is part of his or her estate, Medicaid reserves the right to take from the estate the amount it paid for nursing home or skilled facility care. This is done through a process called **estate recovery**, which is discussed later in this chapter.

Spending Down Assets

For many people, Medicaid may be the only option to pay for the high and sustained costs of long-term care—if not initially, then at some point in the timeline of their ongoing care. In turn, the limit on the value of (countable) assets that a Medicaid recipient can keep—$2,000 to $3,000—often requires individuals to "spend down" their assets to a level that qualifies them for assistance. **Spending down** is the process of depleting private or personal resources in order to become eligible for Medicaid. Many people enter a nursing home or obtain LTC services by initially paying the costs out-of-pocket, and then they apply for Medicaid once they've depleted their resources to the point of meeting eligibility requirements.

Spending down does not have to be limited to spending on care costs or care needs; an individual could spend down by acquiring noncountable assets, for example. What may be problematic is the *transfer* of assets for less than fair market value.

Transfers of Assets

Depending on state rules and the type of care in question, an individual may be disqualified from receiving Medicaid benefits for a certain period if he or she or gives property away (or sells it for less than its full value) to anyone other than a spouse to meet the Medicaid asset limits. The purpose of this rule is to discourage applicants from gifting or transferring property simply to become "poor enough" to qualify for Medicaid.

If an asset is improperly transferred, Medicaid will still count the transferred asset along with the applicant's other assets. When such transfers are added to other countable assets, the total will often exceed the maximum level allowed for Medicaid qualification. The result will be a period of ineligibility—in other words, a waiting period—before Medicaid coverage begins.

Look-Back and Penalty Periods

The transfer rule applies for a specified period before a person applies for Medicaid. This period is known as the **look-back period**. States may "look back" through this period to assess a Medicaid applicant's financial transactions. This look-back period is 60 months. If, during the 60 months before applying for Medicaid, an improper transfer of property was made, it can result in a **penalty period**. The penalty period is the waiting period—the period during which Medicaid will not pay for care.

The length of the penalty period is based on two factors:

- the market value of the property transferred
- the average monthly rate for nursing facility care in the applicant's area

The value of the transferred property is divided by the average monthly nursing facility rate in the applicant's area. The result is the penalty period: the number of months that Medicaid will not pay for care.

Example

For example, suppose Lonny transferred his $30,000 investment holdings to his son, Jake, on March 1, 2020. On August 1 of that year, Lonny enters a nursing home and applies for Medicaid. The state will look back 60 months from the date Lonny entered the nursing home and applied for Medicaid and will bring into its asset assessment all transfers Lonny made during this time—from July 31, 2015, through August 1, 2020. The $30,000 transfer to his son will be included in Lonny's asset assessment. If the average monthly rate for nursing facility care in Lonny's area is $6,000, Medicaid payments for Lonny's care will be withheld for five months ($30,000 ÷ $6,000). The effect is that Lonny will have to pay out of pocket toward the cost of his care an amount equal to the value of the asset he transferred.

When the Penalty Period Begins

Before the Deficit Reduction Act of 2005 (DRA) was passed, the look-back period was 36 months, beginning the month the transfer was made. In addition to increasing the look-back period to 60 months, DRA also changed when the penalty period begins. Before, the penalty period began when the transfer was made; it now begins *when the individual enters a nursing home* and otherwise meets Medicaid's eligibility requirements.

Certain transfers are allowed and will not be penalized. These include:

- transfers to a spouse
- transfers to a third party for the benefit of the spouse
- transfers to disabled individuals

Transfer of a Home

No transfer penalty applies if a recipient transfers a home to any of the following individuals:

- a spouse living in the home (A transfer penalty applies when the community-based spouse transfers the home without full compensation.)
- a child or children under age 21
- a child or children over age 21 living in the home for at least two years before the applicant's institutionalization and who provided care to delay institutionalization
- a child or children of any age who meet the SSI rule for disability or blindness

Spousal Impoverishment Protection

At one time, turning to Medicaid meant impoverishing not only the spouse going to a nursing home, but also the community spouse who remained at home. The at-home spouse was left in financial distress. In 1997, Congress saw the senselessness of creating welfare-dependent spouses and changed the law. Now ways exist to preserve assets for a community spouse while Medicaid pays for care for an institutionalized spouse. These changes in the law permit the at-home spouse to retain specified levels of assets and income. The rules are designed to ensure that married nursing home residents make significant contributions toward the cost of their own care while ensuring that community spouses are not impoverished.

Background

Before 1989, Medicaid's restrictive eligibility rules imposed considerable hardships on married couples. When one spouse required nursing home care, nearly all of the couple's assets—whether held jointly or individually—were considered available to pay for care, as was the institutionalized spouse's income. Although income could be transferred to the community spouse, states usually set the protected income amount significantly below the federal poverty level.

Today, states have leeway to set income and asset eligibility levels within federally determined floors and ceilings adjusted annually for inflation. In addition, though protection was originally aimed at spouses of institutionalized Medicaid recipients, states were given the option of extending spousal impoverishment protections to people receiving long-term care in the community.

Spousal Rules for Income

Rather than requiring a couple to reduce their joint income to the poverty level, federal law permits the community spouse to maintain a higher income for support. This is called a **monthly maintenance needs allowance (MMNA)**. In 2020, for example, states had to allow a community spouse to keep at least $2,114 (rounded) in monthly income, or up to a maximum of $3,216 at the state's option—essentially, between 200 and 300 percent of the federal poverty level.[24] Any income the community spouse receives in his or her *own* name—Social Security, pension, or dividend income, for example—may be retained fully by the community spouse. No portion of the community spouse's own income is required to be assigned to Medicaid or diverted to cover the cost of care for the institutionalized spouse.

As a result, the community spouse's income could exceed the allowed minimum. If, however, the minimum allowance cannot be met by the community spouse's income alone, the state must allow the institutionalized spouse to transfer income to the community spouse to close the gap. This situation may occur, for example, when a breadwinner husband is the institutionalized spouse and a homemaker wife is the community spouse. In such cases, income that is paid to the institutionalized spouse (such as Social Security and pension income, for example) may be transferred to and retained by the community spouse.

Example

For example, assume that Gerald and Lila are a senior couple, living on Gerald's monthly $500 pension and $1,700 Social Security benefit, and Lila's $900 monthly Social Security benefit. Gerald's health has declined severely, and the couple turns to Medicaid for long-term care assistance. The couple resides in a state where the MMNA for a community spouse is $2,114. Because Lila's own income ($900) is less than the MMNA, she will be able to retain $1,214 of Gerald's monthly income to bring her income up to the MMNA amount. Almost all of Gerald's remaining income will be directed to paying for his LTC needs.

In addition, the income allowance can be increased in cases of severe hardship. The allowance is also increased by one-third for every minor or adult dependent child and some other dependents who live with the community spouse.

Spousal Rules for Assets

Community spouses can retain half or more of the couple's combined assets, subject to state and federal minimum and maximum limits. All states must allow the community spouse to keep all countable assets up to a certain minimum ($25,728 in 2020) and up to half of assets if they exceed this limit, up to a maximum amount ($128,640 in 2020). A few states allow the community spouse to keep up to this full maximum amount regardless of whether it is more than half of a couple's combined countable assets.

Medicaid Estate Recovery

Medicaid's rules regarding assets may extend after one's death. With the passage of the **Omnibus Budget Reconciliation Act of 1993 (OBRA '93)**, Congress determined that when a person received Medicaid benefits and owned assets at the time of his or her death, the state must assess whether it can recover from the deceased's estate any assets to cover the Medicaid benefits paid. This is known as the **Medicaid Estate Recovery Program.**

At a minimum, states must seek recovery for Medicaid-covered services provided to a person of any age in a nursing facility, intermediate care facility for the mentally challenged, or other medical institution. The state may, at its option, recover up to the total amount spent on the individual's behalf for other medical assistance services. For individuals age 55 or older, states are required to seek recovery of payments for nursing facility services, home and community-based services, and related hospital and prescription drug services. States have the option to seek recovery for all other Medicaid services provided.

Estate Recovery Rules and Procedures

Estate recovery procedures are not initiated until after the Medicaid recipient's death. If the Medicaid recipient was 55 years old or older at the time of death and received Medicaid benefits on or after October 1, 1993, the state may initiate a recovery claim. Only Medicaid benefits received on or after this date may be included in the state's claim.

Assets subject to recovery include both real and personal property. **Real property** includes homes and land. **Personal property** includes vehicles, furniture, bank accounts, and similar assets. The state may claim a portion of personal property owned jointly with another person.

Recovery of assets from an estate may be made:

- after the death of an unmarried Medicaid recipient
- after the death of the surviving spouse
- when the Medicaid recipient has no surviving child under age 21
- when the Medicaid recipient has no surviving child of any age who is blind or totally disabled

Hardship

In cases where asset recovery from an estate would create an undue hardship, the right to immediate recovery may be waived by the state. Undue hardship is typically based on the following factors:

- whether the asset has been the primary residence of the person claiming the hardship
- whether the surviving family member used his or her own money to maintain the property or pay the taxes
- whether the surviving family member lived in the property and provided a level of care delaying the deceased's entry into a nursing facility
- whether the surviving family member had a contractual relationship with the deceased in which the residence was held as security
- whether the surviving family member is a resident and co-owner of the property
- whether the property produces income and provides funds for the surviving family member necessary for support

Summary

- Many of our nation's elderly find themselves in need of long-term care services. Most are without LTC insurance or the personal financial resources to even begin to cover long-term care's extraordinary costs.
- Some may rely initially on unpaid help from family and friends. However, in most cases, this type of voluntary care is eventually depleted and is no longer deliverable by emotionally drained or financially exhausted friends and relatives.
- With respect to long-term care, Medicaid is the payor of last resort. However, Medicaid does not automatically pay for LTC services for everyone. It is intended to assist low-income individuals, and those who apply to Medicaid must meet strict financial and functional eligibility criteria to qualify.
- Upon the death of a Medicaid recipient, states are required to seek recovery of the amount expended on the deceased's care through his or her estate.

Chapter 4 Review Questions

1. Medicaid is available to pay for LTC expenses for anyone without private LTC insurance.
    A. True
    B. False
2. The federal government:
    A. has no role in state-run Medicaid programs
    B. tells states how much they can pay for LTC services and supplies
    C. gives states flexibility in administering their Medicaid programs
    D. shares equally in Medicaid expenses with each state
3. A burial plot is exempt when determining Medicaid eligibility.
    A. True
    B. False
4. Under current Medicaid rules, what is the look-back period for the transfer of assets?
    A. 12 months
    B. 24 months
    C. 36 months
    D. 60 months
5. Of the factors below, which does a state review to determine a person's eligibility for Medicaid?
    I. assets
    II. income
    III. transfers of assets
    A. I only
    B. I and II only
    C. II and III only
    D. I, II, and III
6. How much of a community spouse's own income must be spent on care for an institutionalized spouse who is receiving Medicaid assistance?
    A. all of it
    B. 50 percent
    C. 25 percent
    D. none of it

7. The process by which a state seeks repayment for Medicaid benefits after a Medicaid recipient dies is known as _____.

    A. spend-down

    B. asset freeze

    C. waiver

    D. estate recovery

Answers to Chapter 4 Review Questions

1. B. Medicaid is limited to those with low incomes or those who incur catastrophic medical expenditures.
2. C. States have flexibility to design and implement their own programs, but funding is not shared equally by the federal and state governments. Annually, a determination is made comparing states' average per capita income to the national average. States with higher per capita incomes receive less federal funding; states with lower per capita incomes receive more federal funding.
3. A. The burial plot exemption is available for the applicant and immediate family members.
4. D. For purposes of determining Medicaid eligibility, the look-back period is 60 months. This period was extended from 36 months to 60 months under the Deficit Reduction Act of 2005.
5. D. Primary factors that are used to determine Medicaid eligibility are exempt and nonexempt assets, level of income, and the proper or improper transfer of assets.
6. D. None of the income that a community spouse receives in his or her name, such as wages or Social Security or a pension, must be diverted to the cost of care for the institutionalized spouse.
7. D. When a person who received Medicaid benefits owns assets at the time of his or her death, the state must assess whether it can recover from the deceased’s estate any assets to cover the Medicaid benefits paid. This is known as the Medicaid Estate Recovery Program.

Chapter 5
Long-Term Care Insurance

Overview

When considering the purchase of an insurance policy—a homeowner's fire policy or an auto policy, for example—the purchaser is likely assuming that the insured risk will never occur. The policy is, simply, assurance against a risk that is not expected to materialize. To appreciate this, consider how seldom we hear of a house fire compared to the hundreds of homes we see in a day or how infrequently we are involved in an auto accident, considering the thousands of hours we spend in our vehicles. Even so, homeowners and auto insurance policies are very common.

Long-term care risks are different. The insurer and the insured operate under a much different set of statistics. More than half of the U.S. population will require some type of long-term care during their lives—nursing home care, home health care, assisted living, or rehabilitative facility care. The risk of needing long-term health care is not remote; it is a 50/50 proposition.

Chapter Objectives

Upon completion of this chapter, you should be able to:

- identify those who are candidates for long-term care insurance (LTCI)
- describe the LTCI policies found in the market today
- know the distinction between comprehensive and noncomprehensive policies
- compare individual and group LTCI policies
- understand the tax treatment given to LTCI policies

A Brief History of Long-Term Care Insurance

The U.S. government began to fund nursing home benefits on a sizeable scale in the 1960s under the Medicare program. Government funding generated extensive nursing home construction. As a result, it did not take long for providers to take advantage of these federal funding resources, and soon, reimbursement rates had to be capped and other restrictions put in place. Then the quality of care began to decline, and nursing homes were further pressed by mandated higher care standards.

In the 1970s, insurance companies began touting the potential of long-term care insurance, mostly because federal law did not allow Medicare to pay for long-term care nor did it intend for Medicaid to pay long-term care bills, except for those of the very poor. When the first private long-term care insurance policies were offered, they were primarily nursing home-only policies and were designed to pay benefits when Medicare benefits were exhausted. These were not the full benefit policies we see today.

Subsequent Generation Policies

The next generation of LTCI policies came about in the mid- to late 1980s. These policies recognized the need for home health care benefits, not just nursing home coverage. However, these policies were laden with requirements designed to preclude the payment of benefits. For example, many policies stipulated that benefits would be available only after a three-day hospital stay. The original policies were very expensive, and they included only limited benefits for home care, so riders were used to provide the home health care reimbursement.

The early 1990s saw integrated, comprehensive LTCI policies that cover a full range of benefits, including home health care, adult day care, assisted living, and skilled nursing care. Under these policies, insureds were able to choose where to receive their care and how to use their policy benefits.

The latest design of comprehensive LTCI policies offers care outside of the United States, coverage for family members on the same policy, and policies that can be paid up after a specified number of years. Today’s LTCI policies include more benefits, options, and types of care than ever before.

What Is Long-Term Care Insurance?

Unlike traditional health insurance, **long-term care insurance** covers the cost of medical and personal care support services, including custodial care. Technically, the definition provided by the NAIC is:

> . . . any insurance policy or rider designed to provide coverage for not less than 12 consecutive months . . . for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services, provided in a setting other than an acute care unit of a hospital . . . [and] a policy or rider that provides payment for benefits based upon cognitive impairment or the loss of functional capacity.

In more practical terms, long-term care insurance typically provides for:

- help in the home with personal activities like bathing, dressing, eating, and the other activities of daily living (ADLs)
- homemaker assistance services, such as cleaning and bill paying
- visiting nurses
- community programs, such as adult day care
- assisted living services, typically including meals, health monitoring, and help with daily activities that are provided in special residential settings other than at home
- skilled nursing care

Who Is a Candidate for Long-Term Care Insurance?

Long-term care insurance can help protect individuals, their families, and their assets against the potentially catastrophic cost of extended long-term care by providing the funds to meet LTC expenses when the time comes. However, long-term care insurance is not for everyone. It usually makes sense only for those who would not be able to fully (or comfortably) self-fund the cost of extended care, but have significant assets to protect. It is probably not appropriate for those on fixed or low incomes or those who have trouble stretching their money to pay for utilities, food, and medicine. People who have only modest levels of assets may have no choice but to spend down to qualify for Medicaid, although state LTC partnership programs promise some relief in this regard. (A later chapter describes LTC partnerships in more detail.)

Cost of Long-Term Care Insurance

For many people, LTC coverage is very expensive. In some cases, insureds pare down the coverage to obtain a policy they can afford and then later discover their benefits are not adequate to pay any meaningful portion of their care. Also, because LTC premiums are based partly on age and health, it is more expensive to buy an LTCI policy when the applicant is older and/or in poor health. This means the cost might simply be prohibitive for some people.

Only an educated consumer, typically with the help of a trusted financial advisor, can determine whether personal assets, income, family situation, and personal risk factors justify the expense of LTCI coverage. As a general guideline, the following factors indicate individuals who should consider purchasing long-term care insurance:

- those who have assets they want to protect
- those who are not (or likely would not be) eligible for Medicaid
- those who are in reasonably good health and would qualify for coverage
- those who express concern about the possibility of needing long-term care
- those who can afford the coverage

With regard to affordability, the industry guideline is that premiums should be no more than 5 to 7 percent of one's annual income. The NAIC notes that some experts recommend consumers spend no more than 5 percent of their income on a long-term care policy. Premiums that amount to more than 7 percent of annual income may not be sustainable.[25]

Today's Long-Term Care Policies

Insureds have a variety of options when choosing a long-term care insurance policy. Among these options are the following:

- individual policies
- group policies
- partnership policies that link LTCI and Medicaid
- products that combine LTCI with life insurance or an annuity

In addition, a buyer has a number of ways in which coverage can be customized to meet his or her needs and budget. Among these options, a buyer can choose the following:

- the care settings and services that are covered (nursing home only, home health care only, or both)
- the daily or monthly benefit amount the policy will pay for services in each care setting covered by the policy
- the length and definition of the elimination period and/or deductible, if any, before benefit payments will begin
- the duration of benefit payments over the life of the policy
- inflation protection
- nonforfeiture protections

Instead of requiring a doctor's certification for treatment, most policies today pay benefits if a social worker, physical therapist, or other health care professional demonstrates that the insured needs help with two or three ADLs. While the benefits and features of LTCI have become more complex, they have also become more practical in meeting consumers' needs. As the demand for long-term care insurance increases, the variety and types of policies will also expand.

With that in mind, let's consider some of the primary features and aspects of LTCI policies and how they are designed. In the next chapter, we will examine more closely specific contract provisions and options.

Policy Coverage

Today's LTCI coverage has broadened to include almost any condition. Earlier generations of policies typically covered care only in nursing homes; today, coverage can extend to care delivered across the LTC continuum. Benefits begin after an elimination period and continue until the death of the insured or until policy limits have been exhausted. A typical LTCI policy will offer benefits for some combination of nursing home care, assisted living, and home and community care. Insureds can choose from the following:

- **a comprehensive policy**—A policy that provides benefits for services at all levels in virtually all settings: skilled nursing facilities, assisted living facilities, adult day care centers, and home care.
- **a noncomprehensive policy**—A policy that restricts coverage to either nursing homes and other care facilities or home care. That is, a noncomprehensive policy covers care in *either* an institutional setting *or* in the patient's home, but not both.
    - **facility-only policy**—Nursing facility-only and residential care facility-only policies cover skilled, intermediate, or custodial care in nursing homes, assisted living facilities, residential care facilities, and other institutional settings. These policies do not cover care that takes place in the home. Facility-only policies usually pay a daily or monthly benefit.
    - **home care-only policy**—A home care-only policy provides benefits only for home care (personal care, homemaker services, hospice services, and respite care) and some community-based care, such as adult day care, depending on the requirements in the state where the policy is sold. However, care in a facility is *not* covered. Home care-only policies pay for skilled nursing care in the patient's residence, but only if the care is furnished by certain providers, such as registered nurses, licensed practical nurses, and licensed therapists. Some policies pay for the services of home health aides and homemaker services; others do not. Policy language will dictate which provider's services are covered. Because of the potential for fraud and the difficulty in monitoring benefits, many LTCI policies will not pay benefits to family members who perform home care services.

When Benefits Are Paid

Benefits under an LTCI policy are paid when the insured provides proof of loss. **Proof of loss** is generally a medically documented inability to independently perform at least two defined activities of daily living (as specified in the policy). Proof of loss can also be a medical certification that the insured has a significant cognitive impairment, which means a deterioration of intellectual capacity for judgment, memory, or orientation.

As a general rule, today's policies impose a single requirement or threshold for the payment of all benefits—in other words, to qualify for benefits under the policy, the insured must have either an ADL deficiency *or* a cognitive impairment. In either case, the policy pays its full benefit. For nursing home benefits, some policies may pay greater benefits for a higher degree of loss—for example, the insured is unable to perform three of six ADLs.

How Benefit Amounts Are Defined

LTCI benefits are usually defined in the contract to be a maximum amount of money payable per day or per month and for a maximum number of years. However, if the claimant uses less than the maximum amount of benefits permissible in a given period, as a rule, the unused excess lengthens the maximum number of years benefits are payable. This is known as the **pool of money clause** found in most policies.

Policies may pay different amounts per day or per month for care in a particular setting, such as a nursing home or assisted living facility. Some pay out a fixed daily amount as reimbursement for the cost of care up to a daily or monthly maximum. Others do not specify daily or monthly limits; instead, they only specify policy limits. Comprehensive policies—those that provide coverage in all types of settings—may define one set of policy limits for home and assisted living care and another for care in skilled nursing facilities.

Inflation Protection

Because most claims do not occur until many years after the purchase of the product, a very important aspect of an LTCI program is **inflation protection**. As noted earlier, in 10, 15, or 20 years, the daily cost of skilled nursing home care may be two or three times what it is today. Virtually all LTC insurers offer either a **guaranteed purchase option**, which allows policyholders to periodically buy additional coverage, or an **annual benefit inflation option**, which automatically increases a policy's benefits every year on a compound or simple interest basis.

Premiums and Premium Increases

Premiums for long-term care insurance are based on the insured's age at the time of issue. As a general rule, the younger the insured is at the time of application, the lower the policy's premium. In addition, LTCI premium rates are set so that the same rate applies over long periods. This is in keeping with the concept that LTCI is designed to be maintained for the long-term. It is not priced or subject to renewal annually.

Almost all states require that LTCI policies be issued as **guaranteed renewable**. For the insured, this means three things:

- The policy must be renewed as long as premiums are paid.
- The policy cannot be canceled or nonrenewed because of the insured's age or health.
- Premiums cannot be increased, except on a class basis.

Consequently, while it is true that individuals cannot be singled out for an increase because of their age or health, insurers can increase premiums for entire classes of insureds, such as all policyholders age 75 and older, based on the company's claims experience. Of course, insurers must justify premium increases to state insurance departments, but states have limited authority to deny those increases, especially when claims experience supports requests for rate increases.

Rate Stability Requirements

Some of the earlier generations of LTCI policies were not priced adequately, the result of poor underwriting, overly optimistic interest rate assumptions, and unanticipated lapse rates. Consequently, a number of LTC insurers were forced to raise their premium rates significantly. The current National Association of Insurance Commissioners **rate stability requirements** are expected to reduce future premium increases. Among these rate stability requirements are certain consumer protections that insurers must provide in the event that premiums increase by a certain amount. (These protections take the form of "contingent benefits" and are explained in the next chapter.) In addition, the requirements mandate the following:

- standards for insurers' loss ratios (the share of premium an insurer is expected to pay in claims over the life of the policy for all of its policyowners)
- certification from the insurer's actuary that initial premiums are reasonable
- regulatory review and approval of initial premium rates by state insurance commissions
- required disclosure to consumers of insurers' previous rate histories

These requirements will apply only to new LTCI policies sold after a state has adopted the NAIC provisions.

Average Annual Premiums

The following chart provides average annual LTCI premiums for policies purchased at various ages and for different benefit periods, with and without automatic (5 percent compounded) inflation protection. It assumes a $200 daily benefit amount and a 20-day elimination period:

Age at Purchase	**With Inflation Protection (5% Compounded Annually)**		
	4 Years of Benefits	***6 Years of Benefits***	***Lifetime Benefits***
50	$4,349	$5,083	$7,347
60	$5,331	$6,269	$8,927
70	$9,206	$10,549	$15,070
75	$13,500	$15,157	$20,930
Age at Purchase	**No Inflation Protection (Benefit Remains at $200/Day)**		
50	$1,294	$1,514	$1,997
60	$2,057	$2,426	$3,307
70	$4,914	$5,834	$7,777
75	$8,146	$8,291	$12,337
A Shopper's Guide to Long-Term Care Insurance, NAIC			

Underwriting

LTCI is underwritten in a way unlike life and health policies. When deciding whether to issue a life or health policy, insurers consider factors such as current age, physical health, health history, lifestyle, occupation, and avocations. LTCI goes a step further and considers *functional ability* and *cognitive health.* Therefore, prospective purchasers should expect not only the customary medical questionnaire but also a professional assessment of their mental faculties. Because memory loss, cognitive impairment, and dementia are major contributors to nursing home admissions and LTCI claims, these conditions are causes of concern for underwriters. The underwriting intent is to screen out applicants who are:

- currently at risk of requiring long-term care
- cognitively impaired and/or
- already experiencing ADL deficiencies

Tools that insurers use to assess LTCI applicants and to determine their insurability include the application, medical records, phone history interviews, and face-to-face assessments conducted by trained nurses or paramedics.

Some LTCI carriers offer more favorable policy pricing for married couples over singles, because married couples tend to have better claims experience.

When to Purchase Long-Term Care Insurance

Because premiums tend to increase dramatically by issue age, deciding when to purchase LTCI is an important consideration. When we are young and healthy, it does not occur to most of us to think about our health in the years or decades to come. It seems even more difficult to imagine a serious illness or injury that could necessitate long-term care. However, when we are strong and well is the time to consider purchasing long-term care insurance. The typical purchaser of LTCI is between 55 and 60, and the average issue age has been declining in recent years. Many companies target buyers as young as 40.

Because premium costs increase based on a person's age at issue, the younger the applicant is when purchasing the policy, the lower the premium will be over the life of the plan. Premiums generally remain the same each year, except when insurers increase rates for an entire class of insureds. Consequently, experts recommend that individuals start thinking about LTC much sooner than they need it.

Individual vs. Group Long-Term Care Insurance

LTCI policies can be issued on either an individual or group basis. Group LTCI is becoming more and more popular as more employers add it to their menus of employee benefits.

Individual Long-Term Care Insurance

An **individual LTCI policy** is a contract between the insurer and the individual policyowner. Underwriting takes place on an individual basis, and policies are usually issued on a preferred, standard, or substandard basis based on the insured's physical and mental health condition. With some insurers, the insured's risk classification determines the premium charged; a nonstandard or substandard rating, for example, may require the payment of a higher premium (or reduced coverage). With other insurers, an applicant's health condition simply determines whether a policy will be issued.

As noted earlier, most individual LTCI policies are guaranteed renewable and cannot be canceled by the insurance company unless the premium is not paid on time. However, every company has the right to increase the premiums it charges to an entire class of insureds with proper notification and approval from the state in which it operates.

Group Long-Term Care Insurance

A **group LTCI policy** is a contract between an insurer and a group sponsor, such as a professional association on behalf of its members, or an employer on behalf of its employees. Members in a group plan do not receive insurance policies. Rather, they receive certificates of insurance. The group's sponsor is the contract owner and holds the master plan.

Employers may be able to obtain LTCI coverage at group rates that are less than individual rates. However, unlike group life or health insurance, premium rates for group LTC coverage may not be much lower than rates an individual would pay for an individual policy. Some employers contribute toward the cost of the coverage, and some even pay the full cost. At other companies—most, in fact—employees covered under the group plan pay all of the costs. Most group LTCI policies usually limit the number of benefit choices. For example, employees may be allowed to select two to four benefit amount options rather than every available option. Group policies usually offer less restrictive underwriting or even guarantee coverage, especially during initial offerings. Experts advise that younger, healthier individuals may be better off with individual policies, whereas those who have health issues and would be declined or rated for an individual policy may benefit by enrolling in a group plan.

Tax Treatment of Long-Term Care Insurance

Long-term care insurance policies are either tax qualified or non-tax qualified. Most policies issued today are tax qualified. **Tax qualified** means that they conform to the 1996 Health Insurance Portability and Accountability Act (HIPAA) and to IRS rules.

HIPAA declared that qualified long-term care insurance must receive the same tax treatment as accident and health insurance. LTCI policies issued before January 1, 1997, automatically qualify. They are grandfathered and treated as qualified as long as they were approved by the insurance commissioner of the state in which they were sold. Policies issued on or after January 1, 1997, must meet federal standards to be considered tax qualified.

Requirements for Tax Qualified Status

To be tax qualified, a policy issued on or after January 1, 1997, must adhere to the following requirements:

- The policy can pay benefits only for *qualified* LTC services. Qualified services are defined as necessary diagnostic, preventative, therapeutic, treating, mitigating, and rehabilitative services and personal care and maintenance services that are required by a chronically ill individual.
- The services must be provided pursuant to a plan of care prescribed by a licensed health care practitioner.
- The policy must offer buyers the options of inflation and nonforfeiture protection, although the buyer can choose not to purchase these features.
- The policy must provide that both activities of daily living (ADLs) and cognitive impairment are benefit triggers. It cannot stipulate a medical necessity trigger. (Recall that triggers are conditions that must be present for benefits to begin.)
    - Under an ADL trigger, the policy must pay benefits when the insured is unable to perform at least ***two of six specified ADLs*** and when a licensed health practitioner has certified that the need for ADL assistance is reasonably expected to continue for at least ***90 days***. HIPAA standardized the ADLs that are to be specified in a qualified policy (bathing, dressing, toileting, transferring, continence, and eating).
    - Under a cognitive impairment trigger, coverage begins when the individual has been certified as requiring substantial supervision to protect him or her from threats to health and safety.

- The policy must be issued as guaranteed renewable or noncancelable.
- The policy must include a third-party notification or other measure for lapse protection.

These provisions are discussed in more detail in the next chapter and in Chapter 8.

Qualified Long-Term Care Policies Receive Favorable Tax Treatment

Congress has clarified the tax treatment of LTC insurance and, for policyowners who itemize, allows a limited tax deduction for premiums. A tax-qualified LTCI policy offers favorable tax treatment for premiums paid, out-of-pocket expenses, and benefit payments. A non-tax-qualified policy does not provide for the same favorable tax treatment—its premiums do not qualify for a tax deduction. (Whether nonqualified policy benefits will be deemed as taxable income is uncertain, because the IRS has not yet ruled on this issue.)

Taxation of Qualified Premiums and Out-of-Pocket Expenses

Premiums paid for qualified LTCI policies and out-of-pocket expenses for long-term care are tax deductible as medical expenses to the extent that the taxpayer's total (unreimbursed) qualified medical expenses exceed 7.5 percent of his or her annual adjusted gross income (AGI).[26]

Example

For example, say 59-year-old Hal's adjusted gross income this year was $50,000, and he incurred $7,000 in qualifying (nonreimbursed) medical expenses. Hal would be allowed to deduct up to $3,250 of those costs from his taxes:

Adjusted gross income	$50,000
7.5 percent of AGI threshold	$3,750
Qualifying (unreimbursed) medical expenses	$7,000
Excess of medical expenses over threshold ($7,000 – $3,750)	$3,250

(The 7.5 percent AGI floor for medical expense deductions was reinstated with the SECURE Act, passed in late 2019.)

However, the deductibility of qualified LTCI premiums is limited by the age of the taxpayer (as of the end of the year), and these limits are adjusted annually for inflation. The following chart shows the amount of LTCI premiums that could have been included as an allowable deductible medical expense in 2019 and 2020:

Tax Deductibility of Long-Term Care Insurance Premiums		
Age attained before the end of the taxable year	**Premium amount allowed as a qualified medical expense**	
	2020	**2019**
40 or under	$430	$420
41 to 50	$810	$790
51 to 60	$1,630	$1,580
61 to 70	$4,350	$4,220
71 or older	$5,430	$5,270

Taxation of Qualified Benefit Payments

Benefits from qualified LTCI reimbursement policies (those that pay for the actual services a beneficiary receives) are not included in income. Benefits from per diem or indemnity policies (those that pay a predetermined amount each day or month regardless of the actual cost) are not included in income except to the extent that they exceed the beneficiary's total qualified LTC expenses or $380 per day (as of 2020), whichever is greater. For those who receive benefits under a long-term care policy, insurers are required to issue a 1099-LTC Form that reports payments made during the tax year.

Again, the taxation of benefits paid under a *nonqualified* LTC insurance policy is not clear. To date, the IRS has not treated such payments as income and has not subjected them to taxation.

Taxation of Qualified Policies Owned by the Self-Employed

For those who are self-employed, the tax treatment of long-term care insurance is even more favorable. Sole proprietors, partners, and limited liability company (LLC) owners can deduct all of the premiums for their qualified LTCI policies subject to the age-based limits described earlier. This deduction is available regardless of whether the taxpayer itemizes deductions. Remember, however, that premium costs for nonqualified policies are not deductible.

Taxation of Group Policies

With respect to group LTCI policies, employers are generally able to deduct as a business expense both the cost of setting up an LTCI plan for their employees and any contributions that the employers make toward paying for employee premiums. Employer contributions to the plan on behalf of employees are not included in the employees' income for tax purposes.

As is typical of any issue that is tax-related, the field is very complex. A tax advisor should be consulted to learn more about the tax implications of LTCI.

Summary

- Health insurance policies do not cover long-term care, nor does Medicare.
- Medicaid will pay for LTC services only when savings and assets have been spent down to very low levels to qualify.
- Long-term care insurance, although not for everyone, is a practical solution for many as a way to meet LTC expenses.
- Those who have significant assets to protect are usually best served by long-term care insurance. Insureds are offered a wide range of options when choosing policies—our next chapter focuses on the choices available in today's LTCI policies.

Chapter 5 Review Questions

1. Long-term care insurance policies are easy to compare and contrast.
    A. True
    B. False
2. An insurance company can increase the premiums on its LTCI policies after policy inception if the insured's health declines.
    A. True
    B. False
3. Group LTCI policies are contracts between the insurance company and each individual member of the group.
    A. True
    B. False
4. All of the following may deduct the full cost of their qualified LTCI premiums, subject to the age-based limits, EXCEPT:
    A. sole proprietors
    B. members of a partnership
    C. employees whose premiums are paid by their employers
    D. LLC owners
5. Most LTC insurance policies are issued as guaranteed renewable. As such, which statement is true?
    A. Policy premiums cannot be increased for any reason.
    B. The insurer must renew the policy as long as premiums are paid.
    C. The insurer must renew the policy as long as the insured continues to be insurable.
    D. Premiums can be increased selectively for individual policies, based on the insured's health.
6. In order for a long-term care insured to qualify for the payment of all benefits under the policy, he or she must be diagnosed with both an ADL deficiency and a cognitive impairment.
    A. True
    B. False

Answers to Chapter 5 Review Questions

1. B. Although some standardization of policies has occurred, especially with respect to state LTC partnership policies, the ability of consumers to compare among LTCI policies is hindered by the complexity of the product.
2. B. However, while companies cannot increase premiums because of individual circumstances such as age or health, they can increase premiums for an entire class of insureds.
3. B. Group long-term care insurance is a contract between an insurer and a group sponsor, such as an employer on behalf of its employees. Members in a group plan do not receive insurance policies; they receive certificates of insurance as evidence of their coverage.
4. C. Sole proprietors, partners, and LLC owners can deduct all of the premiums for their qualified LTCI policies, subject to the age-based limits. Employees who are insured under a group plan and whose premiums are paid by the employer cannot deduct the premiums; however, the premiums paid on their behalf are not included in their incomes.
5. B. For the insured, a policy that is issued as guaranteed renewable means 1) the policy must be renewed as long as premiums are paid 2) the policy cannot be canceled or nonrenewed because of the insured's age or health and 3) premiums cannot be increased, except on a class basis.
6. B. As a general rule, today's LTC policies impose a single requirement or threshold for the payment of all benefits: the insured must have either an ADL deficiency or a cognitive impairment.

Chapter 6
LTC Insurance Policy Designs and Options

Overview

Policies covering long-term care services are a relatively new form of insurance. As yet, these policies are not standardized. While many states have established minimum standards for LTCI policies, coverage and premiums can vary significantly from policy to policy.

In this chapter, we will discuss policy design and the many benefits, options, and features found in most long-term care policies. Some aspects of coverage are found in all policies, while other features and benefits can be added with an additional premium.

Chapter Objectives

Upon completion of this chapter, you should be able to:

- identify the methods of qualifying for LTCI benefits
- understand benefit triggers
- explain LTCI policy benefit amounts, benefit periods, and elimination periods
- describe the many features and benefits of LTCI policies and the options available
- explain the policy exclusions for LTCI coverage

Qualifying for Benefits

Normally, there are two methods of qualifying for benefits under LTCI policies:

- **physical or functional impairment**—People who are physically or functionally impaired need assistance with the activities of daily living. Non-tax-qualified policies may differ in the number of activities of daily living (ADLs) with which a person requires assistance before qualifying for benefits. Tax-qualified policies can specify assistance is necessary with no more than two ADLs.
- **cognitive impairment**—Policies define cognitive impairment differently, but the term generally means a deterioration of intellectual capacity affecting judgment, memory, or orientation. People who are cognitively impaired may have Alzheimer's disease, Parkinson's disease, brain damage, or dementia. Others may have suffered a stroke or head injury. Of course, there are varying degrees of cognitive impairment.

Specifying the Impairment: Benefit Triggers

Benefit triggers are eligibility prerequisites that must occur before a policy's benefits begin. For example, when cognitive impairment prompts the need for care or when the insured is physically impaired and needs assistance with the stated number of ADLs as set forth in the policy, this is said to "trigger" benefits.

Most policies stipulate that the insured must require help with at least two of the listed ADLs before being entitled to receive benefits. Listed ADLs are commonly bathing, eating, toileting, dressing, maintaining continence, and transferring. Virtually all LTCI policies qualify the insured for benefits for a cognitive impairment immediately upon diagnosis.

Claiming Benefits

The process of claiming benefits under a long-term care policy usually begins with a call to the insurer's claims department and the completion and submission of the necessary claims forms. As part of the process, the insured may have to authorize access by the insurer to the insured's medical records. The insured may also be required to submit a plan of care as prescribed by a physician or other health care practitioner. The insurer will gather the necessary information to verify that the insured has met the policy's benefit trigger. The review and evaluation process may take a number of weeks, but if the claim is approved, benefits are usually paid retroactively to the date the insured became eligible.

If a claim is denied, the insured is entitled to know the reason. Common reasons for denial of LTCI claims include the following:

- The insured's condition does not meet the policy's definition of ADL or cognitive deficiency.
- The policy does not cover the service or care delivered.
- The claim amount exceeds the policy's benefit amount.
- The elimination period was not satisfied.
- Services delivered are covered under another LTC or health insurance policy.

If a claim is approved, the insured is usually given the option of receiving benefits directly or having them assigned and paid to the care provider.

The Gatekeeper

An important factor in receiving a policy's benefits is the determination of whether the insured qualifies for or is in need of LTC services. The person or entity in this position is often called a **gatekeeper**. Most policies require a licensed health care practitioner to write a plan of care for benefits to begin. Some insurance companies provide a case manager to determine if the insured qualifies for or continues to qualify for benefits.

Long-Term Care Policy Design

As mentioned earlier, there are no "standard" LTCI policies or "standardized" LTCI plans. Other than having to meet a state's minimum requirements, insurers have a great deal of freedom in designing their products. Consequently, policies can vary considerably in the scope of coverage, in the level of benefits, and in cost. (Note that policies that are tax-qualified and policies that are sold in conjunction with an LTC partnership program *do* have to meet certain design standards. These will be discussed in detail later in the course.)

The particular provisions of any specific policy may also be defined to a large degree by the policyowner, within the parameters the insurer allows. To this extent—the degree to which the owner can select the scope and level of coverage, the benefit amounts, or the length of the elimination period— he or she can also affect the policy's premium. As one might imagine, the greater the benefits and the more comprehensive the coverage, the higher the premium.

Comprehensive vs. Noncomprehensive Policies

The design of an LTCI policy first takes into consideration whether the plan is comprehensive or noncomprehensive. As noted earlier, a **comprehensive plan** is one that covers care at home, in adult day care centers, in assisted living facilities, in nursing homes, and at other institutional sites; a **noncomprehensive plan** may be either a facility-only policy or a home care-only policy.

An LTCI applicant must decide which type of policy is more appropriate for his or her needs. Comprehensive plans are generally much more expensive than noncomprehensive plans.

Indemnity vs. Reimbursement Policies

Long-term care policies are designed as either indemnity or reimbursement plans. **Indemnity policies** pay a specific dollar amount for each day, week, or month spent in a nursing facility or for each home health or home care visit. Some of these policies pay the benefit amount regardless of the charges. **Reimbursement policies**, on the other hand, pay for the actual cost of services received up to the specified benefit amount.

Benefit Amount

LTC benefits are usually referred to in terms of the amount the insurer will pay per day, per week, or per month for LTC services rendered. This amount is called the **benefit amount**. The insured selects the amount that he or she wants to receive for covered services. Daily benefits of $75 to $300 are usually offered. This is the maximum amount the policy will pay for the covered services.

When considering an LTCI policy's benefit amount, it is not necessary to cover the full cost of care. For example, if charges in a particular area are $150 a day, the applicant might select a benefit amount of $100 or $125 per day and pay the remainder out of pocket. A lesser benefit amount will mean a lower premium.

Some policies only pay a portion of the benefit amount, such as 75 percent, when care is provided in the home by friends, family members, or other nonlicensed caregivers. In addition, these policies may limit benefits for care by family members to a specified number of days, typically 365, over the insured's lifetime. This limit does not apply to care by nonfamily members. Other policies will not cover any in-home care provided by family members.

Again, LTCI policies are not standardized. Some policies pay for home care at half the rate of the facilities' care rates. If, for example, such a policy provided a $150 per day benefit for care in a facility, the daily benefit for care provided in the home would be $75. Other policies limit benefits for home care to a specified amount or limit the number of hours at a specific rate per hour. To wisely choose a benefit amount, LTCI buyers and their producers must educate themselves and be familiar with the going rates for long-term care services in their areas.

Benefit Period

The **benefit period** is the length of time, usually measured in years, over which a policy will pay for LTC services. A benefit period begins on the date that the insured first uses the policy to pay for care. Payments continue for the period selected, typically two, three, five, or ten years. Another (less common) option is a **lifetime benefit period**—the benefit period is, essentially, unlimited, with payments that continue for as long as the insured lives.

Benefit periods can also be tailored to suit individual financial needs. For example, a policy with a two-year benefit period will cost less than the same policy with a five-year or ten-year benefit period. Some older policies contain different benefit periods for different types of care, such as four years for nursing home care and two years for home care.

Policies that define their benefits in terms of a benefit period are less common today than they were in the past. They have largely been replaced by those that offer a lifetime maximum benefit or a pool of money.

Lifetime Maximum Benefit

Most LTCI policies sold today define their benefit in terms of a **maximum benefit** they will pay out over the term of the policy. Consequently, these policies define the maximum benefit in *dollar* terms: the insured receives benefits until the total amount paid for all types of care reaches the maximum amount stipulated in the policy, regardless of how much time has elapsed.

Under some policies, the purchaser chooses from round dollar amounts, such as $100,000, $200,000, or $500,000. This is the **pool of money** from which benefits may be paid. Other insurers define the pool of money as the daily or monthly benefit amount multiplied by a certain period. The purchaser chooses a benefit amount over a period of two, three, four, five, six, or ten years. The benefit amount multiplied by the benefit period equals the lifetime maximum benefit.

Example #1

For example, an insured might choose a daily benefit of $200 and a lifetime maximum based on four years. His or her pool of money would be calculated as:

$200 × 365 days × 4 years = $292,000 maximum lifetime benefit

Example #2

Another applicant who chooses a daily benefit of $125 and a lifetime maximum based on eight years would have a total benefit pool of $365,000:

$125 × 365 days × 8 years = $365,000 maximum lifetime benefit

Policies that define benefits in terms of a lifetime maximum do not limit the payment of benefits to a certain period; instead, benefits are paid until the maximum amount is reached. If incurred costs are less than the daily benefit amount, the "savings" remain in the pool of money. This applies even if the maximum benefit amount was originally based on a selected period. As long as funds remain in the pool, benefits are payable, even if they extend beyond the period upon which the maximum benefit amount was calculated.

Example #3

For instance, let's return to the insured who chose a daily benefit of $200 and a lifetime maximum based on four years. As shown, his or her pool of money is $292,000. Now let's assume that the insured accumulates long-term care costs that are only $100 a day—half of the daily benefit. The pool of money doesn't change; it remains at $292,000. However, the period for which those benefits are payable will be longer than four years:

$200 daily benefit ÷ $100 daily expenses × 4 years = actual benefit period (8 years)

Obviously, the greater the lifetime maximum benefit, the more expensive the policy.

Elimination Period

Common to LTCI policies is an **elimination period**. The elimination period, also known as the **waiting period**, is the period that begins when LTC services are first necessary, but policy benefits are not payable. It can be likened to a deductible. The elimination period lasts for the time specified in the policy, such as 30, 60, 90, or 120 days. If the insured recovers before the elimination period ends, the policy does not pay for any expenses incurred during that time. The policy pays only for expenses that are incurred *after* the elimination period has expired.

Service Days vs. Calendar Days

A policy may define the elimination period in terms of service days or calendar days:

- **Service day** elimination periods count days in which the insured receives care, such as in the home or in a skilled nursing facility.
- **Calendar day** elimination periods simply count the number of days the insured needs care, regardless of whether that care is actually delivered.

Some policies may impose more than one elimination period if the insured repeats a stay in a nursing home after a certain period of time. Said another way, in order to have a second nursing home stay counted as part of the first stay—and in order to avoid a new elimination period—the insured's second stay has to be within a certain number of days of the first (30, 90, or 180 days, for example). Other policies only require the insured to meet the elimination period once.

Effect of Elimination Period on Premiums

The longer the elimination period is, the lower the policy's premium. The option of selecting the length of the elimination period is one way that buyers can customize the terms of a policy to suit their needs and budget. Many policies offer a zero-day elimination period, with benefits payable as of the first day that LTC services are required. Coverage with a zero-day elimination period is much more expensive.

Under many policies, informal care counts toward the elimination period if this care is received as part of an approved plan of care. Typically, no required elimination period applies for respite services or hospice care benefits.

Note

Producers and advisors can help their clients decide whether they want to absorb some of the initial cost of long-term care services by explaining how a longer elimination period can lower a policy's premium.

Inflation Protection

Because benefits under an LTCI policy typically begin long after the policy is purchased, inflation protection can be a desirable feature. **Inflation protection** increases the policy's benefit amount over time to help keep pace with inflation and increased expenses.

Generally, insurers use one of two approaches to offer such protection:

- providing the insured the right to add coverage at later dates (a guaranteed purchase option)
- automatically adjusting the policy's benefits every year at a set rate

Guaranteed Purchase Option

The **guaranteed purchase option** allows the insured to purchase additional benefit amounts at specified periods, such as every three years. The insured does not have to reapply for coverage or provide evidence of insurability when additional amounts are purchased. However, with each additional purchase, the policy's premium increases, reflecting both the greater benefit amount and the insured's increased age. Some policies stipulate that the offer to purchase additional insurance amounts ends once the insured reaches a certain age, such as 85, or if the option to purchase additional amounts was declined more than two or three times. Generally, once a policy begins paying its benefit, future purchase options are no longer available.

Automatic Inflation Adjustment

More common is the **automatic inflation adjustment**. The automatic inflation protection increases the policy's benefit automatically each year. The amount of the increase is typically set at 5 percent per year, on either a compounded or simple basis. A simple inflation adjustment adds the same amount to the policy's daily benefit every year; a compounded inflation adjustment compounds the amount added to the policy every year. A simple inflation adjustment may be appropriate for older buyers, but younger buyers should consider adjustments compounded annually, because a good amount of time is likely to pass before benefits are claimed.

The following shows the difference between the increases provided by a simple 5 percent inflation adjustment and a compounded 5 percent inflation adjustment at select points over a 20-year period, assuming an initial daily benefit amount of $200:

Daily Benefit Increases with Inflation Protection		
	Daily benefit based on simple 5% inflation adjustment	**Daily benefit based on compounded 5% inflation adjustment**
Year 1	$200	$200
Year 5	$240	$243
Year 8	$270	$281
Year 10	$290	$310
Year 12	$310	$342
Year 15	$340	$396
Year 18	$370	$458
Year 20	$390	$505

Cost of Automatic Inflation Adjustment Option

An insured who selects an automatic inflation adjustment option pays a higher premium for this feature upon policy issue; however, premiums do not increase each year to reflect the greater coverage. This option can be a significant premium factor depending on one's age. For example, at age 55, an automatic compound inflation adjustment option can double the policy's premium compared to a guaranteed purchase option. At age 75, an automatic compound inflation adjustment election would increase premiums by about 50 percent.[27] Insureds who purchase an automatic inflation adjustment option will find that their coverage increases even after the policy begins paying benefits.

Other Long-Term Care Policy Features

Long-term care insurance policies also contain a number of other features and options that producers and policyowners need to understand.

Free-Look Period

Long-term care policies, like all insurance policies, must provide a free-look period. The **free-look period** is the time during which the insured can return the policy if he or she is not completely satisfied and receive a complete refund. This gives the policyholder an opportunity to fully examine the policy. To receive the full refund, the policy must be returned before the free-look period expires. In most states, the free-look period is typically 30 days. The following language (or similar) must be included in the policy:

> *You have 30 days from the day you receive this policy, certificate or rider to review it and return it to the company if you decide not to keep it. . . . You do not have to tell the company why you are returning it. The company will refund the full amount of any premium paid within 30 days after it receives the returned policy, certificate or rider. The premium refund will be sent directly to the person who paid it. The policy, certificate or rider will be void as if it had never been issued.*

Level Premiums

Most LTCI policies provide for the payment of **level premiums**, a practice actually required in some states. Level premiums remain the same for the life of the policy unless the insurer raises premiums for the entire class of insureds.

In this respect, LTCI differs from other forms of health or medical expense policies whose premiums are adjusted annually. However, regardless of providing for level premiums, some states have prohibited the use of the term "level premium" unless the policy guarantees that premiums will not increase under *any* circumstance (such as with noncancelable policies).

Grace Period

Most LTCI policies provide a **grace period** of at least 31 days for the payment of premium. In other words, the policyowner is given an additional 31 days after a premium is due before the policy lapses for nonpayment.

Third-Party Notification

In addition to a grace period, long-term care policies commonly contain a **third-party notification provision**. This provision allows the insured to name a third party who would be notified by the insurer in the event the policy is about to lapse because of nonpayment of the premium. With this option, the named third party may be able to intervene so that a policy lapse can be avoided.

The third party may be a relative, a friend, or a professional, such as an attorney. After being given notice, the third party has a stated period to see that the insured pays the premium. In some cases, this third party may pay the overdue premium on behalf of the insured. This option is especially helpful for those with cognitive impairments. Most insurers provide this option for no additional premium.

Reinstatement

In addition to the grace period and the third-party notification, long-term care policies often include a provision that provides for reinstatement of coverage, in the event the policy lapses and the insurer is given proof that the insured was cognitively impaired or had a loss of functional capacity before the policy's grace period expired. To effect this option, it must be requested within five months after termination and all past-due premiums must be paid. The standard of proof for cognitive or functional impairment for reinstatement cannot be more stringent than the criteria the insured would have to meet to qualify for the policy's benefits.

Nonforfeiture Benefit

LTCI policies with a **nonforfeiture benefit** provide for the payment of some portion of the policy's benefits even if the insured stops paying premiums. These benefits are payable as cash or as a continuation of coverage for a shortened period.

Some options under the nonforfeiture provision include the following:

- **cash surrender value option**—Gives the insured the option of surrendering the policy for some cash value in the event the policy lapses.
- **return of premium option**—Provides for the return of all or some portion of the premium paid in the event the insured dies. The money is paid to the insured's beneficiary or estate. Depending on the policy, the specific terms of this option will vary. For example, the return of premium option might require the policy to have been in force for a certain period (ten years is common). It might further require that the amount of premium to be returned is to be reduced by any amount paid in claims.
- **shortened benefit period option**—Provides for a paid-up benefit equal in amount to the total premiums paid or to a certain number of days of benefits, such as 30, if this amount is greater.

Though some states require that policies offer a nonforfeiture benefit, it is an optional benefit that owners can accept or reject. A nonforfeiture benefit is expensive and can add 10 to 100 percent to the premium.

Contingent Benefit upon Lapse

In some states, a nonforfeiture benefit as just described must be offered. If the policyowner declines such a benefit, the insurer then must automatically provide a **contingent benefit upon lapse**. This benefit applies in the event that an owner's premium rate is increased to a level that results in a cumulative increase that is equal to or greater than a specified percentage of his or her original premium.

Example

For example, the specified percentage for an individual who purchased a policy at age 65 is 50 percent. If a premium increase for this individual would result in premiums that are 50 percent or more of what the individual originally paid when the policy was issued, the individual must be provided with a contingent benefit if he or she chooses not to pay the increased premium (and did not purchase a nonforfeiture benefit).

A contingent benefit takes one of the following forms:

- the offer to **reduce policy benefits** provided by the current coverage so that required premium payments are not increased
- the offer to **convert the coverage** to a paid-up status with a shortened benefit period. This is the default election in the event the policyowner lapses the policy upon premium increase and does not actively elect a contingent benefit

A contingent benefit upon lapse is a required policy provision specified by the NAIC in its Long-Term Care Insurance Model Act and Regulations. It does not require the payment of an additional premium. The following chart is a partial illustration of when this provision would be applied. If a premium increase is equal to or greater than the percentage shown, the contingent benefit would apply if the owner chooses to discontinue his or her coverage.

Age at Issue	% Increase over Initial Premium	Age at Issue	% Increase over Initial Premium
60	70%	71	38%
61	66%	72	36%
62	62%	73	34%
63	58%	74	32%
64	54%	75	30%
65	50%	76	28%
66	48%	77	26%
67	46%	78	24%
68	44%	79	22%
69	42%	80	20%
70	40%	81	19%

If a policy contains a contingent benefit upon lapse, the value of a nonforfeiture benefit for which an additional premium applies is diminished. Producers should know the terms of the policies they represent and should counsel their clients accordingly.

Guaranteed Renewability

As has been noted, most individual long-term care policies are **guaranteed renewable**. Some states mandate guaranteed renewability. This means that the insured has the right to continue the policy in force as long as the premiums are paid on time. An insurer cannot terminate the policy if the insured's health declines. The insurer also cannot change any provisions of the policy while the insurance is in force without the agreement of the insured. An insurer cannot change the premium charged for the policy unless it receives the approval of the state insurance department and unless the change applies to all members of a class covered by the policy.

Restoration of Benefits

A **restoration of benefits** provision provides for the maximum amount of the original benefit to be restored, even if the insured has previously received benefits from the policy. This feature is initiated when the insured receives benefits and then a stated period passes with no benefits paid. With the restoration of benefits option, the benefit amount reverts to the amount that was originally purchased.

Example

For example, suppose an insured uses $100,000 of his LTCI benefits, and the lifetime maximum benefit is $500,000. The insured recovers and does not require further LTC services for a period specified in the policy, say, seven years. The $100,000 used would be restored to the maximum amount of benefits available. Instead of having only $400,000 in benefits remaining, the insured would have the original $500,000 in benefits available.

A restoration of benefits feature may be a standard policy feature or available as a rider for an additional premium.

Pre-Existing Conditions

Pre-existing conditions are health problems that the insured has at the time he or she applies for an LTCI policy. A pre-existing condition is normally defined as one for which the insured has sought medical advice or treatment or had symptoms within a certain period before applying for the policy. Relatively minor health problems are not considered pre-existing conditions.

In most states, pre-existing conditions must be covered by LTCI policies. However, insurers may impose a pre-existing condition waiting period of up to six months after policy issue. This means that benefits are not paid if the insured requires LTC treatment due to a pre-existing condition within the first six months a policy is in force. After the policy is in effect for six months, it will pay for covered benefits, no matter the reason services are needed.

Pre-existing condition exclusions are becoming less common in individual LTCI policies. Instead, insurers simply factor such conditions into their underwriting and issue policies accordingly. Group LTCI policies, which do not typically include individual assessment and individual underwriting, continue to carry pre-existing condition exclusions.

Joint Long-Term Care Policies

Some insurers offer joint LTCI policies for couples. These policies typically have lower premiums as compared with two separate policies.

Premium Payment Options

As noted, most LTCI policies are issued on a level premium basis. For the payment of those premiums, the insured has a number of options. These include the following:

- **continuous payment option**—With a continuous payment premium option, the insured pays premiums regularly—monthly, quarterly, semi-annually, or annually—as long as the policy is to remain in effect.
- **guaranteed limited payment option**—Under a guaranteed limited payment option, once the insured has made a certain number of annual payments, typically ten, the policy is paid up, and no further premium payments are due. Of course, if rates increase during the premium payment period, the higher rate would apply. However, once the specified number of annual payments has been made, rate increases cannot affect the policy. The policy is fully paid up. Limited payment options include 5-year pay, 10-year pay, 20-year pay, and paid-up-at-age-65.
- **single premium payment**—With the single premium payment option, the insured pays the full premium in advance. Even if rates increase, the insured will owe no additional amount.

Premium Waiver

A **premium waiver** permits the insured to stop making premium payments when he or she enters an SNF. Coverage continues even though premiums are not paid, and no further premiums will be due until the insured leaves the SNF. The typical waiver of premium takes effect after benefits have been paid for 90 consecutive days in an SNF. If the insured leaves the SNF, premium payments must resume.

Upgrading/Downgrading Coverage

Some insurers allow insureds to upgrade their LTCI policies after purchase. However, a new medical questionnaire may have to be submitted. Some policies allow the option of upgrading coverage in the future without having to again prove insurability. An upgrade in coverage will require the payment of increased premiums.

By the same token, some insurers allow policyowners to downgrade their coverage, reduce their benefits, and thereby reduce their premiums. This option is often called a **step-down provision**.

Care Coordination

Becoming more common in today's LTC policies are provisions for the **coordination of care**. These policies cover not only the cost of care services but will pay some amount for coordinating the care. Care coordination is typically provided by a licensed health care practitioner, such as a nurse or a social worker. The insurer may have a contract with a national network of care providers and may recommend their services, or the insured may be required to find a coordinator on his or her own. The objective of care coordination is to answer questions, to provide options and guidance, and to help locate caregivers in the insured's community that can meet his or her specific needs.

Additional Coverage Options

Long-term care policies may also offer additional coverage to be elected at the policyowners' option, designed specifically for joint policies. These additional benefits require additional premiums. They include the following:

- **paid-up survivor option**—This option provides that a policy will be deemed paid up if a spouse dies before the end of a specified period (typically ten years) and if all premiums were paid for the ten-year period.
- **dual premium waiver**—This option is designed to waive a policy's premiums when one spouse begins to receive benefits, assuming that premiums were paid for a specified period (usually ten years).

Long-Term Care Policy Exclusions

Like most insurance, LTCI policies contain limitations and exclusions. In general, it's common for long-term care policies to exclude coverage for services associated with any of the following conditions:

- addiction to drugs and alcohol
- injuries and/or illnesses caused by acts of war
- treatment paid by the government
- injuries that are self-inflicted, such as suicide attempts

Summary

- Long-term care insurance is a fairly new field. Many states have established minimum standards for classifications of LTCI policies, but many have not.
- LTC policies tend to cover a variety of care settings. Common to all policies are benefit amounts, benefit periods, and elimination periods.
- A wide array of features, benefits, and optional coverages are available with LTC policies. Some require an additional premium; others do not.
- It is reasonable to say that because LTC policies are not standardized, they are difficult to compare and evaluate.

Chapter 6 Review Questions

1. Which of the following best describes the elimination period in an LTCI policy?
    A. It is a means of disqualifying unsuitable LTCI applicants.
    B. It a way to restore benefits to the original amount available.
    C. It is a waiting period before benefits begin.
    D. It is a way for the insured to cancel a policy if he or she is not satisfied with it.
2. Which of the following sets forth the length of time an LTCI policy will pay benefits?
    A. the grace period
    B. the elimination period
    C. the benefit period
    D. the restoration period
3. A guaranteed renewable LTCI policy provides that coverage must be continued as long as premiums are paid.
    A. True
    B. False
4. Marcus purchases a long-term care insurance policy at age 45. Which of the following will give him the most protection against the rising cost of long-term care?
    A. level premiums
    B. a comprehensive plan
    C. a lifetime maximum benefit
    D. inflation protection
5. Drake is the owner/insured under a long-term care insurance policy. He purchased the policy at age 58 and included a guaranteed purchase option that enables him to add more coverage to the policy every three years. Under which condition would Drake's ability to purchase additional coverage end?
    I. if he were to utilize the option more than once
    II. once the policy begins paying its benefits
    A. I only
    B. II only
    C. both I and II
    D. neither I nor II
6. Generally speaking, what is the free-look period for a long-term care insurance policy?
    A. 10 days
    B. 21 days
    C. 30 days
    D. 60 days

Answers to Chapter 6 Review Questions

1. C. The elimination period begins when LTC services are first necessary and lasts for the time specified in the policy, such as 30, 60, 90, or 120 days. During this time, the policy will not pay benefits. Benefits begin once the elimination period has expired.
2. C. The benefit period is the length of time, usually measured in years, over which a policy will pay for LTC services.
3. A. Guaranteed renewable means that the insured has the right to continue the policy as long as the premiums are paid on time. If premiums are not paid, the policy will lapse and is not renewable.
4. D. Inflation protection increases the benefit amount over time to help keep pace with inflation and increased expenses.
5. B. As a general rule, once a policy begins paying its benefit, future purchase options are no longer available.
6. C. In most states, the free-look period for a long-term care policy is 30 days.

Chapter 7
Long-Term Care Partnership Programs

Overview

As the need for long-term care grows and as greater and greater demand is made of state Medicaid programs, alternatives to the funding and delivery of such care have become necessary. One such alternative comes in the form of state **long-term care insurance partnership programs**. Partnership programs represent something seldom seen: a genuine cooperation between business and government to address, and hopefully resolve, a major social issue before it becomes unmanageable. These programs exist because leaders in government, the insurance business, and consumer interest groups came together and defined a solution to the problem of ever-rising long-term care costs.

In this chapter, we discuss the basics of state long-term care partnership programs—their origins, their goals and purpose, and their formation and structure.

Chapter Objectives

Upon completion of this chapter, you should understand:

- the basics of state LTC partnership programs, their purpose, and key objectives
- the factors that led to the development of the state partnership initiative
- the role of the Deficit Reduction Act (DRA) in clearing the way for new state LTC partnership programs
- the influence of the NAIC Model Act and HIPAA in the formation and function of state LTC partnership programs
- the benefits of state LTC partnership programs for states, insurers, and consumers

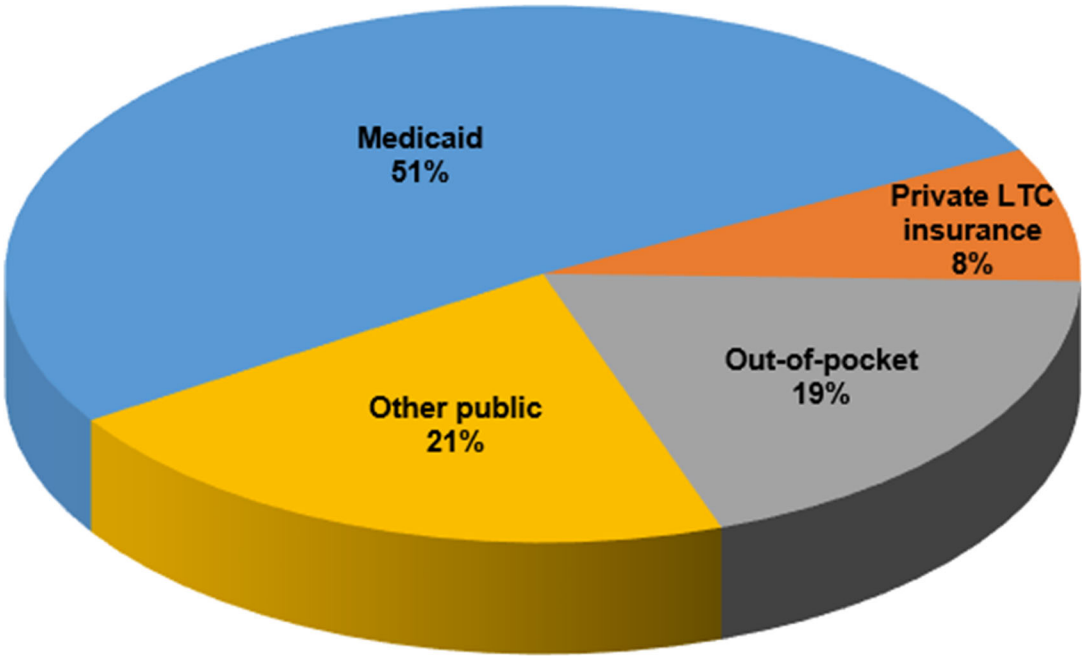
Long-Term Care Partnership Programs

As we have learned, the costs for providing long-term care are borne largely by three parties:

- the government (primarily through Medicaid and, to a limited extent, through Medicare)
- care recipients and their families (through personal resources, assets, and income)
- insurance companies (primarily through LTCI policies)

As shown in the following graphic, the largest share of long-term expenditures in 2013 was covered by Medicaid, which paid 51 percent of the total cost. Other public programs paid 21 percent of the total cost. Consumers paid 19 percent of the nation's long-term care bill out of pocket. Smallest of all was the portion paid by private LTC insurance: only 8 percent. Total long-term care spending from all of these sources in 2013 amounted to $310 billion. Uncounted is the cost of care delivered by unpaid, informal caregivers—family and friends. The economic value of this "donated" care is, alone, estimated to be billions of dollars.

Spending for Long-Term Care by Payor



"*Medicaid and Long-Term Services and Supports: A Primer*," May 8, 2015, Henry J. Kaiser Family Foundation (**www.kff.org**).

Need for LTC on the Rise

The need for long-term care—already a major national expense—is poised for a dramatic rise in the U.S. Without a change in how Americans pay for LTC, the two parties who can least afford it—consumers and state Medicaid programs—will continue to bear the brunt of it. This presents a huge problem. With long-term care financing a major contributing factor, state budgets across the country are already straining under Medicaid's load. They are in no shape to increase that load. Consumers, already struggling to pay their current share, have little capacity to assume more of the long-term care financing burden.

The idea of shifting the burden of long-term care financing from the states to an industry in the business of managing financial risk makes so much fiscal sense that it is the basis for the "Partnership for Long-Term Care" initiative, a unique insurance program introduced in 1988 under the sponsorship of the Robert Wood Johnson Foundation (RWJF). The program's goal is simple: to encourage consumers to purchase affordable long-term care insurance policies and to reduce the burden on state Medicaid programs.

Originally modeled in four demonstration states (California, Connecticut, Indiana, and New York) and supported with funds and technical advice from the Robert Wood Johnson Foundation, the initial partnership programs were designed for the express purpose of giving seniors a way to ensure long-term care funding when needed and, perhaps more importantly, to retain more of their assets while potentially qualifying for Medicaid benefits. The defining element: *a partnership-qualified long-term care insurance policy.*

Purpose: Shift Financial Responsibility to Insurers

States have always relied on a simple approach to Medicaid cost recovery: shift a portion of the financial responsibility to another payor. Traditionally the "other payor" has been the Medicaid beneficiary via Medicaid's asset and income spend-down rules. These rules require beneficiaries to exhaust virtually all personal income and assets (or assign them to the state) in return for Medicaid coverage of long-term care needs. Only a nominal amount of about $2,000 or $3,000 in assets may be retained. In addition, upon a Medicaid LTC recipient's death, a state may recover from the recipient's estate the costs the state incurred in providing the care. This may be of little concern to those with limited or no personal assets, but for individuals and families of even modest means, these spend-down and recovery rules are usually viewed with a blend of dread and loathing.

Partnership programs redefine Medicaid's "other payor" to include the LTCI industry. The individual who owns a partnership-qualified long-term care insurance policy may still be responsible for some long-term care costs, but not until policy benefits are exhausted and he or she applies for Medicaid coverage. Even then, a potentially sizeable portion of the individual's assets will be protected, thanks to the Medicaid spend-down exemption feature common to all state partnership plans.

The Basics of a Partnership Program

The basic concept behind an LTC partnership program is easy to understand:

1. A partnership program joins a state's Medicaid program with private insurance companies that offer long-term care insurance policies.
2. The state's Medicaid program's eligibility requirements are adjusted to provide financial incentives for residents to purchase private LTCI coverage.
3. If the insured requires long-term care services, the LTC policy pays out its benefits.
4. Then, in the event the insured continues to need care after the policy's benefits are exhausted (or the cost of his or her care exceeds the policy's benefit level), he or she can apply for Medicaid. However, the standard asset limit that the state Medicaid program would otherwise impose does not apply to the owner of an LTC partnership policy. He or she will be able to keep assets equal in amount to the benefits the policy provided. In addition, these assets are exempt from Medicaid estate recovery upon the insured's death.

Target for LTC Partnership Programs

LTC partnership programs are aimed primarily at those who have significant assets they want to protect but who may not have the means to fully cover their own long-term health care out of pocket (nor have the ability to pay for an amount of LTCI that would completely finance their future health care needs). By participating in a partnership program and purchasing a private LTCI policy, these individuals can be assured that some amount of their assets will be protected, for themselves and their heirs, if ever they do have to turn to Medicaid for assistance.

OBRA's Effect on Partnership Programs

The four demonstration states—California, Indiana, Connecticut, and New York—put their plans in effect in 1992, four years after the concept was first described with the release of the RWJF partnership initiative. By then, other states were attracted to the concept, and a number of them had passed enabling legislation to establish their own plans.

However, only a short time after the original four states' partnership programs were enacted, Congress began to express concerns. One criticism was that Medicaid would wind up endorsing private insurance products. Another issue was the potential for increased Medicaid spending rather than an intended decline in it—that wealthy individuals or those of above-average means (who were considered likely to purchase LTCI anyway) would participate in the program, retain their assets, and have unintended access to Medicaid services.

Partnership Programs Stalled

As a result of these concerns, Congress enacted new laws that restrained expansion of partnership programs beyond the original four states. The **Omnibus Budget Reconciliation Act of 1993 (OBRA '93)** effectively prevented other states from developing partnership programs by changing the conditions under which states could amend the Medicaid asset disregard. OBRA required any new partnership program to provide asset disregard only for initial Medicaid eligibility; thus, disregarded assets would be deemed subject to estate recovery at the participant's death. OBRA specified that states were required to recover from a partnership participant's estate an amount equivalent to what Medicaid spent on his or her behalf, including any protected assets under the partnership program. In addition, any state that established an LTC partnership program after OBRA became law was required to use an expanded definition of "estate" than what was previously the norm.

Though it chilled consumer interest in the program among new states, OBRA grandfathered the four model states, exempting them from the estate recovery rules. All four states continued operating their partnership programs.

DRA 2005 Clears Way for New Partnership Programs

Were it not for another tax act, there might be no discussion of partnership programs beyond those of the original four states. Fortunately, for the remaining 46 states, that is not the case. The estate recovery rules that froze the program in place were lifted with the **Deficit Reduction Act of 2005**.

Now, every state can implement an LTC partnership program, provided it conforms to certain standards and specific requirements. DRA also requires that partnership programs include specified consumer protections, which largely align with those contained in the NAIC's Long-Term Care Insurance Model Act.

State Plan Amendment Establishes Partnership Program

States that wish to establish a qualified partnership program can do so by first filing with the CMS a **state plan amendment (SPA)** to its Medicaid program. Through the SPA, a state lays out its program's proposed rules, requirements, and effective date. The CMS, a division of the U.S. Department of Health and Human Services, reviews the SPA and either approves, denies, or requests a modification to the amendment.

Note

Because any given state's plan may differ in some respects from what is described here, students are advised to supplement this study of basic state partnership program concepts with a review of their state's specific partnership program.

DRA and the Long-Term Care Insurance Partnership Program

The following is how the DRA defines a qualified state LTC partnership program:

> . . . an approved State plan amendment [to the state's Medicaid laws] . . . that provides for the disregard of any assets or resources in an amount equal to the insurance benefit payments that are made to or on behalf of an individual who is a beneficiary under a long-term care insurance policy. . . .

This paragraph succinctly describes the defining characteristic, and arguably the chief benefit, of any state's LTC partnership program. It states that if an individual who is insured under a qualified partnership policy still ends up needing Medicaid assistance, he or she may apply to Medicaid and, if coverage is granted, keep personal assets—assets that might otherwise be subject to spend-down rules—equal to the total amount of benefits paid by the policy.

Thus, for example, if Gus owns a $150,000 long-term care partnership policy and, after the policy pays its benefit, Gus continues to need long-term care, he would be able to apply for Medicaid and be assured that he could retain personal assets of at least $150,000. Those assets would be protected against Medicaid's spend-down requirement.

Promotes Long-Term Care Insurance Ownership

The basic intent behind every state's partnership program is twofold:

- expand long-term care insurance ownership, especially by those with moderate income or assets (who have the most to lose by turning to Medicaid) and, in so doing,
- expand the insurance industry's role as primary payor

This is a true win-win-win for all three interested parties to the long-term care financing dialogue: consumers, state governments, and the insurance industry:

- **Consumers** who own partnership-qualified long-term care insurance and need long-term care benefit not only through the greater choice in care options afforded policy ownership but also by some measure of asset protection through the Medicaid spend-down and estate recovery exemption. It should be noted that asset preservation is not guaranteed against the insured's consumption of the assets, and assets are subject to probate at death as any other asset.

- **States** benefit by potentially reducing future reliance on Medicaid as a funding source for long-term care services.
- **The long-term care insurance industry** benefits by expanding its pool of insureds. Like all forms of insurance, long-term care insurance is based on risk-sharing principles that distribute the financial risk of long-term care among a pool of individual insureds. The larger the pool, the better for all.

Promotes Asset Preservation

DRA amended the Social Security Act to enable state Medicaid programs to implement the asset spend-down offset rule that is a key feature of partnership programs. In so doing, the act preserved a feature of the state partnership program that has defined the concept since its inception. However, it did something else that further promotes asset preservation and, more importantly, cleared the way for all states to create a partnership program: it lifted the estate recovery rules that had been imposed on all new partnership plans since OBRA '93.

The estate recovery rules had effectively negated the benefits of the spend-down offset by subjecting preserved assets to recovery by the state at the insured's death. With that risk eliminated, individuals who participate in their state's long-term care insurance partnership program are assured asset protection (within specified limits) should it become necessary to apply for Medicaid assistance.

For individuals and families of even modest wealth, the benefit-offset rule is an important feature. It is the states' hope that it will encourage more people to purchase long-term care insurance and thus transfer at least some long-term care financing responsibility from the states' budgets to the insurance industry.

Promotes Uniformity Among States

States have a fair degree of latitude in defining the precise form their partnership programs take. However, to provide consistency and to ensure that minimum standards are applied equally in all states, the federal government defines minimum standards for programs everywhere. In this case, it did so through Subchapter B, Chapter 6021 (Expansion of State Long-Term Care Partnership Program) of the Deficit Reduction Act.

Some standards were created with the original Robert Wood Johnson Foundation Partnership for Long-Term Care initiative. The DRA expanded and clarified the minimum standards for new state partnership plans.

The Question of Reciprocity

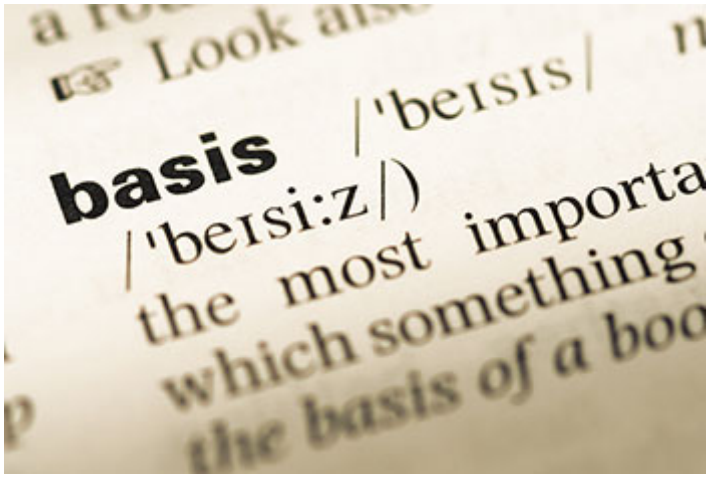
One area of concern even among supporters of the state partnership concept has been reciprocity among the participating states. As required by DRA, the U.S. Department of Health and Human Services developed a reciprocity agreement that would enable insureds in all participating partnership states to use their benefits in other partnership states.

To be eligible to participate in a state's partnership program, an individual must, at the time of policy purchase, be a resident of the state sponsoring the partnership program. More importantly, the individual has to be a resident of the sponsoring state at the time Medicaid application is made. The insured may move to another state following purchase, and insurance coverage would remain in effect; however, only if reciprocity exists between the two states can the insured be certain of Medicaid asset protection in the new state.

Without reciprocity, insureds who move from one partnership state to another may find that, just as when moving from a partnership state to a nonpartnership state, their asset spend-down protection does not apply in the new state. The impact this could have on an individual's LTC and estate plans is both obvious and enormous.

A reciprocity agreement is not a mandate, and though all partnership states are automatically made part of the agreement when their program becomes effective, they may opt out of the agreement. Until reciprocity is a part of every state's partnership program, this will remain a contentious issue in any discussion of state partnership programs.

Basis for Today's Partnership Programs



In defining the terms and conditions for a qualified state LTC partnership program, DRA relied on three significant guideposts:

- the NAIC's Long-Term Care Insurance Model Act and Regulation
- the Health Insurance Portability and Accountability Act of 1996 (HIPAA)
- the experience of the original four demonstration project states

The NAIC Model Act

The NAIC developed its Long-Term Care Insurance Model Act and Regulation ("Model Act") in the 1980s. Since then, the act has been periodically revised as the market and policies have evolved. Like all NAIC models, the Long-Term Care Insurance Model Act was developed through the combined efforts of state insurance regulators, the insurance industry, and consumers. It was created with several goals in mind, not the least of which is to protect consumers by setting a baseline set of standards that provides minimum levels of coverage.

Although the NAIC lacks the regulatory authority to mandate that its models be adopted by the separate states, in practice most states do base their insurance regulations on these models. The NAIC Model Act is the basis of most states' long-term care insurance legislation and regulations. It also figures prominently in DRA's definition of a partnership-qualified long-term care insurance policy.

DRA Uses NAIC Model

Drawing heavily upon the NAIC model, DRA outlines the basic requirements for partnership-qualified LTCI policies in several respects. These include:

- minimum standards for policy provisions and benefits
- required practice standards related to the marketing, sale, underwriting, and reporting of partnership-qualified LTCI policies

Partnership-qualified LTCI policy standards and the provisions of the NAIC LTC Model Act that pertain to partnership-qualified policies are more thoroughly reviewed in Chapter 8.

HIPAA and Long-Term Care Insurance

The second major influence on how partnership-qualified LTCI policies are defined is HIPAA. One of the most important outcomes of that landmark health care law was its creation of the **tax-qualified long-term care insurance (QLTCI) policy**. More precisely, the law defined the terms and conditions that must apply for an LTCI policy to qualify for favorable income tax treatment. Only tax-qualified policies can be used in a partnership program.

Tax-qualified LTCI policies were briefly mentioned in Chapter 5. However, because it figures so prominently in defining partnership-qualified policies, a more extensive discussion of HIPAA's definition of a QLTCI policy is presented in Chapter 8.

Original Demonstration Models

Though it remained frozen in place for nearly 15 years, the original demonstration project made two important contributions to the definition of today's state partnership program:

- It established minimum standards for partnership-qualified LTCI products, some of which are required today.
- It defined the process by which an insured might qualify for Medicaid and shield personal assets from Medicaid's spend-down rules.

As is true with the current partnership program, the original partnership program allowed the four demonstration states a moderate amount of leeway in how their respective plans were defined, while at the same time laying out minimum standards. The minimum standards developed through the original partnership demonstration states included the following:

- **Only tax-qualified policies could be used in a partnership program.** This rule was affirmed with DRA: only QLTCI policies, as defined in HIPAA, may be used in new state partnership programs.
- **The policy must have provided comprehensive benefit coverage.** That is, it must have covered qualifying home health care services as well as services provided in a health care facility. This is no longer required; a policy may or may not provide home and community care coverage in addition to nursing home coverage. However, if a policy does include home and community care, then certain minimum coverage amounts must be provided for these levels of care.
- **The policy must have included inflation protection.** The original partnership model specified an automatic 5 percent annual compound inflation factor, regardless of the insured's age. DRA continues the inflation protection mandate with a more complex requirement that varies according to the insured's age at the time of purchase.
- **Policy benefit coverage had to function on the reimbursement method (by which benefits are payable as reimbursement for actual expenses incurred).** DRA expands the available methods and permits benefit coverage not only on the reimbursement basis but also on a disability (equal cash payments) and indemnity (stated dollar amount) basis.

Again, Chapter 8 will provide a more detailed look at qualified long-term care insurance policies.

Original State Partnership Programs Grandfathered

Because the requirements of today's state partnership program differ in several respects from those of the original demonstration model, the four original model states—California, Connecticut, Indiana, and New York—have the option of either maintaining their existing program unchanged or amending their partnership plans to incorporate the new standards set forth in DRA. However, if a state amends its program, then it must conform to the minimum standards set forth in DRA.

The influence that the original partnership programs had on today's plans will be apparent when the minimum standards for new partnership-qualified plans are reviewed in the next chapter.

State Partnership Programs and Medicaid: A Closer Look

As was discussed in the earlier chapter on Medicaid, two of the most distressing aspects of turning to this welfare program for long-term care financing are the limited choices available when selecting a care provider and the asset spend-down rules. State partnership programs help insureds minimize both downside aspects should it become necessary to apply to Medicaid after insurance coverage and policy benefits have been exhausted.

DRA 2005 addressed more than long-term care insurance in defining the foundation of state partnership programs. Significantly, it also directed the states to amend their Medicaid programs to accommodate the asset spend-down exemption that is an integral part of the partnership program. Let's take a closer look at this side of the program.

The Asset Spend-Down Exemption

Arguably the most important benefit of any state's LTC partnership program is the **asset protection** it provides insureds who find it necessary to apply to Medicaid.

Should the insured's need for long-term care services continue beyond the point where policy benefits are exhausted, or should the cost of care exceed the policy's daily or monthly benefits, the insured may apply for Medicaid coverage to maintain the care. If the insured is an eligible participant in the state's partnership program, and if he or she qualifies for Medicaid assistance, then some portion of his or her personal assets will be shielded from Medicaid's spend-down rules.

To qualify as a participant in the state's partnership program, the individual must:

- own a partnership-qualified long-term care insurance policy
- reside in the state sponsoring the partnership program at the time of Medicaid application (or reside in a state with a reciprocal partnership agreement with the issuing state)
- have resided in the state sponsoring the partnership program when the policy was issued

It helps to separate insurance policy requirements from Medicaid qualification issues when trying to understand state partnership programs. When it comes to the Medicaid side of the discussion, the important question is "How does the state's partnership program offset the asset spend-down requirement for Medicaid qualification?"

How the Asset Spend-Down Offset Works

Two spend-down offset models were used in the original demonstration state partnership programs:

- the dollar-for-dollar offset method
- the total asset approach

DRA removed the total asset approach from the list, and now only the **dollar-for-dollar offset method** is permitted with new partnership programs. However, grandfathering rules permit the original model states to continue using the methods currently in place, and in two cases—New York and Indiana—this includes the total asset approach option. For that reason, both methods are reviewed in the following sections.

As an overview, both methods base a partnership program's spend-down exemption amount on the total policy benefits that are payable from the long-term care insurance policy. Whichever method is used, the benefit concept is the same: a portion of the insured's personal assets is protected from the spend-down rules. That is, personal assets equal to the offset amount are not counted when determining spend-down requirements for Medicaid assistance.

Though it varies by state, the asset eligibility limit for Medicaid assistance is about $2,000 for a single individual and $3,000 for a married couple. (The value of the home may or may not be countable, depending on the individual's circumstance.) As to income, if a person qualifies for Medicaid and enters a nursing home, virtually all of his or her income must be spent on the cost of the nursing home care.

As a point of comparison, an individual applying directly to Medicaid for LTC assistance would be eligible for Medicaid coverage only when he or she had spent down countable assets to his or her state's asset eligibility level (generally around $2,000). Furthermore, applying directly to Medicaid for long-term care financing means fewer choices of care providers.

Note

Partnership participation does *not* protect any amount of an individual's income. An individual who qualifies for Medicaid assistance after exhausting the benefits of a partnership policy is still required to spend most of his or her income on care. Partnership participation protects only an individual's assets.

Estate Recovery Avoided with Partnership Program

Perhaps as significant as the asset spend-down exemption is the DRA's lifting of the estate recovery rule. Recall that the original partnership program was effectively frozen in place with passage of OBRA in 1993, which required that assets that were shielded from Medicaid's spend-down rule would be subject to recovery at the beneficiary's death.

As we have learned, estate recovery gives states the right to recover assets—even those that were deemed "noncountable"—upon a Medicaid recipient's death. So, even if an individual were able to hold onto assets deemed uncountable while receiving Medicaid benefits, possession exists only as long as the individual is alive. Because assets could not be preserved for heirs, the effect of OBRA was to chill consumer interest in partnership programs.

However, DRA changed all that. Now, for individuals participating in their state's partnership program, assets that are protected from Medicaid's spend-down requirements remain protected through the estate settlement process. As assets of the decedent, they become subject to probate and, with proper advance planning, may be passed on to heirs. They cannot be attached or seized by the state.

Dollar-for-Dollar Offset Method

DRA requires that new state partnership programs use the **dollar-for-dollar offset method**. All four demonstration states used—and continue to offer—the dollar-for-dollar method in determining the amount of personal assets that were exempt from Medicaid spend-down rules. (Indiana and New York offer the total asset approach as a second option.)

Under the dollar-for-dollar offset approach, a dollar of the insured's assets is protected from Medicaid spend-down for every dollar of coverage provided through the participating LTCI policy. Once the benefits of the partnership policy have been paid at such a level that the asset exemption will qualify the insured individual for Medicaid, Medicaid benefits will then be paid.

Example A

Alice owns a state partnership-qualified LTCI policy with maximum potential benefits of $150,000. If she were to require LTC services that exceed the policy's maximum benefit coverage, $150,000 of her personal assets plus any noncountable assets and the $2,000 of countable assets she would otherwise be permitted to keep will be exempt from consideration when determining the asset spend-down amount for Medicaid qualification. Therefore, when assessing Alice's financial qualifications for Medicaid, the following will be disregarded:

- countable assets equal to the benefits paid by the LTCI partnership policy ($150,000)
- maximum countable assets allowed under Medicaid ($2,000)
- the value of noncountable assets

The benefits paid by Alice's partnership policy allow her to retain $150,000 more than she otherwise would have been able keep without the policy. What's more, these assets remain preserved for Alice's heirs; thanks to DRA, they are exempt from Medicaid estate recovery rules.

Assets that exceed the asset exemption amount ($150,000 plus $2,000 plus noncountable assets, in Alice's example) are subject to the state's Medicaid eligibility spend-down rules. Furthermore, income is *not* protected in a partnership program. So, though Alice would be able to retain an amount equal to $152,000 in countable assets, if she were to receive a $1,000 per month Social Security benefit and was receiving care that costs $3,000 a month, she would pay the first $1,000 of her care cost by assigning the Social Security benefit to the state's Medicaid program. Medicaid would pay the remaining $2,000 a month.

It bears repeating that a partnership program participant benefits by more than just the Medicaid asset spend-down exemption. In Alice's case, her use of insurance to finance LTC allows her the most freedom (short of simply paying costs out of pocket) in choosing the type of care she needs and, equally important, the care facility she wants.

Example B

Because the asset exemption amount is tied to a policy's maximum benefit amount, it makes sense to consider the estimated value of an individual's countable assets when considering the amount of protection to buy.

Bob, who lives in a state with a partnership program, purchased a partnership-qualified LTCI policy. Not fully understanding how the partnership program works, he followed his insurance producer's advice and purchased a policy with the highest possible maximum benefit for his age and underwriting category—$500,000.

Bob's net worth, consisting of countable and noncountable assets, is approximately $250,000. If Bob requires LTC, his full $250,000 in assets will be protected from Medicaid's asset spend-down and estate recovery rules. However, Bob purchased $250,000 of coverage beyond the amount of his assets.

Assuming the cost of Bob's care does not exceed the daily or monthly benefits paid by his policy, Medicaid will not step in until the policy's benefits are consumed. Had he purchased $250,000 in maximum coverage and still required LTC when policy benefits were exhausted, he could have applied to Medicaid for continuing care coverage. This would have probably been the wiser choice if Bob's sole objective was to preserve his assets. However, for another reason, insurance protection beyond the level of one's assets may be desired.

It's very likely that Bob would be required to move from a nonapproved facility that was caring for him to one approved by Medicaid when policy benefits are exhausted. Medicaid's rules regarding approved care facilities are quite clear and stringent. If the insured is in a nonapproved facility or receiving nonapproved care (for example, home health care) when policy benefits run out, applying to Medicaid could mean a required change in care provider. That possibility might justify ownership of the additional coverage, especially if Bob knew in advance he would want the freedom to choose a non-Medicaid approved facility in the event LTC was needed.

Medicaid Is the Last Payor

Whether an LTC partnership policy must exhaust its benefits completely before the insured can receive Medicaid assistance depends on the state. Most states do *not* require complete payout of a policy's benefits; if the cost of an insured's care exceeds his or her daily or monthly insurance benefits (plus his or her available income), the insured can turn to Medicaid. However, the LTC policy must be in claims status, and Medicaid will only pay for allowable costs beyond what the policy pays. The policy is the primary payor; Medicaid is the last payor. As the policy continues to pay benefits, equivalent asset values will be protected from Medicaid spend-down requirements and will be exempt from estate recovery at the insured's death.

Total Asset Offset Approach

Two of the original partnership demonstration states—New York and Indiana—offer an optional second method for determining spend-down requirements. Besides the dollar-for-dollar method, individuals in these two states have the option of buying a policy that uses the **total asset approach** for determining spend-down requirements. Though new partnership programs are not permitted to use this method, the original plans were grandfathered, and thus, New York and Indiana may continue offering this option.

This method exempts *all* personal assets from spend-down requirements. However, these plans also require significantly higher minimum policy benefit limits than do plans using the dollar-for-dollar method, effectively negating at least some of the apparent discrepancy between the dollar-for-dollar and total asset approaches.

Popular as the total asset approach proved to be in the two states where it was modeled (especially with insureds of considerable wealth), this approach poses too great a risk to states. It is easy to see why. An individual could purchase a policy with the minimum amount of required benefit coverage for this offset method and shield assets worth many times that amount while qualifying for Medicaid coverage. In effect, the state would be subsidizing an individual who had significant means and could otherwise fund his or her own care. For this reason, no new state partnership plan can offer a total asset protection option.

Tailoring Coverage to Need Is Part of Suitability

Anyone involved in the marketing or sale of partnership-qualified LTCI is required to ascertain the **suitability** of such coverage for meeting the needs of the client.

The dollar-for-dollar offset method encourages individuals to tailor their coverage to best accommodate their asset protection need. Return to the examples of Alice and Bob. Alice's total benefits closely matched her net worth, while Bob's total coverage was twice the amount needed to provide coverage and full asset protection. But, full asset protection is not the only thing that should be considered. The cost of

care in the individual's community and the length of a suitable or desired benefit period should also be taken into account

Helping an applicant design an LTCI policy that best fits the individual's needs and circumstances is part of the suitability process. Ascertaining the suitability of any long-term care insurance recommendation is an essential part of the producer's responsibility to the client.

The issue of suitability is an important one and will be discussed in greater detail in Chapter 10 in our coverage of the ethical considerations in the sale of long-term care insurance.

Realities of State Partnership Programs

It is anticipated that LTC partnership programs will provide at least a partial solution to the critical problem of funding long-term care costs. However, these programs have their limits. Consumers who are considering these plans and producers who sell policies for these plans must understand the following:

- Partnership participation does not automatically guarantee enrollment in Medicaid or the payment of Medicaid funds once a policy's benefits are exhausted. The insured individual must still meet Medicaid requirements for eligibility—medically, functionally, and financially.
- Partnership participation protects assets, not income. Once a partnership participant qualifies for Medicaid, almost all of his or her income must be spent on his or her care.
- Partnership participation may not protect all of an individual's assets. Because protection is limited to the amount of benefits paid under the policy, any assets the participant has above this amount may have to be spent down in order for the participant to qualify for Medicaid. (Total asset protection is limited to partnership programs in New York and Indiana.)
- Partnership participation does not guarantee that the insured will be able to receive care in his or her home or in a facility of his or her choosing. If and when a partnership participant turns to Medicaid, he or she may be forced into another facility or be required to forego home care.
- Partnership participation does not guarantee that future Medicaid eligibility requirements will be the same. Income and asset requirements could be more stringent in years to come, making it more difficult to qualify for Medicaid benefits.
- Partnership participation does not ensure that asset protection will be available if the participant moves to another state that does not have a partnership program or that does not have a reciprocity agreement with the original state. Furthermore, reciprocity between states for partnership protection of assets does not ensure that the requirements for Medicaid eligibility will also be the same in each state.

Summary

- Increasing average life expectancies, the baby boomers' advance towards retirement, and a number of other factors have severely eroded the boomer generation's capacity to pay for long-term care and thus have led its members to turn more and more to state Medicaid programs for help, thereby straining the budgets of most states.
- State LTC partnership programs provide incentives for consumers to fund their own long-term care needs through the purchase of a private insurance policy and thus ease the burden on state Medicaid programs.
- By purchasing a partnership policy, consumers are assured that assets equal to the amount of the policy's benefits will be protected from the Medicaid spend-down requirement as well as its estate recovery rule.
- The enabling legislation for today's partnership programs was the DRA of 2005. In addition, these programs are framed by and draw from the NAIC's Long-Term Care Model Law and Regulations and HIPAA 1996, which defined and set standards for tax-qualified long-term care policies.

Chapter 7 Review Questions

1. After being effectively frozen in place for a number of years, state LTC partnership programs were allowed to expand as a result of what legislation?
    A. Tax Reform Act of 1986
    B. OBRA '93
    C. HIPAA '96
    D. DRA 2005
2. Who (or what) pays the largest share of total long-term care expenses in the U.S.?
    A. consumers
    B. Medicaid
    C. Medicare
    D. insurance companies
3. All the following statements regarding the benefits of state LTC partnership programs are generally correct EXCEPT:
    A. Consumers benefit through the assurance of long-term care protection that may help them preserve personal assets.
    B. Insurance companies benefit through an expanded market for their product and a larger pool of insureds to spread the insurance risk.
    C. State Medicaid programs benefit by potentially reducing demand for Medicaid financing.
    D. The federal Medicare program benefits by reducing demand for acute long-term care among seniors.
4. As defined by the Deficit Reduction Act of 2005, an insured who participates in a new state partnership program may be eligible for an exemption to Medicaid's asset spend-down rule equal to what amount?
    A. the sum of premiums paid for an LTC partnership policy
    B. the total benefits paid in the first year by the LTC partnership policy
    C. the total lifetime benefits payable through the LTC partnership policy
    D. the total value of the insured's estate when the LTC partnership policy is issued

Answers to Chapter 7 Review Questions

1. D. DRA 2005 lifted the estate recovery rules imposed by OBRA that had hindered the expansion of the partnership program for a dozen years.
2. B. Medicaid pays about half of the cost of long-term care in the U.S. Medicare accounts for 24 percent, consumers pay 20 percent, and private LTC insurance pays 7 percent.
3. D. LTC partnership programs are concerned only with who bears the expense of LTC and can do nothing about the demand for acute long-term care among seniors, which continues to rise.
4. C. DRA 2005 defines a "qualified state LTC partnership" as ". . . an approved State plan amendment [to the state's Medicaid laws] . . . that provides for the disregard of any assets or resources in an amount equal to the insurance benefit payments that are made to or on behalf of an individual who is a beneficiary under a long-term care insurance policy. . . ."

Chapter 8
Qualified LTC Partnership Policies

Overview

Chapter 7 made clear the need for creative solutions to the problem of rising long-term care costs and emphasized how everyone involved in this issue—the states (especially their Medicaid programs), the long-term care insurance industry, and consumers—are looking to state long-term care insurance partnership programs as one solution. We described the basics of state LTC partnership programs and discussed the role of the Deficit Reduction Act of 2005.

This chapter describes minimum standards required by the Deficit Reduction Act of 2005 (DRA) for long-term care policies that are used in a partnership program and discusses in more detail the influence of the NAIC Model Insurance Act and HIPAA. We will also look briefly at the requirements for marketing and selling partnership-qualified LTC policies.

Chapter Objectives

Upon completion of this chapter, you should be able to:

- understand the minimum policy standards applicable to LTCI policies sold within partnership programs
- discuss the parts of the NAIC Model Act that are reflected in DRA's definition of partnership-qualified long-term care
- explain how the creation of the QLTCI policy under HIPAA laid the foundation for partnership-qualified policies today
- describe the minimum standards for marketing and selling partnership-qualified long-term care insurance
- discuss proposed additional education requirements for anyone involved in the sale of partnership-qualified policies

DRA Mandated Policy Standards

By defining the terms and conditions for a qualified state LTC partnership program, DRA 2005 also outlined the basic requirements for the policies that are to be used in such a program. However, it should be noted that the process of defining minimum policy standards had started well before 2005.

In fact, the definition of a partnership-qualified long-term care insurance policy combines facets of the NAIC's Model Long-Term Care Insurance Act, HIPAA, and the experience of the original demonstration project states. Together these three contributors provide the following:

- the architectural framework that defines many states' LTCI regulations today (the NAIC Model Act)
- the higher standards that apply to tax-qualified LTCI policies (i.e., HIPAA requirements)
- descriptions of how LTCI policies should be configured to best accommodate the needs and goals of the state partnership program (the original demonstration models)

NAIC Long-Term Care Insurance Model Act

As previously mentioned, DRA relies on the NAIC Long-Term Care Insurance Model Act and Regulation in laying out the foundation of the new state partnership programs.

The parts of the NAIC Model Act that are reflected in the DRA's definition of partnership-qualified long-term care insurance include these:

- **Policy provisions:**
    - Policies must provide for benefits for no less than 12 consecutive months.
    - Policies must be guaranteed renewable or noncancelable.
    - Policies cannot be canceled because of the insured's age or health or upon unintentional lapse in paying premiums.
    - Policies that provide a home health and community care benefit must base the benefit amount for these levels of care on a minimum percentage of the policy's nursing home benefit.
    - Pre-existing condition exclusion periods and probationary periods are prohibited in replacement policies or group LTCI policies.

- **Benefit standards:**
    - Policies must include some form of inflation protection.
    - Policies must offer nonforfeiture benefits *and* provide some form of contingent benefit upon lapse if the nonforfeiture benefit offer is rejected.
    - Policies must use the benefit triggers that have been established for tax-qualified LTCI contracts.
- **Insurer and producer standards:**
    - Post-claims underwriting is prohibited.
    - Insurers are subject to the following:
        - reporting requirements
        - licensing requirements
        - filing and actuarial certification requirements
        - standards for marketing
    - Producers and their insurers are subject to suitability requirements, including:
        - explaining and reviewing a personal worksheet with applicants
        - requiring that insurers deliver a *Shopper's Guide to Buying Long-Term Care Insurance* to applicants

HIPAA

As discussed in Chapter 7, HIPAA has been a major influence on how partnership-qualified long-term care insurance policies are defined. Its creation of the tax-qualified long-term care insurance policy, or QLTCI, laid the foundation for partnership-qualified policies today. All policies issued under the new state partnership programs must be *tax-qualified* policies.

A QLTCI policy is:

- any LTCI policy issued before HIPAA's effective date of January 1, 1997 (existing policies at the time HIPAA became effective were grandfathered) OR
- an LTCI policy issued on or after January 1, 1997, that meets a set of minimum policy standards. These standards were defined in HIPAA and are explained next.

Most LTCI policies sold today are tax qualified. Their place in the LTCI market was strengthened with DRA and its mandate that only tax-qualified LTCI policies can be used in state partnership programs. Though insurers are free to design and market non-tax-qualified LTC policies, their number and popularity in the market are diminishing.

Tax-Qualified Long-Term Care Insurance Minimum Standards

HIPAA inspired minimum standards for QLTCI policies under LTC partnership programs and includes the following:

- Benefit triggers are limited to an activity of daily living (ADL) trigger and a cognitive impairment trigger. "Medical necessity" is no longer an allowable benefit trigger. The ADL trigger generally stipulates that an insured is eligible for benefits if he or she is unable to perform without substantial assistance at least **two ADLs** for a period of at least **90 days**. At least five ADLs must be cited in the policy. Allowable ADLs include:
    - eating
    - bathing
    - dressing
    - toileting
    - continence
    - transferring
- In addition, the policy must specify that a plan of care be prescribed by a licensed health care practitioner.
- The policy must include an offer of a nonforfeiture benefit.
- Three benefit payment methods may be used in determining the basis for how the policy's benefits will be paid. It should be noted that DRA mandates that all three benefit payment methods are permissible with new partnership-qualified LTCI policies. The three methods are these:
    - **reimbursement (also known as expense incurred) method**—This approach, which was the only method permitted under the original partnership model, is the most common. Actual expenses incurred by the insured are reimbursed up to the policy's daily or monthly benefit amount. An insured covered under a policy that provides for $1,200 in monthly expenses and who incurs expenses of $1,000 would be reimbursed $1,000 by the policy.
    - **indemnity method**—This method, most commonly used with home and community care services, pays a stated benefit as long as the insured has met a benefit trigger and is receiving care. An insured covered by a policy that provides a $100 a day indemnity benefit will receive $100 a day, regardless of the cost incurred.
    - **disability (also known as cash) method**—This approach, which is similar to the indemnity method, pays a stated benefit on an ongoing basis—daily, weekly, monthly—as long as the insured has met a benefit trigger, regardless of whether he or she is receiving care.

These are the more notable effects that HIPAA and its definition of tax-qualified long-term care insurance have had on the formation of partnership program policy standards. The 1996 law affected other aspects of long-term care insurance (for example, defining qualified LTC services), and those, too, are required of partnership-qualified LTCI policies.

Minimum Standards for Partnership-Qualified LTC Insurance Policies

A review of the requirements for state LTC partnership programs reveals the combined influence of the NAIC Long-Term Care Insurance Model Act, HIPAA's definition of qualified long-term care insurance, and the partnership program experience of the four original demonstration states. Together, these influences define the minimum standards for partnership-qualified policies.

Required Partnership Policy Provisions

Policies used in conjunction with state LTC partnership programs must include provisions that meet or exceed certain minimum standards. These include the following:

- **free-look**—The policy must provide a 30-day free-look period beginning on the date the policy is delivered to the insured.
- **policy renewability**—The policy must be guaranteed renewable or noncancelable.
- **inflation protection**—Besides benefiting the insured, inflation protection is demanded by states as a way to make sure a policy's future benefits rise to match certain increases in the cost of long-term care. Without it, insureds would be more likely to exhaust their plan benefits and apply for Medicaid. DRA goes beyond the requirements of HIPAA or the NAIC Model Act. Where those laws require that inflation protection be offered, DRA requires it for LTC partnership applicants under age 76. The DRA-mandated inflation protection requirement varies by age at the time of purchase:
    - **under age 61**—Compound annual inflation protection must be provided. (Each state determines the rate or measure to be used in that state. Currently, the most common measures are 5 percent or increases in the Consumer Price Index.)
    - **age 61 through age 75**—Some level of annual protection must be provided, but to help control premium costs, the protection does need to be automatic and may be in a form other than compound interest (for example, simple interest rate increases or guaranteed purchase options).
    - **over age 75**—It is not necessary for the insured to have inflation protection. Inflation protection must be offered, but the applicant can decline it and save money on the premium.

- **minimum standards for facility coverage**—All new partnership-qualified LTCI policies must provide coverage for long-term care services in a licensed care facility, such as a nursing home. They are *not* required to provide coverage for home and community-based care; however, they may. If a partnership-qualified LTCI policy does provide coverage for home and community care, then the benefits must be at least equal to half of one year's worth of the policy's nursing care facility benefit.
    - **Example:** Jill owns a partnership-qualified long-term care insurance policy that provides a daily nursing facility benefit as well as coverage for home and community-based care. The nursing facility benefit is $150 per day. In this case, the total home and community care benefits must be at least equal to $27,375:

$$\$150 \times 365 = \$54{,}750 \times 50 \text{ percent} = \$27{,}375$$

- **unintentional lapse protection**—Lapse protection must be included in the policy, giving the insured the opportunity to reinstate the policy without underwriting or premium increases in the event he or she unintentionally fails to make a premium payment. This may be accomplished in one of two ways:
    - **impairment reinstatement provision**—Provides that the policy will be reinstated if the insured provides proof that he or she was functionally or cognitively impaired at the time the policy lapsed. This proof must be provided and outstanding premiums paid within a specified period, such as five or six months after the policy is terminated.
    - **third-party notification provision**—Provides that the insurer will send to a designated third party—such as a family member or an attorney—notification that the policy is about to lapse. The intent is to allow the third party to intervene and to help ensure that the premium is paid and the policy continues in force.
- **extension of benefits provision**—The policy must include a provision that continues nursing facility benefit payments in the event the insured lapses the policy after care in a facility has begun and benefit payments have commenced. Most policies today include a waiver of premium provision that achieves the same basic purpose, so this required provision is largely redundant.
- **nonforfeiture benefit**—The policy must include an offer of a nonforfeiture benefit. In other words, this provision entitles the owner whose policy lapses due to nonpayment of premiums to receive some benefit for the premiums he or she has paid. If a policyowner cancels or otherwise lapses the policy, one of two different options must be offered:
    - **return of premium option**, which returns to the policyowner a percentage of the sum of premiums paid at the time of cancelation
    - **shortened benefit period option**, which extends coverage for a certain period following the policy lapse or cancelation. The length of continued coverage depends on the period the policy was in force and the sum of premiums paid. This is the default option if the policyowner declines the return of premium option or simply makes no decision.

- **contingent benefit upon lapse provision**—If a policyowner chooses not to purchase a nonforfeiture benefit, the policy must provide for a contingent nonforfeiture benefit, which applies in the event that premiums are increased beyond a specified level and the policyowner determines not to pay the higher premium. This contingent benefit upon lapse may take one of two forms:
    - the offer to reduce policy benefits provided by the current coverage so that the required premium payment is not increased
    - the offer to convert the coverage to a paid-up status with a shortened benefit period (This is the default option if the policyowner makes no election.)
- **exclusions and limitations**—The policy may only include the exclusions and limitations as specified in the NAIC Model Regulation.
    - **Pre-existing condition exclusions**, if contained in the policy, must be clearly described. Only pre-existing conditions arising six months or less before the policy's effective date may be excluded, and benefits cannot be denied any longer than six months after the policy's effective date. Note, though, that as a practical matter, most LTC insurers today do not include a pre-existing condition exclusion in their individual policies, but instead underwrite the policy based on disclosed pre-existing conditions.
    - The policy's **incontestable clause** restricts the terms by which the insurer may annul coverage or deny a claim, based on any of the following conditions:
        - If the policy has been in effect six months or less, the insurer need only show a misrepresentation by the applicant of a fact that was material to the coverage's approval.
        - If the policy has been in effect at least six months but less than two years, the insurer must show a misrepresentation that was both material to the policy being issued and is related to the medical condition creating the need for LTC.
        - If the policy has been in effect for two years or more, the insurer has the difficult task of proving that the insured knowingly and willfully misrepresented material facts related to his or her health.

Minimum Standards for Marketing Partnership-Qualified LTC Insurance

The marketing and sale of partnership-qualified LTCI must be done in accordance with standards set forth in the NAIC Long-Term Care Model Act. Notable examples include the following:

- An **outline of coverage** and the NAIC's ***Shopper's Guide to Long-Term Care Insurance*** (or an equivalent buyer's guide to long-term care insurance published by the state) must be provided to the prospective insured at the time of application.
- Previous rate increases must be disclosed, which can help potential buyers judge an insurance company's tendency to raise rates on its guaranteed renewable policies. Disclosure is required before an application is accepted.
- To help protect consumers against unnecessary policy replacement, all partnership policy applications must include **replacement questions** to determine if the applicant:
    - has existing long-term care insurance coverage, and if so,
    - intends to replace that coverage with the policy being applied for
- Post-claims underwriting is prohibited. DRA specifically forbids any form of post-claims underwriting. This is the practice of automatically issuing a policy and then subjecting it to "underwriting" when a claim is submitted (with the usual consequence of coverage being retroactively denied).

Rules for Group Partnership-Qualified Long-Term Care Insurance

Partnership-qualified LTCI may be provided through group insurance contracts that meet certain minimum standards, which are also outlined in DRA.

They include the following:

- **certificate of group coverage**—Everyone covered under a group long-term care insurance policy must be given a certificate of group coverage describing principal benefits and coverages, exclusions, reductions, and limitations.
- **replacement**—If an employer replaces a group long-term care insurance policy with another, the new coverage must be offered to all eligible participants on a guaranteed issue basis.

- **conversion privilege**—Employees covered under a group LTCI policy may, upon termination of employment, elect to either continue their group coverage or convert it to an individual policy providing essentially similar coverage. Either way, the terminated individual is fully responsible for paying premiums (even if the group plan was noncontributory).

Mandatory Producer Education

As products and markets change, so do NAIC Model Acts and Regulations. The NAIC Long-Term Care Insurance Model Act and Regulation was revised to expand education requirements for anyone involved in soliciting or selling long-term care insurance. This is in line with the mandate included in DRA that "any individual who sells a long-term care policy under the partnership receives training and demonstrates evidence of an understanding of such policies."

Summary

- In this chapter, we examined the minimum standards mandated by DRA 2005 for LTC partnership-qualified policies—their structure and provisions, reflecting portions of the NAIC Model Act, as well as their tax-qualified features, following the HIPAA model.
- Under HIPAA's definitions of tax-qualified long-term care policies, benefit triggers are limited to ADLs and cognitive impairment; a nonforfeiture benefit must be offered; and benefits may be paid by three methods—reimbursement, indemnity, or disability (cash). Policies must also offer, among other features, a 30-day free-look period, guaranteed renewability, and protection against inflation and unintentional lapse.
- DRA mandates that the marketing and sale of partnership-qualified long-term care insurance must be done in accordance with standards set forth in the NAIC Long-Term Care Model Act.
- Group QLTCI must offer certificates of group coverage, coverage for all under any replacement policy, and conversion to individual coverage.
- DRA requires additional education for anyone selling QLTCI policies in conjunction with a state's partnership program.

Chapter 8 Review Questions

1. At a minimum, what must partnership-qualified long-term care insurance policies be?
    A. cancelable
    B. optionally renewable
    C. guaranteed renewable
    D. noncancelable
2. All of the following statements regarding minimum standards for partnership-qualified long-term care insurance policies are correct EXCEPT:
    A. Post-claims underwriting is prohibited.
    B. Some form of nonforfeiture option must be offered when a policy is lapsed or surrendered by the insured.
    C. Policies must use the benefit triggers that have been established for tax-qualified long-term care insurance contracts.
    D. Inflation protection is optional for all applicants.
3. Gerald purchased a partnership-qualified LTCI policy that provides coverage for both nursing facility care and home and community-based care. The daily nursing facility care benefit is $150. The total benefit available for home and community care under this policy must be at least what amount?
    A. $27,375
    B. $54,750
    C. $41,063
    D. $82,125
4. What federal law defined tax-qualified long-term care insurance policies?
    A. Tax Reform Act of 1986
    B. Omnibus Budget Reconciliation Act of 1993
    C. Health Insurance Portability and Accountability Act of 1996
    D. Deficit Reduction Act of 2005
5. In defining the terms and conditions for a qualified state long-term care insurance partnership program, DRA outlines basic requirements for partnership-qualified LTCI policies in all the following respects EXCEPT:
    A. minimum policy provision standards
    B. maximum allowable premiums
    C. mandatory inflation protection
    D. mandatory producer training requirements

6. As required by DRA, all long-term care insurance policies used in any new state partnership programs must be tax qualified as defined by HIPAA.

    A. True

    B. False

Answers to Chapter 8 Review Questions

1. C. Regarding renewability, the minimum requirement is that partnership policies must be guaranteed renewable. Alternatively, they may be issued as noncancelable, which would prevent the insurer from raising premiums for any reason.
2. D. DRA requires inflation protection for all applicants under the age of 76.
3. A. The total benefit under a qualified LTC partnership policy for home and community-based care must be equal to at least half of the benefit payable for skilled nursing facility care for one year. In this case, because the benefit for nursing facility care for one year would be $54,750 ($150 a day × 365 days), the home and community-based care benefit must be at least $27,375.
4. C. HIPAA's creation of the tax-qualified long-term care insurance (QLTCI) policy laid the foundation for partnership-qualified policies today.
5. B. DRA mandates minimum policy provision standards, mandatory inflation protection, and producer training requirements, but not maximum allowed premiums.
6. A. DRA mandates that all policies issued under the new state partnership programs must be tax-qualified policies.

Chapter 9
Self-Funding and Other Alternatives to Purchasing Long-Term Care Insurance

Overview

Individuals and their families have two ways to pay for the cost of long-term care services:

1. They can fund the care directly.
2. They can shift the cost to a third party—either a long-term care insurance carrier through the purchase of an LTC policy or to a public assistance program, such as Medicaid.

Of course, shifting the cost to Medicaid—even through a partnership program—still requires that the individual enter the Medicaid system and conform to Medicaid rules, requirements, and restrictions. Long-term care insurance is attractive, but it can be expensive, and not all applicants will qualify for coverage.

This chapter discusses options other than the purchase of LTC insurance to cover the cost of long-term care: self-funding as well as other resources that may be available to help individuals finance all or part of their LTC services. Even those judicious enough to have purchased LTCI may still have to tap into their personal assets when policy benefits fall short. For most, the funding for long-term care, absent qualifying for Medicaid, comes from a combination of sources.

Chapter Objectives

Upon completion of this chapter, you should be able to:

- identify viable alternatives to purchasing long-term care insurance
- be familiar with these methods and explain why they are not always suitable options for funding long-term care

Funding Alternatives to Long-Term Care Insurance

For many people, paying for long-term care services will have to come from personal savings and personal assets, either because they did not purchase a long-term care policy, or they do not qualify (or want to qualify) for Medicaid. Certainly, financing LTC costs is not limited to the purchase of insurance or reliance on Medicaid. There are many other options. These include the following:

- current savings and investments
- home equity and a reverse mortgage
- annuities
- life insurance
- health savings accounts (HSAs)

The discussion that follows deals with how these resources and options can be used to meet long-term care expenses and when they may—and may not—be viable alternatives to purchasing long-term care insurance.

Self-Funding from Current Savings and Investments

Self-funding refers to paying for long-term care costs out of pocket with personal or family money, savings, pension benefits, stocks, bonds, and other investments. Contributions from children or other relatives may also come into play. However, most people find that, even when done in advance, saving a sufficient amount every month or every year for long-term care expenses is extremely difficult. Those who are older may not have enough time to ensure funding is complete.

Consider Future LTC Costs

Our discussion in this course of long-term care costs has primarily pertained to the cost in present-day dollars. However, it is important to remember that when planning for long-term care, the focus should not be on the cost of care currently but what care will cost when it is most likely to be needed. That may be 10 years, 20 years, 30 years, or longer. Nationally, the average annual cost today for a private one-bedroom unit in an assisted living facility is about $48,000. The national average cost for a private room in a nursing home is around $100,000 a year. If we were to assume a 3 percent annual cost increase, long-term care for one year in an assisted living facility may cost as much as $65,000 in 10 years, $87,000 in 20 years, and $117,000 in 30 years. Assuming the same 3 percent annual cost increase, a one-year stay in a nursing home may cost as much as $135,000 in 10 years, $181,000 in 20 years, and $243,000 in 30 years.

The risks of self-funding long-term care costs for even the most prosperous individuals are not insignificant. They include:

- not being able to define future long-term health care costs
- not knowing when long-term care will be needed
- not wanting to "sacrifice" precious money toward care that is intended for inheritance by family members and dependents
- losing the ability, through dementia or similar cognitive failure, to understand what type of care the money should be spent on

Generally, self-funding is possible only for individuals with above average wealth. Those whose disposable incomes exceed the cost of care are the best candidates for self-funding. For most others, attempts at self-funding will result in exhaustion of assets, eventually leading to Medicaid eligibility.

Reverse Mortgages

Many people, especially those who have been in their homes for a very long time, find themselves sitting on significant equity. The homeowners have probably paid off the home, which has likely appreciated over the years. They have also likely made improvements over time, further enhancing the home's value. A **reverse mortgage** is a means of turning the value of home ownership into cash. All or part of the equity in the home can be converted into cash without having to sell the home or taking on additional monthly bills, as would be the case with taking on a second mortgage. To be eligible for most reverse mortgages, homeowners must be *62 years of age or older*.

Comparing Reverse and Conventional Mortgages

A reverse mortgage is best explained by comparing it to a conventional or "forward" mortgage. In a conventional forward mortgage, the lender checks the borrower's income and credit history and appraises the house to ensure that its market value is sufficient to support the loan. The mortgagor borrows money from the lender using the home as collateral and pays the lender each month an amount representing principal and interest. As the debt is paid down, the borrower's equity in the home grows.

A reverse mortgage works in the opposite way. The homeowner receives money from the lender based on the home's appraised value. The loan's collateral is the home's equity, or its appraised value. So, the homeowner doesn't make any monthly payments to the lender—in fact, the lender makes payments to the homeowner each month (or in whatever way the terms of the reverse mortgage have been established) based on the home's appraised value.

With a reverse mortgage, the homeowner is increasing the debt on the home by taking the equity in cash. No repayments are made. The result of a reverse mortgage is just the opposite of a conventional mortgage: the debt increases and the home equity decreases. The amount owed grows larger as more cash is taken and more interest is added to the loan balance.

The loan does not have to be repaid until the owner dies, moves from the home, or sells the home. The final payment to the lender is typically structured not to exceed the home's selling price.

Types of Reverse Mortgages

There are three basic types of reverse mortgages:

- **single purpose reverse mortgages**, which are offered by some state and local government agencies and nonprofit organizations
- **federally insured reverse mortgages**, which are known as **home equity conversion mortgages (HECMs)** and are backed by the U.S. Department of Housing and Urban Development (HUD)

- **proprietary reverse mortgages**, which are private loans that are backed by the companies that develop them

Single purpose reverse mortgages generally have very low costs, but they are not available everywhere, and they can only be used for one purpose as specified by the government or nonprofit lender. An example is to pay for home repairs, improvements, or property taxes. In most cases, homeowners must have low or moderate incomes to qualify for these reverse mortgages.

HECMs and proprietary reverse mortgages tend to be more costly than other home loans. They are widely available, have no income or medical requirements, and can be used for any purpose. The Department of HUD now requires that the homeowner's willingness and ability to meet his or her financial obligations (including payment of property taxes and insurance) must be considered when evaluating an applicant for an HECM.

Annuities

An **annuity** is another option for funding long-term care. Annuities can be used to accumulate funds for a future point and then distribute those funds systematically over the life of the annuitant (or over any period the annuitant desires). Alternatively, an annuity can be used to convert a single amount of money into a series of periodic income payments, which will be paid as long as the annuitant wishes. Thus, a conventional annuity can be used to fund long-term care in two ways:

- to grow and accumulate funds for a future point—i.e., when long-term care will be needed
- to distribute funds systematically for as long as the annuitant wants to help cover the ongoing costs of long-term care; the systematic payout of an annuity's funds over time is "annuitization"

Tax Deferral

One of the advantages of using an annuity as a way to accumulate funds for long-term care (or for any purpose) is **tax deferral**. As the funds accumulate in the contract, they are credited with interest earnings declared by the insurer (fixed annuities), or they grow in relation to the performance of underlying stock and bond investments in which they are deposited (variable annuities). These earnings and this growth are not subject to income tax until the funds are withdrawn from the annuity. Tax deferral enhances the product's ability to accumulate funds: earnings compounded on earnings, unhampered by taxes, produce greater accumulations.

Though annuity earnings are subject to ordinary income taxation when funds are withdrawn from the contract, the annuity owner may at that point be in a lower tax bracket. Obviously, this will lessen the tax liability on withdrawn or distributed annuity funds. Annuity funds can be taken as flexible or systematic withdrawals or as annuitized income payable for a set period or over the life of the annuitant.

Hybrid Annuities

For many, a **hybrid annuity** may be a suitable option for LTC funding. Fairly new to the insurance market, hybrid annuities are fixed single premium deferred annuities with long-term care insurance riders. These products are designed to meet two objectives:

- to provide a means to cover the cost of LTC insurance and to generate LTC benefits if that need arises
- to accumulate funds on a tax-deferred basis for any future purpose, if LTC is not needed

Like a conventional fixed deferred annuity, the insurer credits a certain amount of interest to the hybrid contract. On a regular basis, the annuity's cash value fund is charged an amount for the cost of the LTC insurance rider. (This charge is usually between 60 and 125 basis points of the account value.) The amount of the long-term care benefit the product will deliver is typically set at some multiple of the

annuity's cash value when the first claim for long-term care benefits is made, such as two or three times the value. For example, an individual who deposited $100,000 in a hybrid annuity that grew to $150,000 by the time an LTC claim occurred would have $300,000 to $450,000 of long-term care coverage, depending on the multiple. Other product designs provide for an LTC fund equal to some multiple of the original premium deposit.

If long-term care is needed, the benefit is funded first through monthly payouts of the annuity's cash value at a set percentage (such as two or three percent). If the cash value is depleted and care is still needed, then at that point, the LTC rider becomes operative and will continue to pay the same monthly amount for an extended period, such as 25 or 50 months.

If long-term care is not needed, the hybrid annuity operates as any other deferred annuity. The owner can:

- continue the contract as long as he or she wishes, earning tax-deferred interest
- withdraw the contract's values and pay taxes on the earnings
- annuitize the contract

Having the option to use the contract's funds for other than long-term care is one of the primary advantages of a hybrid annuity. It overcomes the concern many consumers have about purchasing a stand-alone LTC insurance policy: that long-term care will not be needed and that premiums paid for such coverage would be "wasted."

Hybrid annuities are typically issued with a waiting period (such as two years from the time the product is purchased) before benefits will be paid, as well as an elimination period (such as 90 days) once an LTC claim is filed. Many hybrid annuities also offer optional inflation protection provisions.

As noted, hybrid LTC annuity products are fairly new. They have been on the market and available to consumers for only a few years and, to date, have not been widely purchased. However, the Pension Protection Act of 2006 included a provision that may offer greater incentive for consumers to consider these products. Effective January 1, 2010, charges against an annuity's values to cover the cost of long-term care insurance rider benefits are not considered taxable distributions (though they do reduce the owner's basis in the contract).

Annuities and Medicaid

The treatment of annuities with regard to Medicaid eligibility has undergone a number of changes set forth by the Deficit Reduction Act. Medicaid applicants must disclose any annuities they (or their spouses) own or in which they have an interest. And as a general rule, the state now has to be named as a beneficiary of any annuity proceeds remaining upon the institutionalized person's death in the amount of medical assistance paid on behalf of the institutionalized individual. The state must be named as primary beneficiary if there is no spouse, minor child, or disabled child. If there is a spouse or a minor or disabled child, the state must be named as contingent beneficiary, standing second in line to receive any remaining contract proceeds.

So that an annuity purchased by or on behalf of a Medicaid applicant is not treated as a transfer for less than full value, it must be irrevocable and nonassignable, have a payout period equal to the annuitant's life expectancy, and pay out in equal payments (no deferred period or balloon payments).

Life Insurance

Life insurance is a contract that provides for the payment of specified benefits upon the death of an insured. It involves the assumption of the risk of the insured person's death. The element of uncertainty in life insurance policies is not if the death will occur but when the death will occur. This is different from casualty insurance, where the policy pays only in the event of a covered loss.

Life insurance is purchased for a variety of reasons:

- to ensure the financial security of a spouse, children, and other family members
- to preserve an estate
- to meet final expenses
- to pay estate taxes and fees
- to clear up outstanding debt
- to support favored charities

Life insurance provides immediate cash at death. It is designed primarily to provide financial protection and guaranteed resources for those dependent upon the insured in the event of the insured's death. Cash value life insurance was never intended to finance ongoing long-term care costs; however, through a variety of means—loans, partial withdrawals, or policy surrender—its values can be used to cover some LTC costs. It has the best application for this use when its primary purpose (providing a benefit upon the insured's death) has diminished or has been supplanted by living needs. Any use of a life insurance policy's values during life will likely reduce or eliminate the benefit payable at death.

The use of a life insurance policy to meet LTC needs may include any of the following. (Of course, the use of a policy's cash value applies only to permanent policies, not term policies.)

- cash value loans
- cash value withdrawals
- cash value policy surrender
- accelerated benefits
- life insurance settlements

Cash Value Loans

The values in a permanent life insurance policy can be accessed through a **policy loan**. These amounts can be used for any purpose, including payment for LTC services. A loan from a life insurance policy does not have to be repaid; however, any loan amounts outstanding (plus interest) at the insured's death are deducted from the policy's death benefit.

Insurers typically limit loan amounts to 90 percent of the policy's cash value. Loans are usually made at interest rates that are competitive with current market rates. The interest rate that the insured pays the insurer for the loan is always greater than the rate credited to the contract by the insurer. Under most contracts, even the amounts borrowed continue to accumulate interest for the insured at a minimum rate.

Cash Value Withdrawals

With some types of permanent insurance policies—universal life or variable universal life—policyowners can take **withdrawals** from their cash values. Withdrawals may be taken as needed by the policyowner, or they may be set up for automatic and systematic withdrawal.

A policyowner who takes withdrawals from his or her contract is able take full advantage of the tax benefits of the life insurance contract. Unless the policy is a modified endowment contract (MEC), withdrawals are not included in gross income and are not subject to tax as long as they do not exceed the policyowner's cost basis (premiums paid). Life insurance policy withdrawals are deemed to come first from premiums paid. Not until withdrawals exceed premiums paid will interest be considered withdrawn. Withdrawals of interest are subject to tax at ordinary rates.

Like policy loans, withdrawals reduce the amount of cash value and the death benefit payable.

Cash Value Policy Surrenders

Life insurance policies are frequently surrendered in full when the need for which the contract was purchased (providing a death benefit) has passed or when funds are required for another purpose. When a life insurance policy is **surrendered**, the full amount of the cash value (less any loaned amount) is paid to the owner, and the policy expires. Of course, the surrender of the policy means that no death proceeds will be paid at the insured's death.

The amount of cash value received by the policyowner is tax free, up to the amount of premium paid. Amounts in excess of premiums paid are taxable as ordinary income.

Assuming the policy meets the definition of life insurance and is not a MEC, the policyowner recovers his or her cost basis in the policy tax free. The value in excess of cost basis is taxed as ordinary income.

Accelerated Benefits

Specifically targeted to the payment of a life insurance policy's values for long-term care or late life needs are **accelerated benefits**. Accelerated benefits policy provisions and riders are now common to many types of permanent life policies, providing for the payment of all or some portion of the policy's death benefit in the event the insured faces a critical late-life need.

Though they vary from policy to policy, the circumstances that commonly trigger the payment of accelerated benefits include the following:

- diagnosis of a terminal illness or physical condition, with death expected within a specified number of months (typically 12 to 24)
- confinement in a nursing home or skilled nursing facility
- a chronic illness condition
- the need for LTC services due to an incapacitating condition

The amount paid under an accelerated benefit provision varies from company to company and policy to policy. It is usually in the range of 50 to 90 percent of the policy's death benefit. Depending on the terms of the provision, the amount may be paid in a lump sum or in monthly installments.

Amounts paid out as accelerated benefits are subtracted from the policy's death benefit. At the insured's death, any values that remain are paid to the insured's beneficiary or to his or her estate.

Accelerated Benefits for Long-Term Care

Life insurance provisions that provide accelerated benefits for conditions that encompass long-term care services are classified in one of two ways:

1. as those that conform to Section 101(g) of the Internal Revenue Code
2. as those that conform to Section 7702B of the Internal Revenue Code

IRC Section 101(g)

Section 101(g) of the Code stipulates that amounts received under a life insurance policy are tax free, if they are paid by reason of "the death of the insured." It further stipulates that amounts paid on the life of an insured who is *terminally ill* or *chronically ill* will be treated as amounts paid by reason of the death of the insured.

Consequently, provisions that pay benefits for chronic illness and are classified solely under this section of the Code can pay accelerated benefits due to the (pending) death of the insured. They are usually marketed as "accelerated death benefits for chronic illness" and must meet the requirements of the NAIC's Accelerated Death Benefit model regulation (or whatever similar requirements pertain to the state

in which the rider is available). Chronic illness riders under Section 101(g) are considered *life insurance.* They may *not* be sold or marketed as long-term care coverage or long-term care benefits.

IRC Section 7702B

Section 7702B of the Code defines the criteria for qualified long-term care (LTC) insurance. It classifies such coverage as *accident and health insurance* and treats amounts received by the insured as nontaxable reimbursements for medical care (up to certain limits). It defines benefits as being paid to a "chronically ill" insured who meets the following criteria:

- being unable to perform at least two activities of daily living for a period of at least 90 days, due to a loss of functional capacity or a disability *or*
- requiring substantial supervision due to severe cognitive impairment

In addition, the services provided to a chronically ill individual must be delivered under a care plan prescribed by a licensed health practitioner.

Policies that meet the requirements of Section 7702B may be sold or marketed as long-term care coverage or as providing long-term care benefits. Accelerated death benefit riders that cover qualified long-term care are administered very much like stand-alone long-term care insurance policies.

Chronic Illness vs. Long-Term Care: Similarities and Differences

There is often confusion over policies that provide accelerated benefits for chronic illness and those that provide accelerated benefits for qualified long-term care. The confusion may stem from two things: the definition of the condition of being "chronically ill" and the conditions that trigger the accelerated benefits.

Essentially, the definition of chronically ill and the benefit triggers are the same for both (i.e., the inability to perform at least two activities of daily living or severe cognitive impairment). Section 101(g) actually refers to Section 7702B for the definition of "chronically ill."

In addition, both provide benefits by accelerating (and thus reducing) the policy's death benefit. Policyowners can choose to accelerate all, some, or none of the benefits provided by either, once the insured qualifies. Any portion of the benefit that is not paid out as an accelerated benefit is paid to the policy's beneficiaries as a death benefit when the insured dies. Both types of accelerated benefits will likely require ongoing certification that the insured meets the qualifications for benefits and receives treatment under a prescribed plan of care.

But there are important differences between accelerated chronic illness benefits and accelerated qualified long-term care benefits:

- Chronic illness benefits usually require that the condition be *permanent* or *likely to last the rest of the insured's life.* This permanency condition is not required for LTC riders. Instead, an LTC rider will stipulate that the triggering condition must be expected to last *at least 90 days.* Consequently, recoverable conditions that would trigger benefits under an LTC rider (such as physical complications following surgery or a mild stroke) would not be eligible for claim under a chronic illness rider.
- As a general rule, a long-term care benefit provides more comprehensive coverage aimed specifically at long-term care or nursing home costs than do chronic illness benefits. Qualified LTC benefits often provide for the acceleration of 100 percent of the policy's death benefit.
- Chronic illness provisions typically limit the amount that can be paid out as an accelerated benefit to something less than 100 percent of the death benefit, so that the policy will, in fact, pay a death benefit when the insured dies.

- Long-term care benefits are usually underwritten separately from the base life insurance policy (based on morbidity risks), and a separate, additional premium is charged for the rider (or an additional monthly charge is assessed against the policy's cash value, if the policy is a universal life policy).
- Life producers who sell policies that provide qualified long-term care benefits must also be health-licensed (and may have to meet any long-term care training their states require); life producers who sell life policies that include chronic illness benefits do not have to meet any additional licensing or training requirements.
- Chronic illness benefits must be paid out as an indemnity; long-term care benefits can pay as either an indemnity or a reimbursement.
- Long-term care provisions must include certain "consumer protections" (similar to those of a stand-alone qualified long-term care policy) that do not have to be included in chronic illness riders.

The drawback to using accelerated benefits to fund long-term care is that, again, amounts taken from the policy for this purpose are not available to the insured's beneficiaries at death. In addition, the amount of money available under an accelerated benefits option may not come anywhere close to covering the LTC expense. A $50,000 life insurance policy that releases 70 percent of the death benefit for confinement in a nursing home would fund only $35,000 of the cost of that care.

"Hybrid" Life Insurance with LTC Benefit

Life insurance policies can include a long-term care benefit, either as part of the policy or as a rider. These "hybrid" policies provide for an advance on the policy's death benefit, payable tax-free, to cover long-term care costs while the insured is living. If the insured is certified as needing long-term care (i.e., he or she cannot perform two of the six specified activities of daily living), the benefit can be paid as a drawdown on the death benefit. The LTC benefit is typically defined as a percentage of the death benefit, paid monthly. For example, a $100,000 life policy might provide for a monthly long-term care benefit of 3 percent. Accordingly, this policy would pay $3,000 a month, up to 33.3 months, at which point the benefit would be exhausted. Any portion of the death benefit not paid out for long-term care would be payable as a death benefit to the insured's beneficiaries at the insured's death.

As one might imagine, there is an additional cost for adding such a benefit to a life insurance policy—premiums are higher than they otherwise would be if no LTC benefit were included.

Life Insurance Settlements

Life insurance settlements involve the sale of life insurance policies to a third party. They serve as a means to receive some value from the policy while the insured is living.

There are two types of life insurance settlements:

- viatical settlements
- lifetime settlements

Viatical Settlements

A **viatical settlement** is similar to receiving benefits under an accelerated death benefits provision in that it allows the insured to access the policy's death benefit early. Viatical settlements, however, involve the sale of the policy. The insured sells his or her policy to a third party viatical company for some amount less than the policy's face value. The viatical company becomes the owner and beneficiary of the policy. It assumes the responsibility of paying the premiums and, at the insured's death, receives the policy's death proceeds.

Viatical settlements involve only insureds who are terminally ill and have a limited life expectancy—usually two years or less. The payment the insured receives for the sale of his or her policy is not taxable. Though a viatical settlement is for those who face life-threatening illnesses or conditions—and the consequent costs of treatment—the money the insured receives from the sale of his or her policy may be used in any way he or she wishes.

Viatical settlements are controversial because the amount the insured receives for the sale of the policy is usually far less than the policy's face amount. In addition, viatical companies often sell the policies they acquire to other parties—those with no interest at all in the insured but who stand to benefit when the insured dies. However, for some insureds, the sale of their life insurance policies through a viatical settlement may be the only way to obtain needed funds for their end-of-life care.

Lifetime Settlements

A **lifetime settlement** is similar to a viatical, but it does not require a terminal illness to pay out. This type of settlement is specifically targeted to seniors, generally over the age of 65 or 70, and allows them to cash out of their life insurance policies early. Essentially, this product permits policyholders to reapply their policy values to lifetime needs.

Like a viatical, a lifetime settlement is not a surrender of the policy but rather a sale of the policy and a transfer of ownership and rights. The insured sells his or her policy to a settlement funding company that, in turn, becomes the policyowner and beneficiary. The settlement company pays the premiums and receives the death benefit proceeds upon the insured's death. With a viatical, death is looming; with a life settlement, there is no terminal illness involved. The life expectancy under a settlement arrangement is typically much longer—often as long as 10 or 12 years or so. Therefore, the price paid for the sale of the policy under a life settlement arrangement is usually far less than the price paid for a policy under a viatical. The settlement company discounts the policy's death benefit based on underwriting criteria and purchases the policy for a certain percentage of the death benefit. The purchase price will be much less than the policy's death benefit but greater than the cash surrender value to create an incentive for the sale. The benefit to the senior policyowner is cash in the hand.

Health Savings Accounts

Health savings accounts (HSAs) are a fairly recent innovation, designed to help individuals save for and fund qualified health care expenses on a tax-free basis. Included in the definition of "qualified" health care expenses are those associated with long-term care and premiums for a long-term care insurance policy.

An HSA is a special account owned by an individual and used to pay for current and future qualified medical expenses. HSAs are used in conjunction with high-deductible health insurance policies offered by many insurance companies. A high-deductible health plan must have a deductible of at least $1,400 for individual-only coverage and at least $2,800 for family coverage (as of 2020). In addition, these policies must cap annual out-of-pocket expenses, including deductibles and co-pays, to be no more than $6,900 for individual-only coverage and $13,800 for family coverage (in 2020). These amounts are indexed annually for inflation.

The high-deductible health insurance plan is actually the second part of the equation—the first part is the health savings account. The HSA is used to accumulate amounts for health care expenditures on a tax-advantaged basis. Contributions made to the account are tax deductible (subject to certain annual limits); interest earnings on the account are not taxable; and withdrawals taken from the account are tax free as long as they're used to pay for qualified medical expenses. The amounts in an HSA are intended for routine medical care and routine expenses. If and when medical expenses exceed the deductible on the owner's associated health insurance policy, the policy "kicks in" and starts paying for covered medical expenses.

HSAs can be set up by an individual (in which case contributions are tax deductible), or they can be set up by employers on behalf of their employees, in which case employee contributions are made on a pre-tax basis. Contributions to an employer-sponsored HSA can be made by an individual, the employer, or both. Any contribution made by an employer is not taxable to the employee.

HSAs: Custodial Accounts

An HSA is a **custodial account**—that is, it requires administration by a trustee. Many financial institutions offer HSAs. Individuals are responsible and accountable for the funds they use to pay for their health care expenses.

While an HSA account is technically a savings account, it is set up like a checking account, and account holders can take distributions from their accounts to meet qualified health care expenses by writing checks to their doctors or pharmacies or other health care providers. Some financial institutions offering HSAs provide debit cards as a convenient means to pay for care.

The tax-advantaged nature of HSAs makes these products attractive health care funding vehicles for many individuals. Expenses that an HSA can cover are those that would generally qualify for the medical expense tax deduction. They include physicians' fees, prescription and some nonprescription medicines, co-pays, lab fees, diagnostic tests, hospital services, hearing aids, and even eye and dental care. In addition, LTCI premiums for tax-qualified policies are considered qualified medical expenses and can be paid from the account, as can premiums and co-pays associated with Medicare.

An HSA is not a "use it or lose it" device. The account holder owns the funds in the account, and any money not spent at the end of the year may be kept in the account and used toward medical expenses in following years.

Drawbacks to Health Savings Accounts as Long-Term Care Funding Vehicles

While HSAs may seem like a practical alternative to purchasing long-term care insurance because of their tax-favored status and the fact that they are designed for the specific purpose of funding health care needs, their drawback for this purpose is the maximum annual contribution limit. Annual contributions for single coverage are limited to specified amounts ($3,550 for individual coverage and $7,100 for family coverage, as of 2020). There are annual catch-up provisions for those over 55, but these are typically rather small amounts (currently $1,000).

An HSA might be used to fund some long-term care expenses, but contribution limits preclude any significant accumulation. The main way HSAs are used to fund long-term care is to pay for long-term care insurance premiums. However, as discussed earlier, HSA funds used to cover LTC premiums on a tax-free basis are limited to the amount that can be deducted annually as a qualified medical expense, which varies by age.

Summary

- Some individuals have the financial resources to pay for their long-term care costs. However, even they should consider whether they want to risk spending very large amounts of money on care that might have been used to improve their quality of life or to provide for heirs.
- Others frequently think they can come up with alternative means of funding LTC costs: self-funding, reverse mortgages, annuities, and life insurance policies.
- All of these provide ways to help cover the costs of LTC; however, with some exceptions, they are not specifically designed to meet LTC needs and would likely fall short of providing full LTC funding.

Chapter 9 Review Questions

1. In a reverse mortgage, a homeowner receives money from the lender.
    A. True
    B. False
2. A disadvantage to using a conventional deferred annuity to fund late-life long-term care needs is that the contract must be annuitized, and payments must be made over a stated number of years or for life.
    A. True
    B. False
3. All of the following are sound reasons for purchasing life insurance EXCEPT:
    A. ensuring the financial security of a spouse, children, and other family members
    B. preserving an estate
    C. funding anticipated LTC expenses
    D. clearing up outstanding debt owned by the decedent
4. Because taking a withdrawal from the cash value of a life insurance policy is always a taxable event, this technique should *not* be used to fund long-term care needs.
    A. True
    B. False
5. Which of the following refers to the sale of an in-force life insurance policy by a terminally ill insured to a third party for an amount less than the policy's death benefit?
    A. viatical settlement
    B. life settlement
    C. accelerated death benefits
    D. POD arrangement
6. All of the following apply to life insurance policies that accelerate benefits for both chronic illness and qualified long-term care EXCEPT:
    A. To qualify for the accelerated benefit, the insured must be unable to perform at least two ADLs or suffer from severe cognitive impairment.
    B. The benefit is provided through accelerating payment of the policy's death benefit.
    C. The policyowner can elect to accelerate all, some, or none of the available benefit if the insured qualifies.
    D. The benefit must be paid as a reimbursement benefit, not an indemnity benefit.

7. A hybrid annuity combines a fixed deferred annuity product with which of the following?
    A. life insurance
    B. an HSA account
    C. a long-term care rider
    D. a tax-free investment account
8. A health savings account (HSA) is used in conjunction with which of the following?
    A. a long-term care insurance policy
    B. a high-deductible health insurance plan
    C. a Medigap policy
    D. a medical expense policy

Answers to Chapter 9 Review Questions

1. A. The homeowner receives money from the lender based on the home's appraised value. Collateral has already been established by the equity in the home.
2. B. a deferred annuity does not have to be annuitized. Owners can access all or a portion of the contract's funds through lump-sum or partial withdrawals. However, withdrawals do not receive the same tax-advantaged treatment that annuitization is given.
3. C. An LTCI policy is more appropriate for meeting long-term care expenses than purchasing a life insurance policy, which is better suited for providing financial security for surviving family members.
4. B. As long as the insurance policy meets the definition of an insurance policy and not a MEC, policy withdrawals are not taxable unless and until the withdrawn amount exceeds premiums paid.
5. A. A viatical involves the sale of an existing insurance policy by a terminally ill insured to a third-party viatical settlement company. The amount paid for the policy is more than the cash surrender value but less than the policy's death benefit.
6. D. Accelerated benefits for chronic illness must be paid out as an indemnity; accelerated benefits for qualified long-term care can pay as either an indemnity or as a reimbursement.
7. C. A hybrid annuity combines a tax-deferred fixed annuity with a long-term care rider.
8. B. An HSA is used in conjunction with a high-deductible health insurance plan.

Chapter 10
Ethical Considerations in the Sale of Long-Term Care Insurance

Overview

Financial services practitioners often find that consumers lack the education or experience to deal appropriately with their financial matters. This is especially so with older clients and issues related to long-term care. Understandably, older individuals usually do not understand long-term care insurance or how it works—LTCI products can be very complex. Older individuals may not have the knowledge to properly evaluate their need for insurance in light of other options that might be available to them. In addition, they may suffer from cognitive impairment or diminished cognitive ability, making them entirely dependent on the advice of others.

Any financial product recommendation should rely on a needs-based approach to identify the most suitable product for the customer. This holds true for long-term care insurance. Only after a thorough evaluation of the facts and circumstances surrounding an individual's situation can a producer determine the need for an LTC product and make any kind of recommendation for its purchase. In addition, ethical sales and ethical marketing practices must be strictly followed. Older clients are especially at risk if producers do not follow appropriate marketing and sales guidelines because, overall, they are less financially sophisticated and because the consequences of questionable sales practices are heavy.

Chapter Objectives

Upon completion of this chapter, you should be able to:

- explain the concept of needs-based selling and its four steps
- describe the NAIC's Long-Term Care Insurance Model Act and Long-Term Care Insurance Model Regulation and their proposed legislation
- demonstrate appropriate sales and presentation practices when offering LTCI policies
- characterize ethical and unethical practices when presenting LTCI
- describe suitability standards as set forth by the NAIC

Needs-Based Selling

A **needs-based long-term care sale** is an approach to offering long-term care products in which the prospect's overall financial needs are defined and analyzed. This process goes into great detail in discovering and analyzing needs and creating recommendations that align those needs with a suitable product solution.

An LTC needs-based selling system analyzes a customer's situation, needs, and concerns and determines first whether an LTCI policy is an appropriate option and, if so, how it can best be designed or structured to meet the customer's needs. This approach contrasts to recommending and selling based on the obvious aspects and features of the product or on the need of the producer to generate a sale. The process uncovers customers' long-term care concerns, their current financial condition, and projected financial circumstance. Their issues are personalized so that they begin to actually recognize the extent of their needs. Based on the results of the process, the most suitable plan can be developed for meeting the specific needs identified.

Needs-based selling is a four-stage process:

1. **fact finding**—Identifying information about the customer's long-term care needs, wants, wishes, desires, and expectations.
2. **needs analysis**—Reviewing the data collected.
3. **product recommendation**—Offering the most appropriate product based on reasonable grounds.
4. **prospect understanding**— Ensuring the customer thoroughly understands the features and provisions of the proposed solution.

Step 1: Fact Finding

The **fact-finding** process is a technique of data collecting. The questionnaire or survey format is a useful tool, especially if customers can complete it at their own pace. Personal interviews are also a valuable means of fact finding. Often these are used in conjunction with software planning programs that make the entire process of fact finding, needs analysis, and product recommendation very powerful. The customer's plan is developed graphically as the agent enters information. This helps customers to visualize their needs and the necessity for a solution. These programs ensure that all the right questions are asked and asked in the right order.

The Fact-Finding Interview

The fact-finding interview asks potential customers questions such as the following:

- **What is your age?** The younger the applicant, the easier and less expensive it will be to qualify for coverage.
- **What is your net worth?** Some customers may not have sufficient assets to protect and, therefore, may not be candidates for long-term care insurance.
- **What is your source of income?** Individuals whose only sources of income are Social Security and/or supplemental security income (SSI) are probably not candidates for an LTCI policy. Those who have other income resources, such as a pension or investment income and who have the means to pay the premiums are more likely potential buyers and more likely to want the coverage. Younger prospects may still be in their income-earning years.
- **How do you plan to use your assets?** Most people have earmarked their retirement assets for uses other than financing long-term care. How would they feel if those assets had to be directed to covering the cost of care?
- **Do you have heirs or a favorite charity?** Those who have favored charities, heirs, or other people they would like to provide for have additional concerns about protecting assets. It's not just a question of having adequate funds for care. It's also about preserving assets for loved ones and others.
- **What are your objectives?** Most individuals want to remain as independent and self-sufficient for as long as they can. They do not want to become a burden on their families and want to be able to determine for themselves where and how they will receive long-term care. The issues of self-reliance and freedom of choice may be very important. The fact-find should probe to determine how the prospect feels about:
    - protecting his or her assets
    - relying on others as opposed to paying for his or her own care
    - having the freedom and ability to choose where and how care will be delivered when it's needed
- **What are your risks of needing long-term care?** While no definitive way exists to determine whether any one individual will require long-term care, certain factors may point to an increased risk. The prospect should be asked to consider whether his or her medical history, family history, or lifestyle could contribute to an increased risk of needing long-term care.

It's likely that any potential need and desire for long-term care insurance will be revealed early in the fact-finding process. If, based on the prospect's stated objectives, an LTCI policy can help meet a need and advance the prospect's position, and it is clear that he or she has the financial means to pay for premiums, then the fact-find can move to the next level.

The next level is the medical aspect of the fact-finding interview. Customers will be asked if they have ever been medically diagnosed for conditions such as having chronic memory loss, Parkinson's disease or Alzheimer's disease, dementia, strokes, and others. Are they currently on oxygen or kidney dialysis? Do they currently use a walker or wheelchair? Do they currently require assistance with activities of daily living? The answers to these questions will be used for underwriting purposes.

Questions in the financial arena include these:

- **What are the costs of long-term care in your area?** The amount of coverage is dependent on regional costs.
- **How much of the cost of long-term care do you wish to insure?** Depending on assets and the ability to shoulder some of the costs, customers may typically choose covering between 100 percent, 90 percent, 80 percent, or 50 percent of their long-term care costs.

The type of care is the subject of the final phase of the interview. Is the customer interested in home health care-only coverage, nursing home-only coverage, or comprehensive coverage that provides both? Many people have not given this much thought. They simply think of long-term care as one event, not recognizing the various levels or settings for care. Another consideration is whether there are family members nearby who could act as a support system. If so, this may cut down on the amount of coverage necessary, although prospects—guided by the producer—should give much thought to whether family members can be counted on and whether they would even want to be cared for in this way.

Step 2: Needs Analysis

The second step in needs-based selling is analyzing the data gathered. A well-thought LTC **needs analysis**:

- identifies the impact that a long-term care event would have on an individual or family's finances
- assesses the resources available to address that event
- determines the amount of coverage necessary to adequately protect them

It is important to involve clients in the process, allowing them to use their own ideas and assumptions. It is a process that allows clients to participate in creating their own solutions to their needs based upon what they consider important.

The needs analysis step ensures that customers' financial and long-term care objectives are identified and that realistic expectations are accepted. This is the foundation upon which suitable products can be recommended. This step also provides the opportunity to seek and explain other resources the client may have that can help cover the cost of long-term care, such as cash values from a life insurance policy or a reverse mortgage.

Step 3: Product Recommendation

The appropriate product recommendation for a particular customer is based on the analysis of his or her needs. LTCI policies should only be recommended when the customer has sufficient assets to protect and fully understands the policy's features, benefits, cost, and coverage.

Naturally, each customer's financial situation, needs, and objectives are unique. Suitable recommendations can only be made after gathering all relevant information about the customer, recording this information accurately, communicating clearly, and listening to the customer. Carefully evaluating the customer's circumstances and expectations will help ensure that recommendations are appropriate.

Step 4: Prospect Understanding

Ensuring that the prospect understands the recommended product—its features, provisions, benefits, and limitations—is a critical step in the needs-based sales process and is required to ensure a suitable placement. The producer should review the following aspects of the recommended product with the prospect and be prepared to answer any questions or to provide any needed information:

- the way the policy works, in general
- the way benefits are paid

- covered services
- services that are not covered
- the amount of coverage the prospect will have and the basis for that amount
- the date the prospect would be eligible for benefits
- the date benefits would begin
- the importance of inflation protection
- policy options: restoration of benefits, premium refunds, etc.
- nonforfeiture benefits
- provisions for renewability
- the cost of the policy and the date on which premiums are payable

Appropriate Sales and Presentation Practices

Insurance professionals occupy positions of confidence and public trust. They must avoid conduct that violates the law as well as that which violates ethical standards. To preserve the public's confidence, insurers and their agents must possess a level of ethics that allows them to make decisions that best serve the customer, the community, their company, and the industry in general. Agents, insurance companies, and the insurance industry earn consumer trust by demonstrating ethical business behavior in their dealings with consumers.

Representing and placing long-term care insurance puts the producer in the role of an educator and motivator as well as a financial advisor. It's likely that LTC prospects and clients will need to be informed about the risks and costs of long-term care in addition to the options available to cover those risks and costs. The producer should expect to approach prospects and clients with the intent to help them learn the facts about long-term care and the value of planning for it.

Sales Practices

When selling long-term care insurance policies, it is important to maintain clear and appropriate communication with prospects and policyholders. Appropriate communication refers to using language easily understood by laypeople and speaking to customers on a level that they understand, clearly and succinctly. At the same time, customers should never be addressed in a condescending manner. Many

may have high degrees of sophistication and significant investment experience. These customers may want to know the intricacies of the product and are fully capable of comprehending them.

There are special considerations when dealing with older individuals. They may have hearing impairments or may be beginning to experience a decline in cognitive skills. These customers should be treated with extra care. Ideally, they would have a trusted advisor or a family member with them who could help them understand the sales presentation and ask the right questions.

A producer has an obligation to provide a customer with products that are best suited to his or her needs. To this end, the following are considered inappropriate, and therefore unethical, sales practices:

- making any misrepresentation or incomplete comparison for the purpose of inducing or tending to induce a person to purchase or change insurance
- making any statement that is untrue, deceptive, or misleading
- intentionally misrepresenting the terms, benefits, value, cost, or effective dates of any actual or proposed insurance contract or application for insurance
- engaging in any fraudulent, coercive, or dishonest acts or practices
- transferring or placing insurance with an insurer other than the insurer expressly chosen by the applicant or policyholder without the consent of the applicant or policyholder

Presentation Practices

The insurance industry presents applicants with illustrations designed to help them understand a policy. Illustrations are simply hypothetical representations that reflect assumptions the company puts forth to suggest policy results. Insurance illustrations can be very simple or very complex. Long-term care illustrations are simpler than cash value life insurance or annuity contracts because they don't have an investment component.

Long-term care policy illustrations typically include the applicant's age, cost of care in various settings in the geographical area where he or she lives, and inflation assumptions over a period of years. Applicants can see what care will cost them at certain periods depending on the policy type and benefits selected.

Rules regarding illustrations are established by each state's insurance code. The purpose of these rules is to protect consumers and to foster consumer education. The rules typically provide illustration formats, prescribe standards to be followed when illustrations are used, and specify the disclosures that are required in connection with illustrations. The objectives are to ensure that illustrations do not mislead purchasers of LTCI policies and to make illustrations understandable. Generally, insurers must, as far as possible, eliminate the use of caveats and define terms in language that would be understood by a typical person within the segment of the public to which the illustration is directed.

Long-term care insurance policy illustrations typically include a narrative summary. A narrative summary should contain:

- identification and a brief definition of key terms used in the illustration
- a brief description of the policy being illustrated, including a statement that it is a long-term care insurance policy
- a brief description of the premium outlay for the policy
- a description of any policy features, riders, or options and the impact they may have on the benefits of the policy

Illustrations must be signed and dated by the applicant and agent no later than the time the policy is delivered, and a copy must be provided to the policyowner.

Full Disclosure

The purpose of disclosure regulations is to require insurers to deliver to LTCI applicants information that will help them to select the most appropriate insurance plan for their needs. These regulations are intended to improve applicants' understanding of the features of the policy and to increase the applicant's ability to evaluate and compare the costs of similar plans of insurance.

Although disclosure requirements are established by the individual states, all disclosures must be readily understandable, meaningful, conspicuous, simple, direct, and designed to call attention to the nature and significance of the information provided. Some state regulations call for disclosure in large or bold type, or simply that the disclosure be placed conspicuously.

Typical disclosure requirements include the following:

- a statement that projected long-term care assumptions are just that—assumptions—and are not assurances of future costs
- a statement that if the consumer is eligible for Medicaid, he or she should not purchase an LTCI policy
- a description of the principal benefits and coverages provided by the policy
- a statement of the policy's exclusions, reductions, and limitations
- the consumer's privacy rights
- the insurance company's privacy practices
- the policy's renewal and continuation provisions
- an explanation of contingent benefit upon lapse
- a statement indicating whether the policy is intended to be a federally tax-qualified long-term care policy
- a statement as to when or under what conditions the policy's premiums can be increased
- a directive to consumers to read the policy carefully

Typically, disclosures are not required in advertisements and promotional material when the advertisements and promotional materials are considered to be general, such as when describing or listing products offered. An advertisement might list long-term care insurance or life insurance as products available without necessitating disclosures.

Ethical Practices

Principles of ethical conduct apply to all insurance producers in the field working with customers and their peers and interacting in the community. Some ethical practices to keep in mind include:

- conducting business with clients, prospects, and other industry professionals according to high standards of honesty and fairness
- providing efficient handling of business, including complaints and disputes
- providing informed and consumer-focused service
- engaging in fair competition

Unethical Practices

Most unethical practices are regulated at the state level by each state's consumer protection laws and unfair and deceptive trade practices acts. The following sections describe types of unethical conduct typically prohibited by state law.

Misrepresentation

A **misrepresentation** is an express or implied statement contrary to fact. State laws covering misrepresentation are designed to ensure the accuracy of descriptions of goods and services. When an agent makes a representation, he or she has a duty to know whether that statement is true. The consumer is entitled to rely on this representation. Misrepresentation can also occur by omitting information necessary to prevent a reasonable expectation or belief from being misleading.

Agents and producers may not:

- misrepresent or overemphasize their experience or expertise or that of their agency or company
- make misstatements about the capabilities of a product
- make misleading statements when describing policy terms
- engage in any sales practice or use any advertisement that may mislead a consumer or otherwise cause a consumer to reach an erroneous conclusion
- misrepresent the applicant to the insurer

Twisting

Twisting occurs when an agent induces a policyholder to terminate a policy and to take out a new policy when it is not to the insured's benefit to do so. Long-term care insurance should not be sold on the basis of gain or profit to the agent, but on the basis of best coverage at the best price with the best service and without regard to commission.

Puffing

Puffing involves making exaggerated or unsubstantiated statements. Agents should avoid exaggeration, often construed as misrepresentation. Of course, statements of opinion are permitted as long as they are offered as opinions and without the intent to deceive.

Rebates and Gifts

Rebating is the granting of any form of inducement, favor, or advantage to the purchaser of insurance when that inducement is not made available to all purchasers. In some states, this is a penal offense for both the agent and the person accepting the rebate, and the agent's license may be suspended or revoked. An agent also must not accept gifts as an inducement to provide insurance protection.

High-Pressure Sales

High-pressure sales practices and high-pressure sales pitches typically include making "limited time only" offers and repeated and unsolicited contact. Unfortunately, the elderly are often subjected to such tactics. High-pressure tactics must be avoided.

Bait and Switch Tactics

Bait and switch ploys occur when an offer to sell a product is not a bona fide one. Bait and switch is an alluring but insincere offer to sell a product or service that the insurer in truth does not intend or want to sell. Its purpose is to switch consumers from buying the advertised product to buying something else, usually at a higher price or on a basis more advantageous to the insurer.

Failure to Disclose

Failure to disclose is considered a misleading trade practice. Insurers and producers must disclose all facts and information about a policy in order for the consumer to make an informed buying decision. Knowledge and intent are the essential elements of failure to disclose.

Suitability

No insurance product is right for everyone, and that includes long-term care insurance. As important as such coverage is for many people, there will be cases where LTCI is not an individual's best option for financing long-term care. Even when the need for a policy is indicated, care must be given to design and recommend policy coverage that best suits the individual's goals, needs, and circumstances.

This chapter concludes with a discussion of a topic uppermost on the list of regulatory concerns: **suitability**. It is in regulators' best interest to encourage ownership of long-term care insurance—the success of state partnership programs, for example, relies on it—but only when it is in the consumer's best interest to own it. Individuals who are sold inappropriate coverage become unhappy consumers, and if left unchecked, this could erode public confidence in, and support for, long-term care products and ultimately the partnership program concept.

To guard against this, states have implemented rules that require insurers and producers to ascertain the suitability of every long-term care insurance recommendation or sale—including partnership program insurance. This makes sense, because the market conduct rules and regulations that apply generally to long-term care insurance apply equally to partnership-qualified long-term care insurance.

What Is Suitability?

Most of those involved in the financial services arena have a sense of what suitability means. Virtually all forms of financial products sold today are regulated by state and federal laws that include suitability requirements. In that respect, the sale of long-term care insurance is no different than the sale of any other life or health insurance product.

However, having a sense for what suitability means does not necessarily translate into an understanding of what it takes to comply. While it might be tempting to dismiss suitability as being too intangible for compliance, the fact is, clear guidelines are available to help insurers and producers determine the

suitability of the LTC policy being recommended to, or considered by, a consumer. A good place to start is with the NAIC.

NAIC and Suitability

The NAIC addresses suitability in its Long-Term Care Insurance Model Act and Regulation, where it places responsibility on both the producer and the insurer to make sure sales of long-term care insurance adhere to suitability principles.

In this respect, it states:

To determine whether the applicant meets the [suitability] standards developed by the issuer, the agent and issuer shall develop procedures that take the following into consideration:

- the (applicant's) ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage
- the applicant's goals or needs with respect to long-term care and the advantages and disadvantages of insurance to meet these goals or needs
- the values, benefits, and costs of the applicant's existing insurance, if any, when compared to the values, benefits, and costs of the recommended purchase or replacement

The insurer and the producer are expected to make "reasonable efforts" to obtain the information necessary to answer these fundamental questions of suitability. To support this, the model regulation requires that applicants be asked to complete a "Long-Term Care Insurance Personal Worksheet" (reviewed later in this chapter).

Insurers Responsible for Instituting the Suitability Process

The NAIC Long-Term Care Insurance Model Act instructs insurers to develop and use suitability standards to determine whether the purchase or replacement of long-term care insurance is "appropriate for the needs of the applicant." The model regulation does not provide details for how those suitability standards should read, but instead leaves it up to the insurer to define these standards. However they are defined, insurers are required to "maintain a copy of their suitability standards and make them available for inspection upon request by the (state's insurance) commissioner."

Insurers are also responsible for training their agents (and any other producer who sells their LTCI products) in applying their suitability standards.

Producers Responsible for Suitable Recommendations

The NAIC Model Act also makes clear that producers are responsible for determining the suitability of long-term care insurance recommendations. Specifically, the law requires producers to:

- use the suitability standards developed by the insurer in marketing long-term care insurance and make long-term care insurance recommendations
- give applicants a copy of the NAIC disclosure form entitled "Things You Should Know Before You Buy Long-Term Care Insurance" at the same time the personal worksheet is provided to the applicant

When Is Suitability Determined?

Waiting until after a policy is issued to determine the suitability of the product is too late. In its Long-Term Care Insurance Model Act and Regulation, the NAIC specifies a process for determining suitability before the policy is issued. The process begins with the producer engaging the applicant in the fact-finding interview discussed earlier to determine first if an LTCI policy is needed and then what kind of

policy is most appropriate for the person's goals and needs. The process ends with the insurance company, through the underwriting process, confirming the policy's suitability based on personal facts supplied by the applicant.

Suitability at the Time of Sale

The process of determining the suitability of any LTCI product recommendation really begins the moment the producer begins discussing the product with the client. Suitability topics can be separated into two broad categories: knowledge and need.

Does the Applicant Understand the Product?

Does the applicant understand long-term care insurance and how it works? If so, does he or she understand the product being recommended? And, does the applicant understand the specific policy benefits being selected? If the discussion involves a state partnership program, does the applicant understand how the program works, especially the Medicaid asset spend-down exemption?

These are just some of the things that applicants should know before signing an application for long-term care insurance. Most states require that producers help educate consumers by giving applicants several documents intended to answer these and other related questions:

- *A Shopper's Guide to Long-Term Care Insurance*, which explains LTCI in general terms
- "Things You Should Know Before You Buy Long-Term Care Insurance," which is a list of specific issues and concerns the applicant is advised to consider before purchasing a policy
- an outline of coverage, which is a brief description of the policy's most important features as well as disclosures of what the policy does and does not cover

Does the Applicant Need the Product?

Aside from the applicant's understanding of the product, the most important question to ask when determining suitability is, "Does the individual need this coverage?" Related to this question is another equally important one: "Can the applicant afford this insurance?"

In the case of partnership policies, an additional question should be posed: "Does the applicant have assets to protect?" If assets are not sufficient to let the applicant benefit significantly from Medicaid's spend-down exemption, there would seem little benefit in owning a partnership policy.

Partnership policies are designed, in part, to be relatively affordable, but even their premium may be too much for some individuals. Would a smaller benefit level (and its lower premium) be easier for the applicant to maintain? But if benefit levels are too low, will the policy adequately cover the need for care and asset protection?

While the applicant's personal needs and circumstances will dictate the suitability of any recommendation, the following general guidelines may be useful in helping to assess the policy's suitability from a financial need perspective:

- If the policy is being purchased for asset protection, the applicant should have at least $30,000 in assets. At the other end of the spectrum, the sum of the applicant's countable assets is a good target for selecting a policy's maximum lifetime benefit amount.
- Premiums should not exceed 7 percent of the applicant's income.

Of course, these are general guidelines that assume the insured will be paying the premium. If an adult child is paying the premium, for example, the income guideline may not be relevant. As always, the facts of the case should dictate product recommendations.

Suitability Before Policy Issue

Insurance companies reinforce the suitability process by reviewing all long-term care insurance applications during the underwriting and issue process and by verifying that the applied-for coverage matches the applicant's goals, needs, and circumstances. Two documents have been created for these purposes:

- an LTCI personal worksheet for use with all applicants
- a suitability letter for use in cases where the insurer questions the suitability of the applied-for coverage

Long-Term Care Insurance Personal Worksheet

To support insurers in determining suitability, the model regulation directs insurers to develop a "Long-Term Care Insurance Personal Worksheet" that records relevant information such as the following:

- **premium**—The worksheet includes disclosure of the modal premium, a description of the policy's renewal provision, and, if applicable, disclosure of past premium increases for the policy being applied for. It also asks the applicant to identify the source of premium funds (for example, income, savings, or family) and to consider whether he or she could afford to keep the policy if premiums were to increase by 20 percent.
- **income**—The worksheet asks the applicant to disclose annual income and expectations for income changes over the next ten years, and to indicate how he or she expects to pay for the LTCI coverage. The applicant is *not* obliged to answer these questions; they are intended to encourage the applicant to think about how the policy's premiums will be paid and the cost of care that the policy will not cover.
- **savings and investments**—The worksheet asks the applicant to disclose the approximate value of personal savings and investments and expectations for changes in the total value of the assets over the next ten years.

A personal worksheet is required with every individual long-term care insurance policy sale. As described in the NAIC model regulation, it is not required for sales of employer group long-term care insurance to employees and their spouses.

The model regulation goes on to make clear that insurers and producers are strictly prohibited from disseminating any information obtained through the personal worksheet to outside parties.

Suitability Letter

The personal worksheet is submitted with the completed application and is reviewed by the insurer as part of the underwriting and issue process. If a review of the facts suggests that the policy being applied for is not suited for the applicant's needs or goals, the NAIC Model Regulation directs the insurer to send a suitability letter to the applicant explaining its findings and stating the following:

> We [the insurer] have suspended our final review of your application. If, after careful consideration, you still believe this policy is what you want, check the appropriate box below and return this letter to us within the next 60 days. We will then continue reviewing your application and issue a policy if you meet our medical standards.
>
> If we do not hear from you within the next 60 days, we will close your file and not issue you a policy. You should understand that you will not have any coverage until we hear back from you, approve your application, and issue you a policy.

The suitability letter includes a section for the insurer to briefly explain the basic reason for its determination and provides the applicant the choice of checking "yes" or "no" to proceed with the underwriting process.

NAIC Recommendations to Consumers

The decision to purchase a long-term care insurance policy is a significant step that consumers take in seeking to secure their financial futures. Accordingly, the NAIC offers the following advice to consumers before purchasing an LTC policy:

- Ask questions.
- Check with several companies and agents.
- Take your time and compare outlines of coverage.
- Understand the policies.
- Don't be misled by advertising, including endorsements by celebrities or suggestions that the federal government is involved with any specific policy.
- Don't be misled by long-term care marketers who say your medical history is not important.
- Never pay in cash.
- Be sure to get the name, address, and phone number of the agent and the company.
- If you don't receive your policy within 60 days, contact your company or agent.
- Be sure you review your policy during the free-look period.
- Read the policy again and make sure it provides the coverage you want.
- Consider having premiums automatically deducted from your bank account.
- Check the financial stability of the company you're considering.

Annual Reporting Requirement

To help regulators assess the impact of the insurer's long-term care insurance suitability efforts, the model regulation requires that insurers report annually to the state's insurance commissioner the following:

- the total number of applications received from residents of this state
- the number of those who declined to provide information on the personal worksheet
- the number of applicants who did not meet the suitability standards
- the number of those who chose to confirm after receiving a suitability letter

DRA Requires Insurer Partnership Reporting

In addition to the annual reporting requirements that apply to all long-term care insurers, those who participate in a state's LTC partnership program have additional reporting responsibilities. To help the states and the federal government assess the impact of the program on Medicaid expenditures and to give state Medicaid programs the data needed to know who qualifies for the asset spend-down exemption, the Deficit Reduction Act requires participating insurers to report relevant information regularly to state and federal agencies, including the following:

- notice of when (and presumably to whom) policy benefits were paid
- the amount of benefits paid (and presumably to whom)
- notification of policy terminations
- other information as the Health and Human Services Secretary determines may be appropriate in administering partnership plans

Suitability and State Partnership Programs

The preceding discussion of producer and insurer suitability responsibilities applies to the sale of all long-term care insurance in states that have adopted the NAIC model regulation or one similar to it. If the policy being applied for is to be used in conjunction with a state partnership program, there are additional suitability factors to consider, such as the following:

- **the ratio between personal assets and maximum policy benefits**—In a partnership plan, it makes sense to match the policy's total benefits to the amount of assets the insured wants to pass on to heirs. If the ratio leans too heavily one way or another, the insured risks leaving too many personal assets unprotected (too little coverage) or paying more than necessary with coverage that exceeds the total value of personal assets (too much coverage).
- **the desire to avoid Medicaid at all costs**—There are people who, for any number of reasons, prefer to avoid Medicaid. They value the idea of owning LTCI but prefer owning enough coverage to ensure never having to turn to Medicaid. Assuming that they have the means to do so, these individuals may be better suited with a policy that has a very high lifetime maximum. Partnership-qualified LTCI policies generally have limited lifetime maximums; $100,000 to $300,000 is typical. While this helps keep partnership policies relatively affordable (thus supporting a key objective of partnership programs), it may not provide the level of coverage desired by individuals looking to avoid Medicaid.
- **too few personal assets**—Individuals with few or no personal assets generally don't include long-term care insurance on their list of must-owns, and for good reason. First, there is the issue of affordability; those with no personal assets typically are not in a position to maintain insurance premium payments. What's more, with no assets to preserve, the individual would likely qualify for Medicaid assistance without regard for asset spend-down rules.

In short, partnership LTCI policies are best suited for the majority of consumers who fall between the extremes of poor and affluent. These are people who have a modest amount of personal assets worth preserving but not enough to readily pay for long-term care services out of pocket. They can afford a policy providing moderate coverage but not a full-bodied product with unlimited lifetime benefits. They are not averse to applying for Medicaid if necessary—especially if they can preserve some if not all their personal assets in the process.

Other Partnership Suitability Considerations

Besides helping consumers recognize whether a partnership LTCI policy is suitable for them, producers are responsible for making sure that those who do buy the product fully understand the way the policy works in conjunction with the Medicaid program.

For example, an applicant might believe that owning a partnership-qualified LTCI policy shields all their personal assets from Medicaid, when, in fact, only the amount equal to the policy's maximum benefits are protected. Or, an applicant may believe that Medicaid eligibility is ensured by owning a partnership-qualified policy when, in fact, Medicaid coverage is not guaranteed. Long-term care services or long-term care facilities that qualify for insurance reimbursement might not meet Medicaid's certification or payment criteria. For the most part, these additional partnership-related suitability concerns can be resolved by educating the applicant. Topics to address in this respect include all of the following:

- **The choice of care provider is limited.** Medicaid does not include coverage for home and community care in all states, nor does it cover care provided in an assisted living facility. The insured who is receiving care through one of these types of providers could be required to move to a Medicaid-approved nursing home when insurance benefits are exhausted.
- **Total asset preservation is not guaranteed.** In some cases, Medicaid does not step in until all policy benefits are exhausted. While policy benefits are being paid, it may be necessary for the insured to supplement them with personal funds to fully cover the cost of care.
- **Moving to another state does not guarantee Medicaid asset protection.** Medicaid asset protection is provided only in the state sponsoring the partnership program in which the insured participates or, possibly, in another state that has a reciprocal partnership agreement with that state. If the insured moves to a state that does not have a reciprocal agreement with the state sponsoring the program that he or she belongs to, then the insured would not be eligible for Medicaid asset protection.
- **Asset protection is limited to the policy's lifetime maximum.** It is critical that applicants understand that personal assets and future income (such as pension or Social Security benefits) that exceed the spend-down exemption amount must be used to fund long-term care before Medicaid eligibility is possible.
- **Application for Medicaid is required.** An insured might hope that Medicaid coverage would begin automatically when he or she exhausted policy benefits. That is not the case. Insureds are required to apply for Medicaid no differently than anyone else. Furthermore, Medicaid eligibility is not guaranteed, even if the insured qualified for benefits from the partnership-qualified policy.

The risk also exists of a state reversing its partnership program law and subjecting previously protected assets to the spend-down. While it is always possible that a state's legislature might decide to terminate or amend its partnership program, it is unlikely that anyone participating in the program would be adversely impacted. Most states' partnership regulations include a grandfathering provision ensuring current owners of partnership-qualified policies that they would continue to enjoy asset spend-down (and estate recovery) protection in the event the law is rescinded. Political realities being what they are, it is also likely that states that do not have grandfathering provisions in their law would nonetheless grant that status to current program participants should rescission of the program be considered. Of course, this can never be guaranteed.

Summary

- Ethical considerations are extremely important to the subject of long-term care. Treating customers fairly and providing them with the most appropriate product is the best possible way to advance industry standards.
- To a certain degree, determining the suitability of any given product for any given client is somewhat subjective and must be based on the producer's knowledge, experience, and opinions. However, there are tangible steps and actions insurers and producers can take to make sure the policies they market and sell are in the best interests of consumers who buy them.
- Needs-based selling is an approach to offering long-term care products in which the customer's overall financial needs are defined and analyzed. It is an efficient, effective, and appropriate system for determining the most suitable product for a particular customer.

Chapter 10 Review Questions

1. All of the following are steps in the needs-based selling approach EXCEPT:
    A. needs analysis
    B. fact finding
    C. engaging in fair competition
    D. product recommendation
2. Misrepresenting a long-term care policy pertains only to statements the producer makes or literature he or she delivers.
    A. True
    B. False
3. Under the NAIC Long-Term Care Model Act as well as many state insurance regulations, who is primarily responsible for instituting good suitability practices?
    A. consumers only
    B. producers only
    C. insurance companies only
    D. producers and insurance companies equally
4. What is the basic purpose of a suitability letter sent from an insurance company to a long-term care policy applicant?
    A. to obtain personal information that will help the insurer determine if the applied-for policy is suitable for the applicant
    B. to inform the applicant that the insurer has deemed the policy to be unsuitable and is therefore terminating the underwriting process and returning premium deposits (if any)
    C. to inform the applicant that the insurer is questioning the suitability of the applied-for policy, briefly explaining why, and asking the applicant to advise the insurer on whether it should proceed with the underwriting and issue process
    D. to inform the applicant that the insurer has reviewed the facts of the case and has determined that the applied-for policy is well-suited for the applicant's goals, needs, and personal circumstances
5. Before purchasing a long-term care insurance policy, the NAIC advises consumers to do all of the following EXCEPT:
    A. ask questions
    B. compare companies and their policy outlines of coverage
    C. always pay in cash
    D. understand that one's medical history is important

Answers to Chapter 10 Review Questions

1. C. The steps to the needs-based selling approach include fact finding (identifying information about the customer's long-term care needs, wants, wishes, and expectations); needs analysis (reviewing the data collected); product recommendation (offering the most appropriate product based on reasonable grounds); and customer understanding (ensuring the customer understands the features, provisions, and restrictions of the proposed coverage).
2. B. Misrepresentation can also occur by failing to disclose information necessary to prevent a reasonable expectation or belief from being misleading.
3. D. The NAIC addresses suitability in Section 24 of its Long-Term Care Insurance Model Act and Regulation, where it places responsibility on both the producer and the insurer to ensure sales of LTCI adhere to suitability principles.
4. C. If a review of the facts suggests that the policy being applied for is not suited to the applicant's needs or goals, the insurer should send a suitability letter to applicants explaining its findings and stating that it will suspend review until the applicants inform the insurer that they are sure they want the policy.
5. C. The NAIC advises consumers not to pay cash for their LTCI policies.

End Notes

[1] U.S. Department of Health and Human Services, National Clearinghouse for Long-Term Care Information website.

[2] "Projected Age Groups and Sex Composition of the Population, 2017," U.S. Census Bureau.

[3] "Estimates of the Risk of Long-Term Care: Assisted Living Facilities and Nursing Home Facilities," U.S. Department of Health and Human Services, July 8, 2003.

[4] "National Spending for Long-Term Services and Supports, 2011," National Health Policy Forum, February 2013; "Faces of Long-Term Care: A Look in the Mirror," Robert B. Friedland, Long-Term Care Financing Project, Georgetown University, July 2007.

[5] Americans for Long-Term Security, Americans for Long-Term Security (ALTCS) website (accessed September 4, 2007) (hereafter cited as *ALTCS)*.

[6] Ibid.

[7] Ibid.

[8] Peter Kemper et al, "Long-Term Care Over the Uncertain Future: What Can Current Retirees Expect?" *Inquiry,* Volume 42, Number 4, Winter 2005/2006, pp. 335-350 (hereafter cited as *LTC)*.

[9] *ALTCS*

[10] *LTC*

[11] Ibid.

[12] Ibid.

[13] *ALTCS*

[14] *LTC*

[15] *ALTCS*

[16] Family Caregiver Alliance, **https://www.caregiver.org/caregiving**

[17] "The MetLife Study of Working Caregivers and Employer Health Care Costs," MetLife Mature Market Institute, February 2010.

[18] "The Federal Role in Consumer Protection and Regulation of Long-Term Care Insurance," U.S. Department of Health and Human Services, June 1991.

[19] Ibid.

[20] "The Past, Present and Future of Managed Long-Term Care," U.S. Department of Health and Human Services, April 2005.

[21] The Medicare tax on those earning more than $200,000 a year ($250,000 for joint filers) is an additional .9 percent.

[22] The Affordable Care Act (ACA) intended to expand Medicaid eligibility to all citizens whose incomes fall below 138 percent of the federal poverty level regardless of their age or any disability. Before ACA, most nondisabled adults younger than 65 with incomes below this level were not eligible for Medicaid. Under ACA's original provisions, states were to be required, as of 2014, to expand their Medicaid programs to include this group or risk losing federal Medicaid funding. This requirement was included in a legal challenge to the law and was set aside. Currently, states are not required to expand their Medicaid programs to this group, but they can at their option. As of late 2019, almost three-fourths of the states had opted to expand eligibility for their Medicaid programs to include nondisabled adults under 65 whose incomes are below 138 percent of federal poverty levels.

[23] The equity exemption amount limit is indexed. As of 2020, the limit had increased to $595,000 (or, at the state's option, up to $893,000).

[24] The minimum and maximum monthly maintenance needs allowances are subject to adjustments annually: the former adjusts as of July 1 every year; the latter adjusts as of January 1 every year.

[25] "A Shopper's Guide to Long-Term Care Insurance," National Association of Insurance Commissioners.

[26] The AGI limit for the medical expense deduction was set to increase to 10 percent as of January 1, 2019. In late 2019, through the SECURE Act, this limit was lowered to 7.5 percent, for 2019 (retroactively) and 2020. It is set to revert to 10 percent after 2020.

[27] HICAP Benefits Counselor LTC Training Initiative Training Program, March 2005.

Maximizing Integrity in Decisions with Seniors

Contents

Note: In the interest of fairness, both terms "he" and "she" are used at random throughout this course.

Chapter 1
What's Your Comfort Level?

Always do right. This will gratify some and astonish the rest. —Mark Twain

Chapter Objectives

Upon completing Chapter 1, you will be able to:

- Assess your comfort level and understanding of ethical dilemmas
- Define ethics, differentiating ethics from law, religion, and social conventions
- Explain the relationship between ethics and compliance
- Recognize the natural human tendency to perceive situations from a self-centered point of view

Introduction

Bessie, 84, is to all outward appearances in good shape. What you can't see is that three years ago, she had a mild stroke that has played havoc with her short-term memory. She can vividly remember something from 20 years ago, but tell her your name, and she's unable to recall it a minute later.

Her son was talking to her the other day. *"What do you have planned for tomorrow?"* he asked.

"Someone is coming over to sell me insurance," she replied.

"What kind of insurance, Mom?"

"I don't know…health insurance, I think."

"But you have health insurance."

"I know. I'm not going to buy anything from him."

"OK. Do you know this person?"

"No."

"Can you tell me his name?"

"I didn't write it down."

"How did he find you? You're on a don't-call list."

"I don't know."

"Mom, I don't think it's wise to meet with a stranger alone in your apartment. If you can't call him to cancel the appointment, maybe you and a friend could meet him in the lobby and talk there. I wish I could be there, but I can't. But you know, you DO have all the insurance you need."

"I know. I won't sign anything."

The son had misgivings about his mother's judgment and the agent's motives, but gave the agent the benefit of the doubt and at least felt better about his mother's safety if she took along a friend and met in the lobby. The next day, he called her back.

"Hi Mom, how did your meeting go?"

"It was fine. He was a nice young man. I took Evelyn with me. I have some papers he gave me. He's selling long-term care insurance. I don't have any."

Well, she does have long-term care insurance (LTC). But at least she didn't buy duplicate insurance. Some people would figure she just got lucky by not meeting with someone unscrupulous, but the son was thinking not only of her welfare, but of the welfare of other seniors and the potential liability the agent could create for himself, so he got the insurance agent's name and phone number and called him.

"Hi, I'm Bessie's son and I just wanted to follow up on your meeting with her yesterday. I'm kind of curious what kind of list you were working from when you called her."

"Oh sure. It's the membership directory of Good Shepherd Church."

"Did she fill you in on what insurance she now has?"

"No, but I did tell her that a lot of seniors find they need LTC."

"I agree, they do. Tell me, I haven't seen Mom in a few days. She seem OK to you?"

"Yes. Very nice lady. Nice friend, too."

"Good. Could I give you some advice?"

"Sure."

"Well, I know Mom's address and phone number are in the church directory, but did you check it against the no-call list in Colorado?"

"Uh…no. I didn't."

"You might want to do that to stay out of trouble with the Attorney General's office. Just a suggestion."

"Right."

"Another thing: It's really not hard to check to see if a person has dementia. Did you do that?"

"She has dementia?"

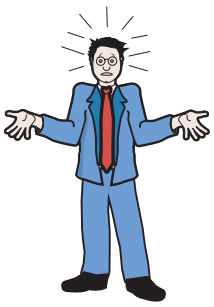
"Yes. In fact, almost half the people her age have some form of dementia, including Alzheimer's. Mom has what's called vascular dementia. It was brought on by a mild stroke she had several years ago."

"Wow. I didn't know."

> *"A lot of people are oblivious to it. The last time Mom had a doctor's appointment, I went with her. After her doctor had given her some instructions, I asked her – in front of the doctor – to repeat what he'd said. She couldn't. It was an eye-opener for the doctor. I'm telling you this because when you work with seniors – when you sell them a financial product in your case – it's critical that you know more about the senior than their insurance needs. Otherwise, you put yourself in the position of inadvertently doing something unethical – to the harm of the senior and yourself."*

You may be asking yourself, *"Why do I need to take an ethics course? I don't lie, cheat or steal. I don't mistreat my senior clients. I'm a good person."*

Of course you are. But being ethical is much more than knowing the difference between right and wrong. It is being able to recognize and find your way through an ethical dilemma, when all the choices seem wrong ... or right. Which one is the most right?



Throughout this course, you'll read about situations in which people who provide products and services to seniors are faced with ethical dilemmas where the choices are not always clear. The scenario with Bessie is a true story and is an example of an ethical misstep, probably unintentional, but nevertheless unfortunate.

As a professional, you'll want to take concrete steps to protect and/or guide your senior clients and not even unknowingly make unethical choices. Studying ethics as it relates to the special needs and issues of seniors will help you make even better choices where you and your senior clients are concerned. After you complete this course, you'll understand the foundations upon which ethical decisions are made, including your own principles and values, as well as the skills you need to make the most ethical choices, such as decision-making, critical thinking, and emotional intelligence. You'll also learn how to avoid the mental traps, errors in thinking, and rationalizations commonly used to support a less-than-ethical decision.

Self-Assessment

How do you feel when you find yourself in an ethical dilemma that requires a decision? Take the following self-assessment to gauge your comfort level with sensitive situations:

Instructions: The six scenarios below describe ethical dilemmas that professionals who serve seniors could easily encounter. Each scenario requires an ethical response or action by the professional. At the end of each scenario, give yourself:

- 1 point for each Yes answer
- 0 points for each No answer

Total your points in the space provided after the last scenario.

If you know what to say or do to resolve the ethical dilemma, type your answer in the space provided. The answers to each scenario will be provided later in this course.

1. **Your area manager** comes into the office, very pleased with himself and crowing about having sold a large investment to one of his senior clients. Both he and you know this particular investment is not beneficial to the client. If you say anything to this manager, you risk the loss of some good leads, and territory assignments are coming up, too—you could be assigned a rotten territory if he's mad at you. If you mention this to your manager's boss, it would be even worse, because your interference will get right back to him.

   Will you say anything, and, if so, to whom? Why or why not?

	Yes	No
I know what to do to resolve this dilemma	_____	_____

   My resolution is:

   _____
   _____
   _____
   _____

	Yes	No
I would probably take this action to resolve this dilemma	_____	_____

2. **Your neighbor, a** long-time client, gives you a referral to her older cousin who can use your services, but who is very reticent about his financial situation. You have some products that would be beneficial, and that would also mean good commissions for you. Your neighbor knows how secretive the cousin is, and happily tells you all she knows about the cousin's financial dealings. You worry about hearing all these personal, confidential financial details from your neighbor, but the information really will help you serve the cousin better (and make the deal). Besides, if you ask the neighbor not to talk about her cousin's business, it will hurt her feelings.

   What do you do? Or, do you do nothing? Why or why not?

	Yes	No
I know what to do to resolve this dilemma	_____	_____

   My resolution is:

   _____
   _____
   _____
   _____

	Yes	No
I would probably take this action to resolve this dilemma	_____	_____

3. **You are meeting** with your clients, Mr. and Mrs. Jones, in their home. They are quite advanced in years, and you have been doing business with them for a long time. Although Mr. Jones has always been a little forgetful, in this meeting you notice that he is behaving in ways that he never has before - ways that resemble the behaviors that you witnessed when your grandfather suffered from Alzheimer's disease. Mrs. Jones seems completely oblivious to the changes in her husband, remaining as cheery and composed as ever. If she doesn't recognize his symptoms, saying something could really upset her.

   What, if anything, would you say to Mrs. Jones? Why or why not?

	Yes	No
I know what to do to resolve this dilemma	_____	_____

   My resolution is:

   _____
   _____
   _____
   _____

	Yes	No
I would probably take this action to resolve this dilemma	_____	_____

4. **Your clients, Francine** and Natalie, partners in their 60s, have been discussing the purchase of an insurance policy with you. They believe the coverage is important; however, they are not very secure financially and express concern over the premiums – at present, they can afford them, but if the premiums increase by very much they will be unable to pay them and thus will lose the coverage. You agree with their need for the insurance, and you also know that premiums will be increased in four months– but you don't know by how much. It could be a small, affordable raise, or it could be a significant jump, as past premium increases have been both types.

   Do you discuss the future increase with your clients? Why or why not? What do you recommend to them?

	Yes	No
I know what to do to resolve this dilemma	_____	_____

   My resolution is:

   _____
   _____
   _____
   _____

	Yes	No
I would probably take this action to resolve this dilemma	_____	_____

5. **You have been** working with your retired clients, Mr. and Mrs. McGee, for many months, and although they seem to trust you and communicate freely with you, they have been unable to make a final decision about your product. You have tried several times to "close the deal" and Mr. McGee repeatedly promises to move forward, even setting dates to do so, but then always comes up with more delay and excuses. You truly believe you have fully informed them, given them alternatives, discussed consequences, and sought and answered all of their questions. You are at a loss to explain why they are "stuck." Then one afternoon, as you are sipping the coffee they have served you in the living room, you overhear an argument in the kitchen. Mrs. McGee is browbeating, criticizing, and verbally abusing her husband. She accuses him of making poor choices, costing them financial losses, being stupid, lazy, and undependable. You can hardly believe what you are hearing. But it is now clear to you why Mr. McGee keeps putting you off – he is afraid of giving his abusive wife further ammunition to use against him – and so avoids making a decision.

   What, if anything, do you do? Why or why not?

	Yes	No
I know what to do to resolve this dilemma	_____	_____

   My resolution is:

   _____
   _____
   _____
   _____

	Yes	No
I would probably take this action to resolve this dilemma	_____	_____

6. **You have joined** the local branch of a company that is well-respected in your industry, and you have negotiated a very lucrative package of commissions and bonuses. After you work there a while, you begin to see some problems. Nothing like fraud or breaking the law, just a little carelessness, and especially some poor communication with senior clients. You don't believe anyone in the company is intentionally doing wrong, but you would like to see more accountability for quality work, and more emphasis on building relationships. This is how you conduct your business, and you are worried that mistakes, intense competition, and downright sloppiness will reflect badly on you.

   What would you do in this situation? Why or why not?

	Yes	No
I know what to do to resolve this dilemma	_____	_____

   My resolution is:

   _____
   _____
   _____
   _____

	Yes	No
I would probably take this action to resolve this dilemma	_____	_____

Total score: _____

The higher your score, the more you consider yourself able to recognize and resolve an ethical dilemma—and the more you feel prepared and willing to respond to it. (These scenarios will be revisited later in the course, and correct ethical responses to them will be discussed at that time.)

Distinguishing Ethics from Other Modes of Thinking

In considering the ethical dilemmas above, did you find yourself thinking about or depending upon laws, or professional regulations? Ethics is frequently confused with the realms of social conventions, religion, and the law.

These areas are often mistakenly taken to be inherently ethical in nature, but think about it: if every practice of every religious system is necessarily ethical, then torturing nonbelievers could be judged as ethical too. If social conventions were the same as ethics, then every social practice within any culture would be ethical, including the social conventions of Nazi Germany. If ethics and the law were interchangeable, then every law within a legal system would be ethical by definition, including laws that permitted slavery or other powerful violations of human rights.[1]

It is important to be able to differentiate ethics from other modes of thinking commonly confused with ethics. Reasonable persons give priority to ethics when religious practices or social practices violate ethical principles. To recognize that laws often emerge out of social conventions means that we cannot assume that human laws are always ethical.

Ethics versus Compliance

Unethical behavior is often justified by someone who says, "I complied with all the regulations," and who is thinking, "As long as I follow the law (regulations) I cannot be accused of being unethical." This is faulty thinking for several reasons:

- It may mean complying with the letter but not the intention of the law.
- No set of regulations can possibly address every eventuality or opportunity for unethical conduct.
- Assuming that all regulations are ethical is confusing ethics with laws, as discussed above.
- Complying with all applicable professional regulations may be **necessary**, but is not **sufficient** to guarantee ethical action.

- Relying only on compliance with regulations may prevent a person from even recognizing an ethical dilemma, or allow one to avoid thinking through all sides of an issue.

[1] Paul, Richard and Linda Elder. Critical Thinking. Upper Saddle River, New Jersey: Pearson Education, Inc., 2002

Profile

Bernice is a tax preparer, working with her client Patricia. Patricia is a widow who lives independently and has to watch her spending very carefully to make ends meet. They are meeting so that Patricia can give Bernice the information she needs to file this year's tax return. One of the first questions Bernice asks is, *"Do you have any other income you need to declare?"*

Patricia looks Bernice right in the eye and says, "*You have my Social Security and my pension figures…no, that's all.*"

Bernice remembers that last summer she was trying to reach her client and was told that Patricia was house- and pet-sitting for several months for her son's business colleague. Now normally that kind of service is paid in some way. Bernice hesitates to ask about it, however, because she knows Patricia can't afford to pay any more in taxes than she already does. Besides, Bernice knows the regulations say that the tax preparer *"has the right to believe the taxpayer* ***absent other evidence.****"*

Patricia says she had no other income, so Bernice chooses to believe her. Is this the right thing to do?

Profile Discussion

Although the letter of the law says that Bernice has the right to believe her client, she actually has knowledge of facts that may contradict what the client is saying. She is ethically and legally bound to ask Patricia about the house-sitting and whether any income came from it.

Any professional may be subject to ethical dilemmas coming from three directions: the regulatory requirements, which may not be specific enough to address an ethical issue; the informal code of conduct about duties between fellow professionals; and the ultimate loyalty to the client's interests. Again, the rational person thinks through the facts and the applicable ethical principles involved to come to the best decision. Beware of the temptation to think, "The regulations define my obligations in terms of right and ethical action. I complied with the regulations, and so what I have done (or failed to do) cannot be unethical."

In cases involving the best of intentions, relying exclusively on codes of ethics for guidelines can result in "rule-bound behavior," which can be naïve, obsessive, or paranoid. This can also result in behavior that is limited, disconnected from any aspirations to higher ethical behavior, and disassociated from noticing and caring about the impact on another person.

Recognizing Human Self-Centeredness

Ethical reasoning requires resistance to a natural tendency to see the world from a self-serving perspective. It is not uncommon for people to view everything within the world in relationship to themselves. A person doesn't naturally appreciate the point of view of others, or the limitations of his own point of view unless he is trained to do so. He doesn't easily recognize the tendency to make assumptions, to interpret and use information to support his own position, and to overlook the implications of self-centered thought. For example, in our seemingly youth-obsessed culture, it may be difficult for the younger person to understand and appreciate the perspective of a senior or elderly person.

The person who is unaware of or unconcerned about self-serving thinking is not typically concerned with protecting the rights of others. She is not typically willing to sacrifice her desires to meet someone else's basic needs. It is easy for this person to ignore ethical principles if doing so enables her to maintain power or to gain in some way.

"Wait a minute," you say. *"I'm not a selfish person!"* The point here is not whether you are selfish but **how well you adjust your perceptions and your thought processes to include the perspectives of others.** It is natural to have a blind spot when it comes to the perceptions of other people. You may think that you are an exception, but it is a good idea to "look over your shoulder as well as using your rear-view mirror" to eliminate that blind spot when making decisions or facing ethical dilemmas.

Fortunately, humans are not always guided by self-centered thinking, and each person can develop greater integrity. You can increase your ability to identify ethical dilemmas by not oversimplifying complex issues.

Even more importantly, you can counteract a tendency to ignore ethical principles because you are trapped in your own point of view by learning how to see things from the points of view of others, especially your senior clients.

You must seek to understand what principles lie behind your motivation. Identify and scrutinize your purposes and agendas, and hold yourself accountable. Here are some suggestions for ways to expand your ability to see other perspectives:

1. To correct the natural tendency to "forget" facts that do not support your thinking and "remember" facts that do support it:

   Consciously seek evidence and information that do not support your thinking. If you look and cannot find such evidence, you may not have searched hard enough.

2. To break the habit of thinking within an overly narrow point of view:

   Seek points of view that conflict with your own. For example, read thoughtful commentaries by individuals with generational, political or social viewpoints that are opposite to your own.

3. To avoid overconfidence that you possess the truth:

   Regularly remind yourself how little you actually know. Think about—even write down—the unanswered questions about whatever knowledge you may have. Ask other people what questions they may have about the topic. If you don't discover there is much more you don't know than you do know, search harder for questions.

4. To develop consistency between the standards you apply to yourself and those you expect others to follow:

   Frequently compare the two sets of standards. Are they the same? Why or why not?

5. To avoid being hypocritical:

   Identify inconsistencies between what you say you believe and how you behave. Do you walk your talk? If you don't find inconsistencies between your thinking and your behavior, you may not have dug deeply enough.

6. To avoid your natural tendency to oversimplify in order to maintain your favored beliefs:

   Ask yourself: Where do you ignore real and important complexities in the world? What do you typically see as a simple right or wrong, bad or good? If you don't discover that you have oversimplified some important issues, you may not have really recognized the complexities inherent in them.

Reflection Question

Can you think of a situation in which you oversimplified a complex issue in order to avoid an ethical dilemma?

What could you have done differently?

Profile

Owen is an insurance agent who specializes in long-term care (LTC) policies. He has new clients, Mr. and Mrs. Gardner, with whom he has met just once. It seemed like they all hit it off very well. In this initial meeting, he gave them an overview of LTC insurance, and left them with quite a bit of written information.

Before his second meeting with the Gardners, Owen was advised that the premium on the policy they are considering will take a significant jump very soon. Normally, Owen would spend the time in a second meeting discussing the various decisions to be made by the client, answering questions, and making sure the clients completely understand their own needs and think about their future plans, before even accepting an application from them. Then, usually in a third meeting, he would document their discussions and help them prepare their application. The Gardners are in their early 60s and seem to be completely healthy. They are also very cautious and detail-oriented people, who are most comfortable taking plenty of time to make decisions. In this case, however, taking all that time will likely cost them an additional several hundred dollars a month in premiums.

Owen is tempted to simplify the terms and conditions upon which they will base their decision to make it easier for them to choose a policy, and make it possible to submit their application in time to qualify for the current, lower premium. He feels this is in the best interests of his clients.

Should he do this? Why or why not?

Should he tell them about the imminent increase in premium?

Profile Discussion

Owen should avoid the temptation to oversimplify his explanations. It is self-centered to think you know what is in the best interests of your clients based on such a short relationship. It is also unethical to withhold **any** information that prevents a client from making an informed decision, even if you believe it is "for their own good."

Telling the Gardners about the upcoming premium increase raises two concerns:

- If Owen does so, will they think he is using this information to pressure them into making a quick decision?
- Will the Gardners appreciate the opportunity to save some money and make an impulsive decision?

The key concept here is presenting **all** information to the clients and making sure they take enough time to understand it, so they can make an **informed decision**.

The most ethical thing to do is tell the Gardners about the premium increase and strongly encourage them to take adequate time to make their decision, regardless of the possibility that this will cost them more. Put into perspective for them the potential higher cost over the life of the policy versus making a bad decision (choosing the wrong policy or terms).

Chapter 1 Summary

Religion, law and social customs do not necessarily conform to the most ethical perspective. A thinking person is able to compare ethical principles to religious practices, laws, and social customs, and judge whether they are consistent.

It is especially important in the financial professions to understand that compliance with law and regulations is necessary, but perhaps not sufficient, to guarantee ethical choices.

It is helpful to recognize that as humans we naturally tend to view the world from our own perspective, sometimes making assumptions or placing our own interests above those of others. Awareness of this tendency is key to overcoming it and walking the most ethical path.

Test Your Comprehension

1. Why can't you depend primarily on laws and regulations to guide your ethical decisions?
2. How will you know if you are encountering an ethical dilemma?
3. What are some characteristics to watch out for, in an effort to be less egocentric?

Test Your Comprehension Answers

1. Laws and regulations cannot possibly be detailed enough to cover all possible situations.
2. An ethical dilemma presents one or more options that seem equally valid, but conflict with each other.
3. Oversimplifying, being inconsistent in how you apply standards to yourself and others, and maintaining a narrow point of view are all evidence of egocentric thinking.

Chapter 1 Review Questions

1. Bernice, a tax preparer, has an ethical decision to make that none of the laws or regulations seems to address. Bernice should
   a. look at the laws and regulations more carefully.
   b. call the IRS hotline.
   c. think through the facts and check the options against ethical principles.
   d. narrow the decision down to two possibilities and then choose one by "trusting her gut."
2. Ruth considers herself ethical, but others know she typically puts her desires first over others' needs. To expand her ability to see others' points of view, Ruth should
   a. apply different standards to others than those she uses for herself.
   b. be more confident that she knows the truth.
   c. notice inconsistencies between what she says she believes and her behavior.
   d. seek points of view that agree with her own.
3. Patrick always follows all the laws or regulations of his industry. By following those laws and regulations, he
   a. may be following the letter but not the intention of the law.
   b. is always ethical because laws and regulations are ethical.
   c. always thinks through all sides of an issue.
   d. is always informed when new laws and regulations are written.
4. Seeing the world in relationship to yourself is
   a. natural and common.
   b. a way of thinking that you must learn to develop.
   c. necessary for ethical reasoning.
   d. usually something only younger people do.

Answers to Chapter 1 Review Questions

1. c
2. c
3. a
4. a

Chapter 2
Key Components of an Ethical Decision

"…a man may be very sincere in good principles without having good practice." —Samuel Johnston

Chapter Objectives

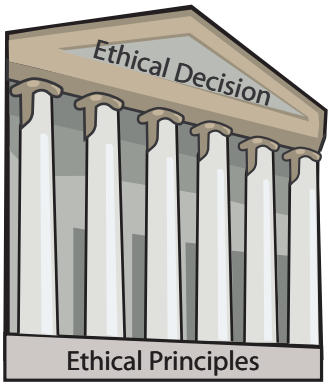
Upon completing Chapter 2, you will be able to:

- List basic ethical principles
- Examine your own ethical principles
- Describe the Six Pillars of Character and how they are used in making ethical decisions

Introduction

In Chapter 1: What's Your Comfort Level, you assessed your own comfort level with ethical dilemmas, having defined ethics and differentiated between ethics and compliance. In this chapter, you'll examine the foundation upon which an ethical decision is built—ethical principles—and what supports it—the Six Pillars of Character.

Ethical Principles: The Foundation



The most basic ethical principles include honesty, integrity, justice, equality, and respect. In many cases, applying these principles is simple. However, in other cases, as you saw in the six scenarios in the previous chapter, it is difficult. Simple examples of unethical conduct include lying about, misrepresenting, or distorting the facts to gain a material advantage over seniors: clearly all violations of the basic principle of honesty. Treating seniors as if they were worth less than you violates the principles of integrity, justice, equality and respect.

Situations become more complicated when you must consider counter-arguments from differing **and** equally ethical points of view. This is when you face an ethical dilemma. Think about the concept of cruelty. Cruelty means to cause unnecessary pain: allowing an innocent person to experience unnecessary pain and suffering when you have the power to alleviate it, without – and here is where the ethical dilemma may arise – sacrificing something of equal value, such as honesty.

Think back to the self-assessment scenario about Mr. and Mrs. Jones. Would it be cruel to discuss with Mrs. Jones the possibility that her husband has Alzheimer's disease? Or would her possible distress be outweighed by the opportunity to medically help him?

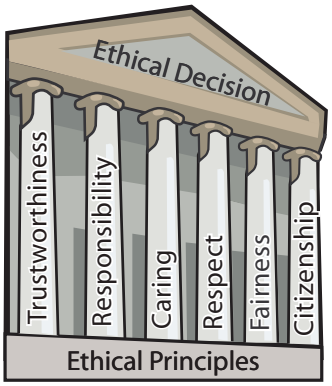
Principles are deeply held beliefs upon which all our rules in life are based. Without them, emotions, situations, and selfishness can take over your ethical decision-making.[2]

Reflection Question

What are your ethical principles?

The Six Pillars of Character: A Tool for Assessing the Ethical Quality of your Decisions

Trustworthiness. Respect. Responsibility. Fairness. Caring. Citizenship. The Six Pillars of Character are ethical values to guide your choices.[3]



There is nothing sacrosanct about the number six. There might reasonably be eight or 10, or more. But most universal virtues fold easily into these six. The number is not unwieldy and the Six Pillars of Character can provide a common language. Why is a common language necessary? So that people can see what unites our diverse and fractured society. So we can communicate more easily about core values. So we can understand ethical decisions better - our own and those of others.

The Six Pillars act as a multi-level filter through which to process and assess your decisions. For example, being trustworthy is not enough—you must also be caring. Adhering to the letter of the law is not enough—you must accept responsibility for your action or inaction.

The Pillars can help you detect situations where you might be focusing so hard on upholding one moral principle that you sacrifice another—where, intent on holding others accountable, you ignore the duty to be compassionate; where, intent on getting a job done, you ignore how.

In short, the Six Pillars can dramatically improve the ethical quality of your decisions, and thus your character and life—and the lives of your senior clients.

Pillar 1: Trustworthiness

When others trust you, they give you greater leeway because they feel you don't need monitoring to assure that you'll meet your obligations. They believe in you and hold you in higher esteem. That's satisfying. At the same time, you must constantly live up to the expectations of others and refrain from even small lies or self-serving behavior that can quickly destroy your relationships.

[2] Josephson, Michael. Making Ethical Decisions. Los Angeles, CA: Josephson Institute of Ethics, 2002

[3] Ibid.

Simply refraining from deception is not enough. Trustworthiness is the most complicated of the six core ethical values and concerns a variety of principles and qualities like honesty, integrity, reliability and loyalty.

Honesty

Honesty is much more than diligently accounting for funds, or always telling the truth. Honesty includes telling the **complete** truth, including the consequences of actions (or inaction). It includes keeping appropriate records of services for legal and consulting purposes, and holding all records in strict confidence. It means not allowing technical or legalistic "fine print" language to confuse the client or obfuscate the issues. It means admitting to a mistake and apologizing and/or mitigating the results. Honesty is being authentic with the client, putting into words what you are experiencing with the client during your consulting. Authentic behavior leads to higher trust and mutually successful relationships.

Profile
Marty is meeting with his clients Mr. and Mrs. Dean, to discuss long-term care insurance. Mr. Dean says, "Well, this meeting shouldn't take too long. I wish we had more time to spend with you, but I would appreciate it if you could just sum up what we need to know and then we'll think it over. Maybe you could leave us some written information." Marty experiences feeling resistance (in spite of the fact that Mr. Dean called to inquire about this insurance and initiated the appointment). He is afraid to be perceived as "pushy" if he insists on taking more time. He is concerned that Mr. and Mrs. Dean will have difficulty understanding all the issues and how they can impact their situation. Marty wants to help them make the best decision, but he feels like Mr. Dean doesn't respect his time or his professional competency. Marty could say "I understand you are busy. I'll check back with you next week to see if you have any questions," hoping that his clients will agree to talk more then. What is the best thing Marty can say?

Profile Discussion
Marty **should** say, *"I appreciate your time constraints, but the issues surrounding this type of insurance can be somewhat complicated. I want to make sure that you consider all the relevant questions, and that I explain everything well enough that you can make the best decision for your family. Can we reschedule this meeting for a day when you have enough time to really discuss this important information?"*

The non-authentic advisor responds indirectly and impersonally, and makes it easier for the client to stay distant and treat the advisor's concerns in a procedural way. The authentic response would focus on the relationship between the advisor and the client, and encourage the client to give importance to the advisor's role and value to the client.

There is no more fundamental ethical value than honesty. We associate honesty with people of honor, and we admire and rely on those who are honest. But honesty is a broader concept than many may realize. It involves both **communications and conduct**.

Honesty in communications is expressing the truth as best you know it and not conveying it in a way likely to mislead or deceive. There are three dimensions:

- **Truthfulness**. Truthfulness is presenting the facts to the best of your knowledge. Intent is the crucial distinction between truthfulness and truth itself. Being wrong is not the same thing as lying, although honest mistakes can still damage trust insofar as they may show sloppy judgment.
- **Sincerity**. Sincerity is genuineness, being without trickery or duplicity. It precludes all acts, including half-truths, out-of-context statements, and even silence, that are intended to create beliefs or leave impressions that are untrue or misleading.
- **Candor**. In relationships involving legitimate expectations of trust, honesty may also require candor, forthrightness and frankness, imposing the obligation to volunteer information that another person needs to know.

Honesty in conduct is playing by the rules, without stealing, cheating, fraud, subterfuge and other trickery. Cheating is a particularly foul form of dishonesty because one not only seeks to deceive but to take advantage of those who are not cheating. It's a violation of both trust and fairness.

Not all lies are unethical, even though all lies are dishonest. What? That's right, honesty is not an inviolate principle. Occasionally, dishonesty is ethically justifiable, as when the police lie in undercover operations or when one lies to criminals or terrorists to save lives. But don't kid yourself: occasions for ethically-sanctioned lying are rare and require serving a very high purpose indeed, such as saving a life—not hitting a management-pleasing sales target or winning a game or avoiding a confrontation.

Reflection Question

How can you be honest and tactful at the same time?

Integrity

The word integrity comes from the same Latin root as "integer," or whole number. Like a whole number, a person of integrity is undivided and complete. This means that the ethical person acts according to her beliefs, not according to expediency. She is also consistent. There is no difference in the way she makes decisions from situation to situation; her principles don't vary at work or at home, in public or alone.

Because she must know who she is and what she values, the person of integrity takes time for self-reflection, so that the events, crises and seeming necessities of the day do not determine the course of her moral life. She stays in control. She may be courteous, even charming, but she is never duplicitous. She never demeans herself with obsequious behavior toward those she thinks might do her some good. She is trusted because you know who she is: what you see is what you get. People without integrity are called "hypocrites" or "two-faced."

When you make promises or other commitments that create a legitimate basis for another person to rely upon you, you undertake special moral duties. You accept the responsibility of making all reasonable efforts to fulfill your commitments. Because promise-keeping is such an important aspect of trustworthiness, it is important to:

- **Avoid bad-faith excuses.** Interpret your promises fairly and honestly. Don't try to rationalize noncompliance.
- **Avoid unwise commitments.** Before making a promise consider carefully whether you are willing and likely to keep it. Think about unknown or future events that could make it difficult, undesirable or impossible. Sometimes, all we can promise is to do our best.
- **Avoid unclear commitments.** Be sure that, when you make a promise, the other person understands what you are committing to do.

Reflection Question

Have you ever made an unwise or an unclear commitment? What happened? What might you do differently in the future?

Reliability

Think of someone you know that you consider reliable. How are you defining reliable? Dependable, consistent, and unfailing are synonyms of reliable. Reliability means that you can be counted on to do what you say you will do, when you say you will do it. Being reliable means that you are **always** dependable, not just when it is convenient for you.

In order to be reliable you must also avoid the tendency to over-promise (and under-deliver) when, perhaps with the best of intentions, you make a commitment but then find it is impossible to keep that promise. Your failure may be due to time limitations or other factors out of your control, but those are factors that you should have taken into consideration before making the commitment.

Your senior clients appreciate reliability, as it is a quality they learned when young and valued all their lives.

Loyalty

Some relationships — husband-wife, employer-employee, citizen-country — create an expectation of allegiance, fidelity and devotion. Loyalty is a responsibility to promote the interests of certain people, organizations or affiliations. This duty goes beyond the normal obligation we all share to care for others.

- **Limitations to loyalty.** Loyalty is a tricky thing. Friends, employers, co-workers and others may demand that you rank their interests above ethical considerations. But no one has the right to ask another to sacrifice ethical principles in the name of a special relationship. Indeed, one forfeits a claim of loyalty when he or she asks so high a price for maintaining the relationship.
- **Prioritizing loyalties.** So many individuals and groups make loyalty claims on us that we must rank our loyalty obligations in some rational fashion. For example, it's perfectly reasonable, and ethical, to look out for the interests of your children, parents and spouse even if you have to subordinate your obligations to other children, neighbors or co-workers in doing so.

- **Safeguarding confidential information.** Loyalty requires you to keep some information confidential. When keeping a secret breaks the law or threatens others, however, you may have a responsibility to "blow the whistle."

Profile
Gary is an active member of a certain faith community. He doesn't ever try to proselytize to his clients or even discuss issues of religion. When he works on financial plans with his clients, he often finds it necessary to refer them to other agents or advisors. He makes a point of referring business only to professionals in his own faith community, even though sometimes there may be a colleague outside of this community that is more specifically qualified. Does Gary have a conflict of interest? Why or why not?

Profile Discussion
Choosing another professional to refer for **any** reason other than that he or she is the very best qualified is unethical. Gary clearly has a conflict of interest if his recommendation rests upon the advisor's faith rather than the advisor's qualifications. Trusted advisors have a duty to make all professional decisions on merit, unimpeded by conflicting personal interests. They owe ultimate loyalty to their clients.

Pillar 2: Respect

People are not things, and everyone has a right to be treated with dignity. You certainly have no ethical duty to hold all people in high esteem, but you should treat everyone with respect, regardless of who they are and what they have done. You have a responsibility to be the best you can be in all situations, even when dealing with unpleasant people.

The Golden Rule — do unto others as you would have them do unto you — nicely illustrates the Pillar of respect. Respect prohibits violence, humiliation, manipulation and exploitation. It reflects notions such as civility, courtesy, decency, dignity, autonomy, tolerance and acceptance.

A respectful person is an attentive listener, although his patience with the boorish need not be endless (respect works both ways). Nevertheless, the respectful person treats others with consideration, and doesn't resort to intimidation, coercion or violence except in extraordinary and limited situations to defend others, teach discipline, maintain order or achieve social justice.

People need to make informed decisions about their own lives. Don't withhold the information they need to do so. Allow all individuals, including maturing children, to have a say in the decisions that affect them. Accept individual differences and beliefs without prejudice. Judge others only on their character, abilities and conduct.

Profile
Sarah is meeting with her favorite client, Mr. Fine. She has worked with him for several years, and watched him cope with retirement and some age-related health problems. She feels real affection for Mr. Fine, and usually brings him treats like cookies or a new magazine, when she keeps an appointment with him in his charming home. Mr. Fine respects her competence and looks upon her as a trusted advisor. He is also warm and friendly, and looks forward to her visits. In this meeting, Sarah is expecting Mr. Fine to make a decision among investment vehicles they have been discussing. After greeting each other and a little small talk, Sarah says "*Well dear, do you have any more questions about Investment A or Investment B?*" Mr. Fine responds, "*I don't think so, I compared the returns at maturity and also the time factors, and I have chosen Investment A.*" She pats him on the hand. "*I'll be glad to fill out all these confusing forms for you and then all you have to do is sign them.*" Is Sarah treating Mr. Fine with respect? Why or why not?

Profile Discussion
Although Sarah may have the best of intentions, and warm, caring feelings toward Mr. Fine, her words ("well dear" and "confusing forms") and her behavior (patting his hand, weakening his autonomy) are condescending and unprofessional.

Pillar 3: Responsibility

Life is full of choices. Being responsible means being in charge of your choices and, thus, your life. It means being accountable for what you do and who you are. It also means recognizing that your actions matter and you are morally on the hook for the consequences. Your capacity to reason and your freedom to choose makes you morally autonomous and, therefore, answerable for whether you honor or degrade the ethical principles that give life meaning and purpose. Ethical people show responsibility by being accountable, pursuing excellence and exercising self-restraint. They exhibit the ability to respond to expectations.

An accountable person is not a victim and doesn't shift blame or claim credit for the work of others. He considers the likely consequences of his behavior and associations. He recognizes the common complicity in the triumph of evil when nothing is done to stop it. He leads by example.

The pursuit of excellence has an ethical dimension when others rely upon your knowledge, ability or willingness to perform tasks safely and effectively:

- **Diligence.** It is hardly unethical to make mistakes or to be less than "excellent," but there is a moral obligation to do one's best, to be diligent, reliable, careful, prepared and informed.
- **Perseverance.** Responsible people finish what they start, overcoming rather than surrendering to obstacles. They avoid excuses such as, "*That's just the way I am,*" or "*It's not my job,*" or "*It was legal.*"
- **Continuous Improvement.** Responsible people always look for ways to do their work better.

Your clients may take for granted that their advisors are competent. But competency does not only mean knowing your products and services. The degree of competence in the performance of services required by ethics goes beyond the level of the average professional in his specialty and area of practice. A professional's ethical duty is to perform at the highest levels of competence that he can achieve: to strive for excellence. If his abilities, training, and competencies are above average, he cannot ethically perform at average levels. Nor can he argue that his performance is still what the majority of professionals would do and thus meets his ethical duty. Ethics can and should be more personalized and demanding.

Included in true competency is the ability to communicate your knowledge to your client in a way he or she will understand and be able to use. A person who is competent is also accountable – they do what they say they will do, when they promised to do it. They acknowledge and correct a mistake immediately.

Being competent also includes embracing opportunities to learn, not only about the products and services of one's own business, but about the needs and concerns of one's clients, about skills and abilities that will improve one's effectiveness, and about the business climate in general.

Profile
Charlie is an insurance agent, like his father, who has just retired. Charlie has taken over his father's business. Mr. and Mrs. Boyce were clients of Charlie's father for years – so long, in fact, that Charlie has practically grown up with them. Mr. Boyce died last year. Mrs. Boyce was highly dependent upon Mr. Boyce to make all the financial decisions. Unfortunately, in the last few months of his illness, Mr. Boyce didn't take care of some things. Now Mrs. Boyce comes to Charlie and asks him what to do about some CDs that are maturing, and some stock option due dates that are coming up. Charlie is pretty sure he knows exactly what decisions Mr. Boyce would have made about these financial issues. Does Charlie tell Mrs. Boyce these things or does he refer her to another professional, knowing that she will probably incur consulting fees?

Profile Discussion
Even though Charlie wants to help Mrs. Boyce, her investment decisions are outside of his field of expertise and he should refer her to another professional. Clients sometimes attribute competency beyond the scope of the advisor's expertise, and so you may be called upon to set boundaries and make referrals. Knowing the limits of your own competency is fundamental to ethical performance. Referring to equally competent colleagues (rather than referring to someone who is less competent but who will benefit you as a result of the referral) is also essential. Keeping in mind that you will be evaluated on the competency of those to whom you refer, be informed and thoughtful when you do so.

Reflection Question

Other than the required CE courses, what are you doing to improve yourself professionally?

Responsible people exercise self-control, restraining passions and appetites (such as lust, hatred, gluttony, greed and fear) for the sake of longer-term vision and better judgment. They delay gratification if necessary and never feel it's necessary to "win at any cost." They realize they are as they choose to be, every day.

Pillar 4: Fairness

What is fairness? Most would agree it involves issues of equality, impartiality, proportionality, openness and due process. Most would agree that it is unfair to handle similar matters inconsistently. Most would agree that it is unfair to impose punishment that is not commensurate with the offense. The basic concept seems simple, even intuitive, yet applying it in daily life can be surprisingly difficult. Fairness is another tricky concept, probably more subject to legitimate debate and interpretation than any other ethical value. Disagreeing parties tend to maintain that there is only one fair position (their own, naturally). But essentially fairness implies adherence to a balanced standard of justice without relevance to one's own feelings or inclinations.

Process is crucial in settling disputes, both to reach the fairest results and to minimize complaints. A fair person scrupulously employs open and impartial processes for gathering and evaluating information necessary to make decisions. Fair people do not wait for the truth to come to them; they seek out relevant information and conflicting perspectives before making important judgments.

Fair people are impartial, and make decisions without favoritism or prejudice. An individual, company or society should correct mistakes, promptly and voluntarily. It is improper to take advantage of the weakness or ignorance of others.

Pillar 5: Caring

If you existed alone in the universe, there would be no need for ethics and your heart could be a cold, hard stone. Caring is the heart of ethics, and ethical decision-making. It is scarcely possible to be truly ethical and yet unconcerned with the welfare of others. That is because ethics is ultimately about good relations with other people.

It is easier to love "humanity" than to love people. People who consider themselves ethical and yet lack a caring attitude toward individuals tend to treat others as instruments of their will. They rarely feel an obligation to be honest, loyal, fair or respectful except insofar as it is prudent for them to do so, a disposition which itself hints at duplicity and a lack of integrity. A person who really cares feels an emotional response to both the pain and pleasure of others.

An essential component of fair-mindedness (the ability to treat all perspectives relevant to an issue in an objective manner) is **empathy**. This is the ability to understand the importance of imaginatively putting oneself in the place of others, to genuinely understand them. To serve well as an advisor, it is important to understand not only others' points of view, but also their feelings, fears, and desires. For example, if you are working with seniors, it is important to know that the **top three concerns of seniors** are:

- Outliving their assets
- Losing their independence
- Injury, illness, and diminished mental capacity

However, **knowing what these major concerns are and understanding how it feels to have these fears are two different things.**

How would you feel if you had a fixed income with no possibility of increasing it, and you were aware of inflation's effect on the increasing cost of almost everything?

Can you imagine how you would live if you could no longer drive a car, or walk, dress or even eat without assistance?

What activities would you have to change if you knew a fall would very likely cause a broken bone, with attendant suffering and possible complications that could even take your life?

Profile
Peter is an estate planner and has been working with Mrs. Brown, 79, for several months. In his latest visit to her apartment, he noticed that she was walking quite slowly when she answered the door, and was in a wrinkled housecoat rather than her usual neat-as-a-pin blouse and skirt. Peter showed concern, asking, "*Are you feeling well, Mrs. Brown? Have you had breakfast this morning?*" She replied, "*I just don't have much energy today. But I do want to keep our appointment.*" In speaking with Mrs. Brown, Peter noticed that her words were somewhat slurred, and the right side of her face seemed to be drooping down a little. He also could see that she wasn't using her right arm —it was hanging by her side. Peter recognized the signs of stroke, and called 911 to get her medical help. Did Peter do the right thing?

Profile Discussion
Peter did exactly the right thing. An advisor working with seniors needs to be aware of symptoms of certain illnesses, such as stroke, angina, diabetes, and urinary tract infections. The advisor also mustn't be afraid to ask caring questions about how the client feels, and to take action if immediate medical attention is indicated.

Pillar 6: Citizenship

Citizenship includes civic virtues and duties that prescribe how we ought to behave as part of a community. The good citizen knows the laws and obeys them; but that's not all. She volunteers and stays informed on the issues of the day, the better to execute her duties and privileges as a member of a self-governing democratic society. She does more than her "fair" share to make society work, now and for future generations. Such a commitment to the public sphere can have many expressions, such as conserving resources, recycling, using public transportation and cleaning up litter. The good citizen gives more than she takes.

Reflection Question

Which of the Six Pillars of Character is most essential to ethical behavior? Why?

Profile
Your friend Jim has asked you to speak with his parents, both in their 80s, and review all their various insurance policies with them. You do not handle their coverage—their old agent died, and they have met with his replacement, but say they don't like him—he seems rushed and pushy. They are just asking for a favor. Jim is a good friend, his parents know you, and you want to help out. When you meet with the parents you have a nice time reminiscing about the old neighborhood. The parents get to talking about their future plans, and in the conversation they reveal they have changed their will to exclude Jim, leaving everything to a charity. You know that Jim is counting on an inheritance as part of his retirement income. You even suspect the parents might be dropping this information so that you will be the one to tell Jim, enabling them to avoid any upset it might cause. What do you do? Do you mention to the parents that their son is expecting an inheritance? Do you hint to Jim that he'd better take another look at his retirement plan? Where does your loyalty lie?

Profile Discussion
Even though Jim's parents are not your clients, you are not helping them choose wallpaper - they are consulting you in a professional capacity. Your responsibility is to respect their confidence, and also to respect their wishes. Under no circumstances should you offer an opinion about the disposition of their estate. And you must treat the inheritance information as a confidence, even if you think Jim's parents' intention was to manipulate you into informing Jim. Further, if Jim asks any questions about his parents' business, your response must be that your professional code of ethics requires that any information they shared with you is confidential. In a situation like this it would have been better to refuse to do the favor, instead recommending a competent agent with a manner the parents would be more comfortable with. That way you wouldn't risk any possibility of a conflict of interest stemming from your friendship with Jim.

Chapter 2 Summary

Understanding ethics is much more than simply knowing the difference between right and wrong. It is being able to recognize when you encounter an ethical dilemma, having a set of **principles** to guide you, and choosing behavior that is the **most** right.

The Six Pillars of Character are ethical values to guide your choices. They are:

- Trustworthiness
- Respect
- Responsibility
- Fairness
- Caring
- Citizenship

These values act as a multi-level filter through which to process decisions, and can help you detect situations where you might be focusing so hard on upholding one moral principle that you sacrifice another.

Test Your Comprehension

1. Why are principles important in making ethical decisions?
2. Why is it useful to identify and discuss the Six Pillars of Character?
3. What makes trustworthiness such an important principle?
4. How can you use the Six Pillars of Character to guide you in ethical decision-making?

Test Your Comprehension Answers

1. You must have a basis for making one choice over another.
2. Naming the values upon which ethical behavior is based gives us a common language, so we can clearly understand what guides ethical choices.
3. Trustworthiness is the most complicated of the six core ethical values and concerns a variety of principles and qualities like honesty, integrity, reliability and loyalty.
4. Think of the Six Pillars as filters, or standards by which to judge your choices, being careful to consider all of them. Avoid the danger of basing an ethical decision on just one of the values, to the exclusion of the others.

Chapter 2 Review Questions

1. Facing an ethical dilemma means
   a. deciding whether to be honest or not..
   b. considering counter-arguments from different points of view.
   c. finding a law or regulation that supports what you want to do.
   d. choosing the most simple decision in almost all cases.
2. John believes he is an ethical, but smart, taxpayer. “After all,” he says, “we don't have to pay any more tax than the law requires.” If John is ethical, which statement would be something he would say?
   a. "If any of these deductions are questionable, let the IRS catch me."
   b. "If any of these deductions are questionable, I don’t take them."
   c. "If I cheat a little, what is the risk versus the possible benefit?"
   d. "Everyone cheats on their taxes. I do it less than most people."
3. Harriet, a rich, important client, is demanding and overbearing. When she comes in to the bank, the trust officer flatters her and is overly anxious to serve her in any way. But after Harriet leaves, the trust officer says what a difficult and unpleasant customer she is. The trust officer is
   a. lacking integrity. His conduct is based on the good he thinks a rich client will do for the bank’s business.
   b. just human. As long as Harriet doesn’t hear him complain, he does no harm.
   c. two-faced, but that’s not unethical.
   d. acting with integrity. He’s telling the truth at the same time he’s required to please an important customer.
4. A co-worker tells you in confidence she is thinking about making a decision that to you seems extremely unethical. She appears to want your opinion, but you doubt you can change her mind. What do you say?
   a. "I’m uncomfortable with the situation and would rather not get involved."
   b. "You’ll regret this forever and it’s just not worth it."
   c. "Have you considered what would happen if you get caught?"
   d. "Have you thought about other alternatives?" Then, you encourage her to make the ethical choice.

5. Trustworthiness is the most complicated of the six pillars of character because it
   a. is very difficult to be 100 percent honest and reliable.
   b. involves sincerity, which is not always how you really feel.
   c. may not apply in every situation and you have to be true to yourself.
   d. includes a variety of principles and qualities like honesty, integrity, reliability and loyalty.

Answers to Chapter 2 Review Questions

1. b
2. b
3. a
4. d
5. d

Chapter 3
Ethics and the Trusted Advisor

"All good people who have power over others, even just a little power and even for just a little while, need access to an ethic that can guide their use of it." —Perry London

Chapter Objectives

Upon completing Chapter 3, you will be able to:

- Describe what it means to be a trusted advisor
- Take the power differential into consideration and use your influence ethically
- Appropriately and adequately respond to situations involving possible elder abuse
- Foster senior autonomy in making decisions
- Correctly and ethically respond to situations involving questions of the senior client's cognitive capacity
- Recognize normal and possible signs of abnormal cognitive changes in seniors
- Adequately document interactions with senior clients

Introduction

In Chapter 2: Key Components of an Ethical Decision, you learned that principles are the foundation of ethics, and you can use the Six Pillars of Character to assess the ethical quality of your decisions. In this chapter, you'll look carefully at the kind of special ethical challenges you may face as a trusted advisor to seniors, in which you will be called upon to stand on your principles and use the Six Pillars to make the most ethical decisions.

What Does it Mean to be a "Trusted Advisor?"

An **advisor** is a person who offers professional advice: ethical, appropriate advice within a specific discipline, and knows where to get help outside his own specialty. A **trusted advisor** is dedicated to working in the best interests of the senior client, and distinguishes himself among professionals by a commitment to ethical business practices and a thorough knowledge of professional issues. The trusted advisor consistently focuses on doing the next right thing, rather than aiming for a specific outcome. The trusted advisor places a higher value on maintaining and preserving the relationship

than on the outcomes of the current transaction, and is motivated more by the drive to do the right thing than by an organization's rewards or dynamics.[4]

The relationship between the advisor and the client requires trust, because the client relies on the information given by the expert. This is especially true when the client is a senior who is living with limitations—whether physical, mental, or social. Ethical requirements for professionals are all based on this inequality of knowledge, and the necessity to trust the expert.

Basic Ethical Professional Duties When Serving Seniors

Ethical requirements for professionals who serve seniors usually include these basic duties:

1. Protect the interests and welfare of the senior client.
2. Be loyal and do not engage in conflicts of interest by preferring the interest of other clients, or those of the professional himself, over that owed the particular senior client.
3. Protect confidential information the senior client gives to the professional – and know what to do if it appears the senior client may be in jeopardy of being harmed, or of harming others (for example, a senior who appears to lack the required physical and mental skills and abilities to drive safely).
4. Do not appropriate or misuse the client's property.
5. Perform the professional services requested by the client competently, or else find another professional specialist who can do so.

Seniors often make decisions based more on trusted relationships than on facts or figures that a number of qualified professionals can present equally well. This puts an extra responsibility for ethical conduct on the advisor who works with seniors.

Using Your Influence Ethically with Seniors

As a trusted advisor, you probably have a lot of influence with your senior clients. Essential to your ethical orientation is understanding the power differential and its impact on the relationship you have with your senior clients.

Power differential is the difference between expert and client which results in a vulnerability on the part of the client.[5] As an advisor, you have greater power and influence than your client does. People who are in power positions sometimes don't recognize it, **but not recognizing it doesn't mean you don't have it.**

The power differential is created by inherent factors that are **perceived** by the less-powerful. Examples of such factors are:

- The advisor's knowledge and information
- The advisor being paid a fee

[4] Maister, David, Charles Green and Robert Galford. Trusted Advisor. New York: Simon & Schuster, 2001

[5] Barstow, Cedar. The Right Use of Power. Boulder, CO: Many Realms Publishing, 2003

- The advisor encouraging the client to be self-revealing
- Perceptions of status based on education, race, gender, title and class [6]

Many seniors, comfortable with tradition and respectful of achievement, are especially vulnerable to a power differential between themselves and an advisor who has education and skills outside the seniors' experience.

Understanding this power differential is key to managing the use of your power and influence in a completely ethical way. This also requires an awareness of how your power and influence affects others.

If you have developed a **trusted advisor** relationship with a client, she will look to you for recommendations. You may influence her decisions. Your influence can also be used to empower your client – encourage her to consider options, seek more information, ask questions – and then make a decision based in part on her own efforts, rather than solely on your recommendation.

In your dealings with senior clients, you may encounter situations that are outside of your areas of expertise, in which you will refer your client to another professional who can meet their needs. It is essential to your ethical performance to know your limits and set boundaries with your clients that define your capabilities, and then -- when making a referral -- recommending the very best advisor that you know to meet needs that you cannot. Your clients will be depending on the recommendation that comes from you, their trusted advisor.

What to Do If You Suspect Elder Abuse or Neglect

One of your basic professional duties is to protect the interests and welfare of the client. Unfortunately, you may encounter circumstances that may seem to indicate physical or financial risk to your client, and you must decide whether or not to intervene (and if so, how) – especially as you strive to uphold another professional duty – that of protecting confidential information. Following are some questions that you may at some point ask yourself:

- You know to refer a senior client who has needs outside your specialty to other professionals, but what do you do in a situation that you think needs immediate intervention? Is it ethical to step in and try to "rescue" someone?
- Are you breaching confidentiality? Are you very sure you know the whole story?
- When is doing nothing appropriate and when is it unethical?
- What if your instincts are telling you something may be amiss, but you don't want to "blow the whistle," because you don't have anything specific to tell?
- Do you know what resources are available to you and your senior clients in case emergency assistance is needed?

Find Out If Your State Has an Elder Abuse Statute

Financial professionals dealing with seniors should know whether their state has an elder abuse statute, and if so, what their responsibilities are under the statute. Also, you can check with the National Center on Elder Abuse (**www.elderabusecenter.org**) or a local social services agency.

[6] Ibid.

These resources can help you determine whether any action on your part is appropriate, and what that action might be.

If you are uncomfortable with a situation but don't have concerns about a senior's immediate health or welfare, it may be helpful to be able to discuss the situation, in confidence, with a professional from a different – but senior-oriented – field than yours. Any advisor working with seniors should develop relationships with colleagues in service areas such as elder care, social work, pastoral care, or geriatrics. This is not just for the purpose of referrals, but also for guidance you may seek if you encounter circumstances that are not reportable but that are concerning you.

Documentation is a crucial strategy in certain circumstances, and it will be covered in more detail later in this chapter.

Profile
Judy has been working with Mr. Wray, 83, for some time, and knows that he is occasionally quite confused. Lately Hector, the home health aide, has been present in her meetings with Mr. Wray. In fact, Mr. Wray keeps looking to Hector, who seems to be answering questions for Mr. Wray. Judy is concerned about undue influence. She finally meets with Mr. Wray alone, who can't seem to express himself or, when he does, he is not consistent. Judy is thinking about asking permission to speak to Mr. Wray's doctor, attorney, or accountant. Is that the right thing to do?

Profile Discussion
Judy is considering the right response. She has witnessed what appears to be undue influence and possible financial abuse by Hector, and when she sees Mr. Wray alone, his inadequate and inconsistent statements are a big red flag. Bringing in another advisor, with Mr. Wray's consent, will make it possible to protect him in the event Hector is trying to benefit from Mr. Wray's condition. It is incumbent upon you to stop the process of a financial transaction and alert other parties (for example: doctor, attorney, accountant) if you have concerns about undue influence or elder financial abuse. Judy should tell Mr. Wray that she is concerned about his welfare and ask permission to speak with one of his other advisors. She can say "I feel something is not quite right here, and I am reluctant to continue with what we are working on until I am sure you're okay." It may be appropriate to meet with family members, but exercise care if they would benefit from the transaction, or if your senior client seems to try too much to please them, to his own detriment.

How to Foster Senior Autonomy in Making Decisions

When working with seniors, it may be tempting for the trusted advisor to believe he knows what is best for the senior, and use his power to influence the senior in a certain direction. If you assume that the advisor sincerely has the best interests of the senior at heart, what is the harm in that?

The harm is that overbearing influence, even coming from a place of competence, caring, and unselfish aims, erodes the senior's autonomy – his confidence in himself, his feelings of being capable, and his precious independence. Further, the advisor may **not** understand all of the senior's circumstances, or his desires and concerns, as well as he thinks.

Profile

Mel, a Certified Financial Planner®, was working with Mr. and Mrs. MacDonald to reposition some assets to give them better protection against inflation. He was frustrated because his clients were ignoring his recommendations. Mr. MacDonald was extremely risk-averse, having as a teenager lived through the Great Depression, hearing all of the stories about stock market and bank failures. He was one step above keeping his savings in a coffee can buried in the back yard. He didn't trust financial institutions but felt even more strongly about the stock market, calling it "riskier than gambling at the race track."

Mel, in his 30s, had seen huge gains in the stock market most of his professional life. He had also studied the runaway inflation of the 1970s and had already seen his own parents' fixed incomes suffer from the effects of normal inflation.

Mel and Mr. MacDonald were each perceiving a different reality. What are some tips you could give Mel to more successfully advise the MacDonalds?

Profile Discussion

Mel's recommendations perhaps were too aggressive for Mr. MacDonald's comfort level. He also had not given Mr. MacDonald enough information (facts, graphs, comparisons, etc.) and enough time to digest and discuss the information. Mr. Macdonald wanted the opportunity to tell stories about the traumatic experiences he had endured as a young man. But he also could understand and accept the need to consider inflation as another type of risk, against which he could do a better job of protecting himself.

Mel might have more success identifying a diverse combination of investments, including government bonds, mutual funds, a small annuity, and a series of laddered bank Certificates of Deposits that Mr. MacDonald could move around himself to get the very best rates at any given time. With an appropriate portion of his assets more liquid and accessible, Mr. MacDonald might be more receptive to investing in an inflation hedge or two.

The way to avoid weakening a senior's autonomy is to place your emphasis on a mutually respectful relationship. You have knowledge and experience that equips you to advise the senior. The senior, in turn, has intentions, priorities, fears, questions, and experiences that, when shared, help you to advise correctly.

To achieve this mutually respectful relationship, you must develop and maintain an open mind. Especially if you represent a different generation than the senior, your life experiences have been very different. Your perception of the world, your place in it, and your future, is most likely not the same as the senior's. So recognize those differences, and seek as much information as possible to clarify your perspective and give you insight into that of the senior. Offer all the information you have and can obtain to your senior client, and give him time to digest it. Give him other resources to consult. Then, most importantly, create an environment where the senior is comfortable expressing his perspective, desires and concerns to you, and is comfortable asking questions.

By these means, you will strengthen your relationship with your senior client, and help him preserve his autonomy in making decisions, secure in the knowledge that you have given him everything you can to ensure his decisions are appropriate.

Ethical Conduct When Seniors Have Various Levels of Cognitive Capacity

What happens when a long-time conservative client of yours calls and wants to name a new beneficiary to all her insurance policies – her home health care aide?

You know this is a decision that is inconsistent with the client's lifetime goals and values, as well as the adverse effects it will have on the client and her heirs. You have good relationship with the family, which includes two grown children. Your first thought is to call them, but are you acting illegally? Unethically? What would you do?

This may seem like an extreme example, but this sort of thing is not uncommon. A senior who is mentally competent may be intimidated by a younger, influential person, or may be fond of and unwilling to disappoint or conflict with that person. The senior may also be dependent upon a younger friend or family member. For any one or more of these reasons, seniors may knowingly allow another individual to take advantage of them.

Also common is the senior client who calls in the morning requesting a transaction, and then doesn't remember the request in the afternoon when you call with the confirmation.

This is an example of where the client's mental capacity is questionable or intermittently impaired. And it is sometimes the financial or insurance professional who is the first one to identify what could be diminished capacity. Trusted advisors often work closely with clients over many years, come to know them quite well, and may be in the position of being the first person to question the client's decision-making ability. Family members may be in too close proximity to the senior to notice the gradual changes in competency, or may be in acute denial.

Temporarily diminished capacity is by no means limited to seniors. Loss of a spouse or parent, loss of a job, divorce, or serious illness can all affect a person's ability to make decisions, regardless of their age. Certain medications, depression, alcohol or illicit drugs can also diminish decision-making abilities.

Normal aging may include loss of hearing, a change in vision, prescription drugs, sleep disorders and even a nutrition deficit—all of which can mimic symptoms of diminished capacity. One of the symptoms of a urinary tract infection in seniors is confusion, which quickly disappears when the infection is treated. When a senior is developing memory problems, or intermittently diminished capacity, even physicians experienced in geriatric competency assessments frequently disagree in their competency judgments.

A financial advisor who works extensively with seniors should be aware of the normal cognitive changes that come with aging. The most common cognitive change is a decline in speed of mental processing. The speed with which adults are able to take in and process information declines with age.[7] Seniors will be just as likely as younger adults to understand material being presented to them, but they benefit from more time to absorb the information.

Also, learning or encoding of new information into memory storage is slower, so seniors may be less able to "store" new material that is presented rapidly. So it takes longer to learn new information in late life, and takes seniors longer to recall information.

It is important to understand that these changes are minimal in normal aging, and do not generally impair the daily functioning of healthy seniors, through the 70s and beyond. However, by age 85,

[7] Ibid.

nearly half are affected by Alzheimer's disease or some other type of dementia. Memory loss is the symptom most common in dementia and is typically the first noticeable cognitive change. Dementia also affects an individual's orientation to place and time, language functioning, ability to solve problems, and good judgment.[8]

Who is qualified to determine whether a client is competent, incompetent, or intermittently competent? Certainly not the financial advisor. But following are some suggestions to help the professional provide better, more ethical service to the senior client who appears to be showing signs of changing or diminished mental capacity.

Know Your Senior Clients

As you know, understanding your senior clients – their values and goals – is your commitment as an ethical, trusted advisor. Being familiar with how your client makes decisions can give you a basis for comparison if you suddenly feel that something is different. A change in investment philosophy after a senior client has worked with you for 15 years could be a signal that something may be wrong.

If you, a financial advisor, have concerns about a senior client's competency – whether gradual, sudden, or intermittent, there are several courses of action you can take: validate your concerns, check for understanding, and document.

1. **Validate your concerns.** See the client at different times of day and different days of the week. In a caring way, ask general health questions, like *"Are you having any trouble hearing me?"* or *"How have you been feeling lately?"* If you believe there is an urgent medical problem, see that the client gets to a doctor. If you fear there is a competency issue, you may need to postpone a transaction until the client's competency is checked.

Profile
George, an elder law attorney, has had Eleanor as a client for a number of years. He has helped her with her will, a Medical Power of Attorney, and some social security issues. Eleanor had always been consistent and stable – until this year. George has had five different requests from Eleanor to change her will this year, some of which she does not seem to remember. At this point, George tells Eleanor that he is concerned about her memory, and some of the decisions she is making. Eleanor is very upset with him and says, "*We have a long-standing relationship! Why are you refusing to help me now?*" In the kindest way he can, George recommends that Eleanor get a medical and neurological checkup, and Eleanor is highly offended: "*Are you saying I'm losing my mind?*" What should George do?

Profile Discussion
George has these choices: he can continue to fulfill her requests; he can give up Eleanor as a client; or he can work with her and her family to obtain a competency evaluation (which can be a lengthy, emotional, and somewhat costly procedure). Which would you do if you were George?

[8] Society of Certified Senior Advisors. Working with Seniors: Health, Financial and Social Issues. Denver Colorado, 2005

Ask yourself these questions: Have you "pushed" the right choice enough? Have you repeated the discussion with your senior client in different settings and at varied times of day? Have you asked your senior client if you may speak of the issue with her when including family members, her doctor, attorney, or other professionals?

If you have a question about competency, is it in your senior client's best interests to accept her decisions and implement them? It may not be, if those decisions are inconsistent with what you know the client's previous decisions have been over time.

Is it neglectful or unethical to give up a client, if she is in denial about competency issues and uncooperative when you try to give guidance that is consistent with past patterns, or when you request that she get medical help?

Is it unethical to call the client's accountant, pastor, or a social worker, for example, to get some support for your concern about the client's competency? Consult your profession's Code of Ethics or other ethical guidelines. You may find that the client's permission is required or recommended in order to contact other professionals about the client If the client agrees, it can be very helpful to call together several of the client's advisors to give support and guidance to a client who is suffering from diminished capacity, in a way to preserve as much of the person's dignity as possible.

If you have exhausted all professional and productive attempts to do the right thing for the client, there may come a time when you have to think about self-protection, and give up the client.

2. **Check for Understanding.** Given the cognitive changes that come with normal aging, deterioration in a senior's vision or hearing, or the possibility of some intermittent capacity problems, it is important for any trusted advisor to frequently check that the senior understands what is being said. Summarize by giving cue words: *"We talked about doing something with your CD that matures next month. Could you tell me what your understanding is?"*

   It is also helpful to convey information in ways that make it easier for the senior to process. Segment your information as much as you can. Don't use compound sentences, multiple concepts, or a list of choices, all at once. Divide up the information in separate little pieces. Use bullet points or numbers and go over each, one at a time. Slow down. Say, *"Let's talk about this first point. What do you think is good or not good about this option?"*

   Be sensitive to hearing and vision issues, and limit distractions. Speak clearly and face your client. Use type sizes that are not so small they are difficult to read, and provide generous lighting. When you document your discussions or your client's decisions, go over your memos and letters together. This way you ensure that the client has received, read, and understood the documentation.

   It may even be feasible to have an objective, third-party observer in a meeting (only with the senior client's prior permission). This should be someone completely impartial to any transaction and not connected with the advisor. The family attorney or CPA might be a good choice. Sometimes even the senior client will suggest that another family member (adult child, for example) be present at such a meeting. (Perhaps the client is feeling uncomfortable with making decisions but not ready to admit it.) If the client suggests that a family member attend a meeting, this can be ideal for you, the financial professional, because it gives you the opportunity to meet the extended family before a capacity situation becomes critical.

3. **Document, Document, Document.** Many times a client will not legally have to provide written authorization for a transaction. However, this could still expose an advisor to liability should a client change his mind or forget the agreement. While you may think it is not practical to have every direction from a client in writing, in some cases it is the proper thing to do. If you have any doubts about the client's decision-making capacity, it is best to put his orders in writing. If you are questioned by the client, you can truthfully say that you are uncomfortable executing those orders without written authorization.

   In other circumstances, where there is no specific transaction involved, but a discussion takes place that you are uncomfortable with or believe the client may not remember, take notes. If you are in the habit of documenting your meetings with a certain client, both of you can turn to these notes for reference.

   Send your client a letter or a memo referring to your last meeting—what was discussed and what was decided. Take a copy of it the next time you meet and go over it. If there is a question about competency, or if you are aware of manipulative relatives, caregivers or others, or if the client is making an ill-chosen decision, have him initial the document. If you see a pattern of behavior developing that is inconsistent with what you know to be your client's values and history, document it. Make notes of telephone conversations and document those conversations with the client.

   These efforts will go a long way toward protecting both your senior clients and you if any problems arise later. They also ensure clarity and help eliminate mistakes. Documenting much more thoroughly than you may have in the past is well worth the effort.

Profile

Mr. and Mrs. Harris had been clients of Miranda's for many years, and they had a great relationship. It was apparent to Miranda that Mrs. Harris was suffering some increasing memory problems, but since Mr. Harris, who was completely competent, made most of the decisions (always with Mrs. Harris present), Miranda wasn't too worried about it. One day Mr. Harris called Miranda and expressed frustration that every time the three of them had a meeting, afterward Mrs. Harris couldn't remember what was discussed and kept asking the same questions repeatedly. Mr. Harris asked Miranda if she would be willing to audiotape the meeting to help Mr. Harris remind his wife about what was said.

What should Miranda do?

Profile Discussion

Miranda thought that taping their meeting was a good idea, and on the first occasion of taping, asked Mr. Harris to state that the recording was being done at his and his wife's request. She provided Mr. Harris with copies of the tape recording and in this way helped him to make sure his wife understood the discussion.

Plan Ahead

It is a good idea to discuss competency issues with clients before they happen. Talking about a hypothetical future event is much easier than waiting until it is reality. Help the client and the family plan for any eventuality – find out what the client would want you to do, in the event she starts to become incompetent. Perhaps at this time you would obtain permission to go to another family member, or some other professional advisor, if in the future you were to become concerned about the client's decision-making capacity.

Discuss the subject of competency with your senior clients. Encourage them to think about the future, and to complete the documentation (Medical and General Powers of Attorney, Do Not Resuscitate Orders, etc.) that will enable their chosen representatives to make medical and/or financial decisions for them if it should ever become necessary.

Profile

Chester and Duke are partners in an insurance and financial planning business. They work together and share clients, combining their expertise and offering clients great responsiveness and availability. Mr. Cole, 75 years old and apparently of sound mind, has been their client for many years. His wife is institutionalized with Stage 3 Alzheimer's Disease. In the past couple of years, Mr. Cole has become deeply involved with a 50-year old woman, even building a new home and moving into it together. Mr. Cole makes sure his wife has the best care available, although he no longer visits her.

One day Mr. Cole comes to Chester and Duke's office, and during their meeting instructs them to sell an investment so that he can use the funds to finance his girlfriend's new business. She has been a government employee for many years but wants to open a flower shop, and he plans to pay for it. Later in the day, Chester and Duke receive a call from Mr. Cole's grown son and daughter, pleading with them to "do something!"

After this call, Chester and Duke enter into a heated discussion about Mr. Cole's situation. Chester says "*It's Mr. Cole's money to do with as he wishes. Heaven knows he has had a terrible struggle with his wife's illness, and now he has a chance for happiness. Who are we to poke our noses into his personal life?*" Duke says "*Mr. Cole has clearly lost his mind. This woman is obviously manipulating him to her own ends, and we have a responsibility to protect him.*"

Who is right? What should Chester and Duke do?

Profile Discussion
Mr. Cole is the client, not his grown children. He has not authorized any sharing of his confidential financial information with them or anyone else at this point. **He has no apparent incapacity**. Chester and Duke are obligated to follow his instructions. That being said, Chester and Duke are well-advised to do two things: 1. Clearly describe the consequences of Mr. Cole's decision from a financial standpoint, giving him time to consider the pros and cons of selling the investment. If the sale is detrimental to Mr. Cole's financial well-being or even imprudent, advise Mr. Cole against it. 2. Document information and recommendation being given to Mr. Cole and have him initial the documentation. Chester and Duke need to be careful not to become involved in judgment, emotional responses, or family dynamics. They should keep their conduct professional, thorough, and confidential, while at the same time protecting themselves from any liability for a poor decision Mr. Cole insists on making.

Chapter 3 Summary

Helping to preserve a senior's decision-making autonomy is a special obligation of trusted advisors working with older clients. The way to avoid weakening a senior's autonomy is to place your emphasis on a mutually respectful relationship. You have knowledge and experience that equips you to advise the senior. The senior, in turn, has intentions, priorities, fears, questions, and experiences that, when shared, help you to advise correctly

Another consideration when working with senior clients is the possibility you may encounter some degree of diminished capacity, or what appears to be diminished capacity, on the part of the senior. Knowing your client and some members of your senior client's family can help you respond appropriately if – and better yet, before – questions of capacity arise. Documenting your interactions with a client, or having an impartial (to you) third party present during business meetings are both ways to protect both you and your client if you believe his competency is in question. Initiating a discussion about the future can help your client to plan ahead in case competency ever becomes an issue.

Be knowledgeable about your responsibilities under your state laws and/or professional ethics that pertain to elder abuse or neglect. Know when it is appropriate and how to intervene, and what resources you can call upon.

Test Your Comprehension

1. How do we often unintentionally diminish senior decision-making autonomy?
2. What is intermittently diminished capacity?
3. What are other causes of behavior that seems to indicate the senior is incompetent?
4. Why should you spend time documenting interactions with senior clients when the understanding or decisions they make is perfectly clear?
5. Is it ever advisable to have a third party present in meetings with senior clients?

6. How do you handle a senior who wants to defer decisions to you?
7. How do you deal with a senior who has full mental capacity but who refuses to consider your professional recommendation and insists on making a poor decision?

Test Your Comprehension Answers

1. Sometimes, with the best of intentions, an advisor will believe she knows best, and make a strong enough recommendation that the senior feels powerless. Also, condescending words and behavior diminishes the senior's role in making the decision.
2. Some seniors can suffer diminished capacity on an irregular, temporary basis. One day they are clear-minded and competent, and the next they are confused or forgetful.
3. What appears to be incompetence can be caused by medications, alcohol abuse, depression, and even some sensory changes due to normal aging, mimicking the symptoms of diminished capacity.
4. Documenting the discussion and decisions reached during meetings with your senior clients can be helpful to the senior and protect the advisor from problems that could arise if the senior's capacity comes into question.
5. As long as the third party is completely impartial to your interests, and there is no indication of manipulation or intimidation (undue influence), it can be helpful to include a third party in your meetings with a senior client.
6. Kindly and politely refuse to make decisions for the senior. Take plenty of time to educate and review facts so the senior has all the information necessary to make an informed decision. If the senior is still unable to decide, suggest he enlist the help of another advisor or a trusted friend or family member.
7. Make sure the senior has all the facts, time to digest them, and an opportunity to discuss his viewpoint. Sometimes a senior just needs to be heard. If this client continues to insist on a decision against your best recommendations, choose between giving up the client or documenting all your facts and recommendations, having the senior initial the document, and carrying out his instructions.

Chapter 3 Review Questions

1. A trusted advisor's priorities would most likely be in this order:
   a. maintain professional certification, follow all laws and regulations, and perform regular speaking engagements.
   b. develop a strong relationship with clients, complete all documentation correctly, and file honest and complete tax returns.
   c. maintain and preserve a close professional relationship with clients, do the right thing, and always try to improve professional abilities.
   d. carefully explain all information about the transaction, ask for referrals, and achieve financial success.
2. Del's client has some dementia and lives in a nursing home. Lately she has complained to Del about how rough the aides are when giving care. Del is concerned but knows her client is hyper-sensitive. The nursing home has a very good reputation for quality care. Should Del say anything?
   a. No. The client is just complaining, and after all, no nursing home is perfect.
   b. No. The client is probably just imagining mistreatment.
   c. Yes. Del should report her complaints to the nursing home administrator and follow up the next time he visits.
   d. Yes. Del should call the elder abuse hotline immediately.
3. Ethical requirements for professionals usually include
   a. protecting the interests and welfare of the client, avoiding conflicts of interest, and protecting confidential information.
   b. managing your time effectively, being loyal, and exceeding the continuing education requirements of your profession.
   c. volunteering as much as possible, giving referrals to other professionals with whom you have reciprocal agreements, and never being dishonest.
   d. developing presentation skills, communicating all facts and figures in detail, and keeping senior clients from harming themselves or others.
4. The power differential is the difference between
   a. the highest and the lowest producer in your field.
   b. an expert and client that results in a client vulnerability.
   c. men and women.
   d. the recently retired and the most elderly.

5. You are a financial advisor and your neighbor and good friend Merrill is a tax accountant. You two often refer clients to each other. Is this a conflict of interest?
   a. Yes, because Merrill is also your friend.
   b. Yes. You should spread your referrals around to other tax professionals.
   c. No, as long as Merrill doesn't pay you any kickbacks.
   d. No, but you should reveal that Merrill is also your neighbor and friend when you refer him.

Answers to Chapter 3 Review Questions

1. c
2. c
3. a
4. b
5. d

Chapter 4
The Ethical Decision-Making Process

"If someone tells you he is going to make a 'realistic decision,' you immediately understand that he has resolved to do something bad." —Mary McCarthy

Chapter Objectives

Upon completing Chapter 4, you will be able to:

- State the core principles of sound decisions
- Identify the main characteristics of decisions that are both ethical and effective
- Follow a logical and thorough eight-step process for making ethical and effective decisions

Introduction

Now that you've learned about the special needs and issues involved in serving senior clients, you're ready to learn a decision-making model that you can apply in these and other situations to ensure your decisions are thoughtful, sound, ethical, and effective.

Ethical and Effective Decision Making

You have read a number of scenarios where the financial advisor needs to make a decision. In the following pages, you will see an eight-step model that will help you work through the important steps in making the right decision. First, however, it is important to note that good decision-making is based on the acceptance of two core principles:

1. We have the **power** to decide what we do and what we say.
2. We are morally **responsible** for the consequences of our choices.

The goal of decision-making is to decide among a set of alternatives, selecting the one most in keeping with our welfare as a trusted advisor and the welfare of others. **Good decisions are both ethical and effective.**

Ethical Decisions

A decision is **ethical** when it is consistent with the Six Pillars of Character – ethical decisions generate and sustain trust; demonstrate respect, responsibility, fairness and caring; and are consistent with good citizenship. If you lie to get something you want and you get it, the decision might well be called effective, but it is also unethical.

To make ethically sound and good decisions, you must both discern what to do and do it:

1. **Discernment:** requires knowledge and judgment. It is not obvious to everyone, for example, that it is just as dishonest to deliberately deceive someone by half-truths and omissions as to tell an outright lie. It's also not always clear how to respond most effectively.
2. **Discipline:** the strength of character to do what should be done even when it is costly or uncomfortable. Exercising discipline may at times involve the advisor's skills in Emotional Intelligence (discussed later in Chapter Five: Obstacles to Ethical Decision Making).

Profile
Scott is a relatively new insurance agent, eager to build his business and to serve his clients well. He is recently trained, with a good understanding of the conditions that are required in order for an application for coverage to be approved. Scott feels that it is his responsibility to sell the policy, and develop a relationship with his clients – and it is the underwriter's job to approve or deny the coverage. He scrupulously guides his client to fill out the application correctly and completely. Sometimes he sees something that he knows will cause the application to be declined, but he always submits it to the carrier anyway. Scott doesn't want to be the "*bad guy*" – "*It's the underwriter's job to approve or deny the application.*" Is Scott discerning? Is Scott making ethical decisions?

Profile Discussion
True, it is the underwriter's decision whether to accept the application or not; however, if Scott **knows** the application contains information that will cause it to be declined, he is not being honest with his client. His decision to "be the good guy" in this case is not ethical. Further, he may be creating unrealistic expectations if his clients do not clearly understand that they do not have coverage until the underwriter approves the application.

Effective Decisions

A decision is **effective** if it accomplishes something you want to happen and advances your ethical purposes. A simple test is: are you satisfied with the results? A choice that produces unintended and undesirable results is ineffective. For example, if you make a casual remark to make someone feel good but it makes him feel bad instead, you were ineffective. If you decide to do something you really don't want to do just to please a friend and the decision ends up getting both of you in serious trouble, it's ineffective.

We all make thousands of decisions daily. Most of them do not justify extended forethought. They are simple, repetitive or without significant consequence. In such cases, it may be safe to just go with your feelings. It's OK to decide spontaneously what to wear and eat and what to say in casual conversations. When the issues are not morally complex and the stakes are small, our normal instincts are sufficient.

The problem comes when you don't distinguish between minor and potentially major issues, when you "go with the flow" in situations that demand a much more careful approach.

Eight Steps to Making Ethical Decisions

Now it's time to examine the decision-making process. Following is a good eight-step model to use when you're facing an ethical dilemma and need to make the best decision you can.

Step 1: Recognize Your Dilemma

You must recognize that you face an important decision. Much of the worst decision-making is the result of the failure to recognize that a decision is at hand. Often people have a hard time recognizing the dilemma. What is your dilemma? Define it.

Step 1: Recognize Your Dilemma

Many decisions are made subconsciously, or mindlessly – and when the results of the decision become apparent, the reaction is *"It never occurred to me!"* or *"I just didn't realize!"* [9]

Reflection Question

*Can you think of a time when you made a decision **not to** make a decision?*

The chart below lists the most common ethical questions you may be presented with and suggestions that will lead you to make the best decision. This table appears again in Chapter 6: Making New and Better Decisions so that you may print it for use as a resource.

Ethical Issue	Ethical Response
Confidentiality	**Who is your client?** Have you the client's permission to share any of her personal, financial, confidential information with any other individual? If not, do not! This applies especially when your clients are married couples. One spouse may tell you something in confidence that the other one does not know about. You must treat such information as confidential unless you have express permission from the confiding spouse to share it with the other one.
Competency	**Specifically, what event is leading you to question the client's competency?** Know your client in order to know if he has been behaving inconsistently with past decisions and goals. It is unethical to continue with a transaction if you have a question about the client's competency. But you must obtain the client's permission to involve a family member or an advisor such as attorney, physician, or social worker in order to address the issue. Document your interactions with the client.

[9] Paul, Richard and Linda Elder. Critical Thinking. Upper Saddle River, New Jersey: Pearson Education, Inc., 2002

Ethical Issue	Ethical Response
Conflict of interest	**Is there any possibility that your behavior or the choice you are making is not in the absolute best interest of you and/or your client?** Be aware of possible sources of a conflict of interest for you. This includes situations where seniors may out of gratitude wish to offer you gifts, especially when they have developed a trusting relationship with you. Do not offer or accept any gifts from any individual that exceed the limit on the monetary value of gifts that is established by law, regulation and/or your profession's code of ethics.
Informed decision	**Are you withholding any information, no matter how minor it seems?** Never, ever withhold any information from a client for any reason. Check for comprehension and solicit questions to make sure the client has all the facts she needs in order to make a completely informed decision. Document your interactions and remember that in the end, the choice is the client's.
Senior autonomy	**Do you always treat seniors with respect and seek to enhance their self-determination?** Do not, out of a misguided desire to help the client, try to make a decision for the client or take any action that the client is capable of taking for herself. Create an environment of understanding, patience and respect that encourages the senior to remain autonomous.
Setting expectations	**Do you and your senior client know what to expect from each other?** From the beginning of a relationship with a senior client, set the boundaries of your expertise and your advice. Let your client know what you expect from him. From the beginning of your relationship, establish an understanding with the client with regard to confidentiality, representation, and documentation. **Note:** When your clients are married couples, you must take the extra step of clearly communicating to both spouses that you represent each of them equally, and that one of your expectations is that you will require the knowledge and approval of each of them to execute any decisions relative to their account—you will conduct no transactions without first obtaining the knowledge and approval of both spouses.
Elder abuse or neglect	**Do you suspect elder abuse or neglect?** Know your responsibilities under your state's elder abuse statutes. Develop your network of senior advisors who can help you analyze a situation and determine what, if any, action to take.

Ethical Issue	Ethical Response
Time and patience	**Do you expect a senior client to respond as quickly as a younger client?** Understand older adults' cognitive changes and be as patient as you need to be when speaking, explaining, and developing the kind of relationship that is so important to the senior.
Stubborn/arbitrary client	**Is your client holding tightly to a viewpoint or a decision that you sincerely believe is not in her best interest?** Take enough time to explain and solicit questions about the issues. Document what information you have furnished and what your client's responses are. Decide whether you can ethically continue the transaction and if not, encourage the client to consult another advisor like a CPA or attorney.
Professional development	**What have you done lately to develop your professional skills?** Be on the lookout for more opportunities to learn and advance. Develop a network of ethical, competent colleagues from specialties other than your own and regularly get together with them.

Step 2: Stop and Think

Step 1: Recognize Your Dilemma
Step 2: Stop and Think

One of the most important steps to better decisions is the oldest advice in the world: think ahead. To do so, it's necessary to first stop the momentum of events long enough to permit calm analysis. This may require discipline, but it is a powerful tonic against poor choices.

The well-worn formula to count to 10 when angry and to a hundred when very angry is a simple technique designed to prevent foolish and impulsive behavior. But we are just as apt to make foolish decisions when we are under the strain of powerful desires or fatigue, when we are in a hurry or under pressure, and when we are ignorant of important facts.

Just as we teach our children to look both ways before they cross the street, we can and should instill the habit of looking ahead before they make any decision.

Stopping to think provides several benefits. It prevents rash decisions. It prepares us for more thoughtful discernment. And it can allow us to mobilize our discipline.

In advising senior clients, it is important to urge them to stop and think too, before making an important decision. What are the likely consequences of this decision versus a different decision? What future events can you predict that would have a bearing on the decision? Be sensitive to the fact that seniors are sometimes reluctant to visualize a future that may include diminished capacity, physical disability, loss of independence, purchasing power, or mobility.

Step 3: Determine Facts

Step 1: Recognize Your Dilemma
Step 2: Stop and Think
Step 3: Determine Facts

Be sure you have adequate information to support an intelligent choice. You can't make good decisions if you don't know the facts.

To determine the facts, first resolve what you know and then, what you need to know. Be prepared to get additional information and to verify assumptions and other uncertain information.

Once you begin to be more careful about who, what, where, when, how, and why, you often find that there are different versions of them and disagreements about their meaning. In these situations, part of making sound decisions involves making good judgments as to who and what to believe.

Here are some guidelines:

- Identify what kind of information is important to get, and where to find it. Ask yourself: Do I need this information to make a decision? This helps you focus on the most important information and make the best use of your time.
- Consider the reliability and credibility of the people providing the facts.
- Consider the basis of the supposed facts. If the person giving you the information says he or she personally heard or saw something, evaluate that person in terms of honesty, accuracy and memory.
- Remember that assumptions, gossip and hearsay are not the same as facts. Why is this important? Your assessment of the consequences of the different options you generate will only be as good as your information. Your facts and information must be accurate, complete and precise.
- Consider all perspectives, but be careful to consider whether the source of the information has values different than yours or has a personal interest that could affect perception of the facts.
- Where possible seek out the opinions of people whose judgment and character you respect, but be careful to distinguish the well-grounded opinions of well-informed people from casual speculation, conjecture and guesswork.
- Finally, evaluate the information you have in terms of completeness and reliability so you have a sense of the certainty and fallibility of your decisions.

Profile

Mr. and Mrs. Gardner had been clients of Leroy's for years and they had a good relationship. They were discussing the purchase of an annuity, and the various choices that were available to them. Leroy carefully gave them all the information regarding each type of annuity, and then reviewed the information to make sure the Gardners understood it. It was time for a decision, and Mr. Gardner said to Leroy, "*What would you do if you were in my shoes?*"

How should Leroy answer that question?

Profile Discussion
An informed decision takes into consideration individual values, goals, facts, and consequences. The fact is, Leroy was NOT in Mr. Gardner's shoes, and his values or goals might be quite different from those of the Gardners. Leroy should simply lay out the pros and cons of each option – if necessary, restate the facts and consequences of each decision **for Mr. and Mrs. Gardner**. He might say, *"I've heard you say that the most important thing to you is…What do you feel would most help you accomplish that?"* In the role of a trusted advisor, it is your responsibility to make sure that your senior clients have access to and understand all of the facts that are relevant to their decision. Be aware that sometimes seniors can be looking for someone to relieve them of the necessity to make a decision, and resist the temptation to do so.

Step 4: Develop Options

Step 1: Recognize Your Dilemma
Step 2: Stop and Think
Step 3: Determine Facts
Step 4: Develop Options

Now that you know what you want to achieve and have made your best judgment as to the relevant facts, make a list of options: a set of actions you can take to accomplish your goals.

If it's an especially important decision, talk to someone you trust so you can broaden your perspective and think of new choices.

The failure to accurately recognize the alternatives comes in two forms:

- Thinking unrealistically
- Thinking too narrowly

Are you thinking something is an alternative when it is really not? Are the alternatives you are considering realistic? Or are you in denial, ill-informed, or stuck in a fantasy? If you can think of only one or two possible options, or if your choices look the same or similar, you probably are thinking too narrowly. In this case, sometimes brainstorming or getting suggestions from others can help expand your options.

Your senior clients may occasionally need just this sort of encouragement—to open their minds and let the ideas flow—in order to be able to consider **all** the options available to them. Facilitating this step in the decision-making process can be very helpful to someone who is hampered by stress, emotion, lack of confidence or experience, or fear that she will make a wrong decision.

Reflection Question

Has there ever been a time when you have chosen an unrealistic alternative? Was this an effective decision?

Step 5: Consider Consequences

Step 1: Recognize Your Dilemma
Step 2: Stop and Think
Step 3: Determine Facts
Step 4: Develop Options
Step 5: Consider Consequences

Several techniques help reveal the potential consequences:

- **"Pillar-ize" your options.** Filter your choices through each of the **Six Pillars of Character:** trustworthiness, respect, responsibility, fairness, caring and citizenship. Will the action violate any of the core ethical principles? For instance, does it involve lying or breaking a promise; is it disrespectful to anyone; is it irresponsible, unfair or uncaring; does it involve breaking laws or rules? Eliminate unethical options.
- **Identify the stakeholders** and how the decision is likely to affect them. Consider your choices from the point of view of the major stakeholders. Identify whom the decision will help and hurt.
- **Identify the trade-offs for each option.** They might be time, money, values, relationships – decide what the priorities are.
- **Determine your risk tolerance for the options.** Specifically identify the "best case" and "worst case" consequences of each option. Decide how much you will sacrifice, if there is no perfect "right" answer.

The following **Quick Check** may also be helpful to you in thinking through the consequences of your decision. Ask yourself these questions:

- **Is it legal?**

  As you know, legal and ethical are not equivalent concepts. However, this is a good first filter through which to pass your decision. If the answer is no or raises objections, you must stop, reject the action and take another course. If the answer is yes, go on to the next question.

- **How would it look in the news?**

  It's one thing for you or even your close associates to know about your decisions and actions, but quite another when people who don't know you learn about them. How would your actions be perceived? Would you be embarrassed to have them known? If the answer is unacceptable, stop, reject the action and take another course. If the answer is acceptable, go on to the next question.

- **Am I treating others as I want to be treated?**

  Is the result of the action fair, considerate, and consistent? Can you put yourself in the place of your client and honestly say you would be comfortable? If the answer is no, reject the action and take another course. If yes, move on to the next question.

- **Did I take enough time to consider my decision?**

  Often when subsequent information is available, we regret our actions – but we also realize that we make decisions with the information available at the time. If the decision does not need to be made immediately, have you given your proposed action enough reflection to feel confident about its outcome? If the answer is no, take more time and/or consider more information before making a decision. If the answer is yes, move on to the next question.

- **How will I feel after the decision is known? Can I face myself the next morning?**

  When you look at yourself in the mirror are you satisfied you have done the right thing? Have you acted in the best interest of your client? If the answer is no, stop, reject the action and find another course. If yes, take the action with good confidence you have resolved your dilemma.

Remember: Sometimes what seems to be the obvious decision is not the best one. How do you determine which alternative is the most effective **and** most ethical? Have some criteria against which the alternatives can be measured, and be able to predict with some confidence the consequences of each alternative.

Profile
Michael was financial advisor to Daniel, who lived in a nursing home – paid for partly by his long-term care insurance and partly by income from his assets. Daniel was mentally competent but suffering from cancer of the larynx and unable to speak. He preferred to have Michael make investments for him and keep him informed in writing, as it was difficult for him to try to communicate verbally. Over the years Michael had come to know most of Daniel's family – his three adult children and their families too. Daniel's wife had passed away many years before. Daniel was comfortable financially and likely to die before using any of his principal. One day Michael realized he was about to make an investment choice that would clearly benefit Daniel's heirs – but would actually reduce Daniel's cash flow and was not a decision that Daniel would have made for himself. How could Michael avoid such a situation in the future?

Profile Discussion
Michael had been tempted to invest for the benefit of the beneficiaries instead of his client, Daniel, and vowed to be more diligent and focused in the future, to avoid making a mistake like this. Michael would also benefit from reviewing the basic ethical requirements for professionals listed in Chapter 3: Ethics and the Trusted Advisor.

Step 6: Consult

Step 1: Recognize Your Dilemma
Step 2: Stop and Think
Step 3: Determine Facts
Step 4: Develop Options
Step 5: Consider Consequences
Step 6: Consult

Good ethical decision-making should not be done in a vacuum. It is easy to get sidetracked by our own issues, and our own viewpoints and way of thinking. If the dilemma is important enough, you should probably run it by someone else.

Consultation is more effective if you have done some "pre-thinking," including defining the dilemma (Step 1 of this model) and what the potential options are for resolving it (Step 4) and the potential consequences of each option (Step 5). It is also effective to think through what type of input would be most helpful, and who would be best able to supply that input. Finally, be clear about what information the person with whom you are consulting will need, in order to provide effective consultation.

Consulting with another person will also help you to avoid thinking about the dilemma in a self-centered way.

Step 7: Choose

It's time to make your decision. If the choice is not immediately clear, see if any of the following strategies help:

Step 1: Recognize Your Dilemma
Step 2: Stop and Think
Step 3: Determine Facts
Step 4: Develop Options
Step 5: Consider Consequences
Step 6: Consult
Step 7: Choose

- **Talk to people whose judgment you respect.** Seek out friends and mentors, but remember, once you've gathered opinions and advice, the ultimate responsibility is still yours.
- **Ask yourself what the most ethical person you know would do.** Think of the person you know or know of (in real life or fiction) who has the strongest character and best ethical judgment. Then ask yourself: what would that person do in your situation? Think of that person as your decision-making role model and try to behave the way this person would.
- **Ask yourself if this is what you would do if you were sure everyone would know.** If everyone found out about your decision, would you be proud and comfortable? Choices that only look good if no one knows are always bad choices. Good choices make us worthy of admiration and build good reputations. It's been said that character is revealed by how we behave when we think no one is looking and strengthened when we act as if everyone is looking.
- **Use the Golden Rule or the Platinum Rule**[5]. We don't want to be lied to or have promises broken, so we should be honest and keep our promises to others. We want others to treat us with respect, so we should treat others respectfully. You can take the Golden Rule to a higher level, to the Platinum Rule: treat others as **they want to be treated.** Using the Platinum Rule demonstrates empathy and understanding of the other person.
- **Revisit the Six Pillars of Character (see Step 5)**. Have the self-discipline to act on the best alternative. It is not enough that you discern the ethical and effective course—you must follow it. This often takes will power or moral courage: the willingness to do the right thing, even when it is inconvenient, scary, difficult, or costly.

Step 8: Monitor and Modify

Since most hard decisions use imperfect information and "best effort" predictions, some of them will inevitably be wrong. Ethical decision-makers monitor the effects of their choices. If they are not producing the intended results or are causing additional unintended and undesirable results, they re-assess the situation and make new decisions.[10]

Step 1: Recognize Your Dilemma
Step 2: Stop and Think
Step 3: Determine Facts
Step 4: Develop Options
Step 5: Consider Consequences
Step 6: Consult
Step 7: Choose
Step 8: Monitor and Modify

Profile
Curtis is a top-notch producer that really puts in a lot of time into retirement planning for his clients. Mr. and Mrs. Miller are his clients who are just approaching retirement. The focus of both Curtis and his clients at this point is managing their assets, as opposed to planning for all contingencies. Curtis has constructed a detailed plan for the Millers, including asset allocation, risk tolerance, and growth. There is one obvious gap: no provision for long-term care (LTC). Curtis briefly discussed the issue with his clients, who indicated they have enough cash to accomplish their investment goals, but not pay for LTC insurance, too. Besides, Mr. Miller says when he goes, he'll just "*drop dead,*" and the kids will make sure Mrs. Miller is well cared for. Curtis is fine with their decision, believing that they will grow their assets enough to self-insure in the event they need LTC "*far off in the future.*" Is it ethical for Curtis to agree with his clients' decision or should he risk sounding pushy if he insists on planning for LTC in some way?

Profile Discussion
Curtis' focus on investment and growth dovetails with Mr. and Mrs. Miller's problem with denial. They are not giving enough consideration to the likelihood that one or both of them will need some form of long-term care – whether they live to be very old or not – and that their children may not be able to provide skilled care without tremendous sacrifice. Curtis is making recommendations based on very shaky ground – who knows whether they can grow their assets enough to self-insure? Encouraging his clients to define what long-term care means to them and how they plan to pay for it is not being pushy, nor is educating them about a variety of options for funding it, including life insurance or LTC insurance. He has an ethical responsibility to make sure they understand ALL their risks so they can make an **informed** decision about LTC planning.

[10] D'Aprix, Amy. Institute for Ethical Decision Making, Inc. 2400 Queen St. East, Suite 208, Scarborough, ON, Canada M1N 1A2; 289 251-2468

Chapter 4 Summary

Good decision making is both ethical and effective. It requires consciously recognizing that a decision is at hand, identifying and evaluating realistic alternatives, and having the self-discipline to act on the best alternative.

When you are about to make an important or difficult decision, it is helpful to take eight steps:

1. Recognize your dilemma
2. Stop and think
3. Determine the facts
4. Develop options
5. Consider consequences
6. Consult
7. Choose
8. Monitor the results and if necessary, modify the decision

Test Your Comprehension

1. What is the difference between an ethical and an effective decision?
2. What is the first step in the eight-step decision-making model?
3. Why is it so important not to confuse assumptions and hearsay with actual facts?
4. What should you do when the choice seems obvious?
5. How can you be sure you have considered all the consequences?
6. In Step 6 of the model -- Consult, should you avoid telling the person whom you are consulting what your conclusions are, so he can give you a perspective that is free from your influence?

Test Your Comprehension Answers

1. An **ethical** decision is one that is consistent with your ethical principles (or the Six Pillars of Character). An **effective** decision accomplishes something you want to happen, at the same time as it advances your ethical purposes.
2. Many times, the trickiest part of the dilemma is identifying it. Step 1 of the model is Recognize Your Dilemma. It can be useful to write out the dilemma in one or two sentences in order to focus on the issue(s).
3. Your assessment of the consequences of the different options you generate will only be as good as your information. Your facts and information must be accurate, complete and precise. Be prepared to get additional information to verify assumptions and other uncertain information.
4. The most obvious choice may not always be the best choice. Don't skip steps – develop as many options as you can and then carefully consider the consequences of each one.
5. Step 6 of the model can be very helpful to you in considering all of the consequences. The person you are consulting might think of consequences you did not imagine. You might also frame your analysis of the consequences in a "best case – worst case" format.

6. No. Give the person you are consulting all the information you have, including your perspective and conclusions. If you have chosen wisely, this person will not be influenced by your thinking – just by the facts and their own experiences.

Chapter 4 Review Questions

1. A good decision is ethical when it is consistent with the
   a. decision you made last week.
   b. six pillars of character.
   c. laws and regulations that govern your profession.
   d. decision most of your colleagues would make.
2. Whitney needs to make financial arrangements for a client with intermittent incapacity. She is considering discussing her client's portfolio with the client's family, because they don't have much time to maximize her client's earnings. What type of ethical dilemma is Whitney facing?
   a. conflict of interest
   b. senior autonomy
   c. time and patience
   d. confidentiality
3. Fred, working hard to build his business, hasn't taken a vacation for three years. He finds it hard to spend more than the required time for continuing education. He decided to attend a conference with national speakers where he will be able to network with other professionals in his specialty. Which ethical issue does Fred feel he must address?
   a. time and patience
   b. informed decision
   c. professional development
   d. elder abuse or neglect
4. The second step in the 8-step decision-making model, "stop and think," provides this benefit: it
   a. prevents rash decisions.
   b. gives you practice counting to ten.
   c. prepares you for steps three through eight of the process.
   d. provides you time to define the dilemma.
5. In step four of the decision-making process, "develop options," what are the two most common types of failure?
   a. being in denial and getting stuck in a fantasy.
   b. thinking unrealistically and too narrowly.
   c. not using accurate facts and taking time to stop and think.
   d. thinking you have an ethical dilemma when you really don't, and vice versa.

Answers to Chapter 4 Review Questions

1. b
2. d
3. c
4. a
5. b

Chapter 5
Obstacles to Ethical Decision Making

We have forty million reasons for failure, but not a single excuse. —Rudyard Kipling

Chapter Objectives

Upon completing Chapter 5, you will be able to:

- Identify common rationalizations used to justify less-than-ethical behavior
- Apply critical thinking skills to ethical dilemmas
- Avoid common psychological traps in processing information and making decisions
- Describe and demonstrate emotional intelligence in interactions with senior clients

Introduction

You've now learned an eight-step model that will help you make the most ethical decisions. However, even after learning this decision-making tool and a lot about ethical dilemmas involving seniors' special needs and issues, sometimes you can still encounter barriers to making the most ethical choices. One of these barriers is self-centered thinking, which we discussed in the beginning of this course. In this chapter, you'll learn what other common barriers are and how to avoid them: rationalizations, lack of critical thinking, mental traps and lack of emotional intelligence.

Rationalizations

Making the right decision can be difficult. Integrity and self-discipline are sometimes not as strong as they need to be, and in making tough decisions, people can be distracted by rationalizations. Some of the most common rationalizations are:[11]

If It's Necessary, It's Ethical

This rationalization rests on the false assumption that necessity breeds propriety. The approach often leads to ends-justify-the-means reasoning and treating non-ethical tasks or goals as moral imperatives. For example, a client needs insurance coverage by a certain date. You missed getting his signature on one document, and it is physically impossible to get to the client for this necessary signature and still meet the deadline. He signed all the other documents, and his intentions are clear – so you forge his missing signature in order to obtain the needed insurance on time.

[11] Browne, M. Neil, Stuart Keeley. Asking the Right Questions: A Guide to Critical Thinking. Upper Saddle River, New Jersey: Prentice Hall, 2001

If It's Legal and Permissible, It's Proper

This substitutes legal requirements (which establish minimal standards of behavior) for personal moral judgment. This alternative does not embrace the full range of ethical obligations, especially for individuals involved in upholding the public trust. A common example of meeting legal requirements but not ethical standards when an advisor is satisfied with providing the investments' due diligence documents to a senior client even though the information is in such tiny print that the client can't even make them out, much less understand them.

It's Just Part of the Job

Conscientious people who want to do their jobs well often fail to adequately consider the morality of their professional behavior. They tend to compartmentalize ethics into two domains: private and occupational. Fundamentally decent people thereby feel justified doing things at work that they know to be wrong in other contexts. They forget that everyone's first job is to be a good person. A compliance officer might enter fictional numbers on a report in order to meet the deadline date for submitting the report, because she simply does not have enough time to obtain or calculate the true figures.

It's All for a Good Cause

People are especially vulnerable to rationalizations when they seek to advance a noble aim. "It's all for a good cause" is a seductive rationale that loosens interpretations of deception, concealment, conflicts of interest, favoritism and violations of established rules and procedures. For example, a financial advisor might have a personal passion for environmental causes. He prefers to do business with "green" vendors, and consistently recommends their products to his clients, even though they are sometimes not quite the best fit for a particular client.

I Was Just Doing It for You

This is a primary justification for committing "little white lies" or withholding important information in personal or professional relationships. This rationalization pits the values of honesty and respect against the value of caring. An individual deserves the truth because he has a moral right to make decisions about his own life based on accurate information. This rationalization overestimates other people's desire to be "protected" from the truth, when in fact most people would rather know unpleasant information than believe soothing falsehoods. Consider the perspective of people lied to: If they discovered the lie, would they thank you for being thoughtful or would they feel betrayed, patronized or manipulated?

I'm Just Fighting Fire With Fire

This is the false assumption that promise-breaking, lying and other kinds of misconduct are justified if they are routinely engaged in by those with whom you are dealing. If you find yourself working with someone who is unethical or not truthful, don't adopt their behaviors but rather make the decision to sever the relationship. This may not be a choice that is easily made, and may take time and effort to do so. But remember: when you fight fire with fire, you end up with the ashes of your own integrity.

It Doesn't Hurt Anyone

Used to excuse misconduct, this rationalization falsely holds that one can violate ethical principles so long as there is no clear and immediate harm to others. It treats ethical obligations simply as factors to be considered in decision-making, rather than as ground rules. Problem areas: asking for or giving special favors to family, friends or clients; disclosing confidential information to benefit others; using one's position for personal advantage. An example of this is a financial advisor who presents two apparently comparable investment products to a client. The documentation for these products suggests that they have the same risks, equivalent track records, and very similar projected returns. Instead of encouraging the client to make her own choice between the investments, the advisor recommends one over the other, because the sale of this particular product will boost him into a production level that brings him a healthy bonus.

Everyone's Doing It

This is a false, "safety in numbers" rationale fed by the tendency to uncritically treat cultural, organizational or occupational behaviors as if they were ethical norms, just because they are norms. It is easy to get caught up in competitions or contests and find yourself "pushing product" along with everyone else – when it is not really in your client's best interest.

It's OK If I Don't Gain Personally

This justifies improper conduct done for others or for institutional purposes on the false assumption that personal gain is the only test of impropriety. A related but narrower view is that only behavior resulting in improper financial gain warrants ethical criticism. Say you are an Enrolled Agent working with your client's tax returns and you see the client has huge medical and prescription deductions. Your brother-in-law just happens to be a pharmacist and you know he has been struggling lately to get enough business. You recommend him to your client. Is this an ethical thing to do?

I've Got It Coming

People who feel they are overworked or underpaid rationalize that minor "perks"—such as acceptance of favors, discounts or gratuities—are nothing more than fair compensation for services rendered. This is also used as an excuse to abuse sick time, insurance claims, overtime, personal phone calls and personal use of office supplies. For example, you have a senior client who loves to talk, and can really use up a lot of your time gabbing about nothing to do with business. She is financially very comfortable, so you suggest a weekly lunch visit at your favorite upscale restaurant, which she is perfectly happy to pay for.

I Can Still Be Objective

By definition, if you've lost your objectivity, you can't see that you've lost your objectivity! It also underestimates the subtle ways in which gratitude, friendship and the anticipation of future favors affect judgment. Does the person providing you with the benefit believe that it will in no way affect your judgment? Would the person still provide the benefit if you were in no position to help?

Reflection Question

Which rationalization(s) have distracted you?

Lack of Critical Thinking

The use of "sound bites," the popularity of simplistic arguments, and the amount of information to which we are exposed every day have all increased dramatically, making it necessary for you to hone your critical thinking skills. [12]

Critical thinking is systematically evaluating what you have heard or read. It is the ability to ask and answer critical questions at appropriate times. Critical thinking also requires that you accurately identify the issue without being distracted by emotions or ambiguous language.

One of the most important aspects of critical thinking is the ability to question assumptions. Assumptions are beliefs about what is true and factual. They are based on the unique experience and education of each individual. In this course, we have examined many conflicts **in value assumptions**, addressing the questions *"What is right?"* and *"What should we do or be?"* Conflicts in **reality assumptions**, however, address the questions "What is true and factual?" and *"What do we take for granted or as a given fact?"*

A critical thinker examines the reality assumptions of self and others that form the foundation of decisions. Advisors working with seniors must be aware that people in different age cohorts may have very different reality assumptions. For example, a senior who remembers bank failures during the Great Depression may be hesitant to trust the safety of his bank deposits—even to the extent of keeping large amounts of cash hidden somewhere in the home.

Reflection Question

What reality assumption do you make that may be different from that of a senior?

It is the professional's ethical responsibility to help senior clients make decisions that are informed and that are in their best interests. To fulfill this responsibility, the advisor must understand the assumptions the senior is making, and must help the senior understand the consequences to the options under consideration.

Profile
Mrs. Wong called Frank, her financial planner, and said she wanted to establish an irrevocable living trust with her grandson as beneficiary. Frank got data he needed from Mrs. Wong, and made an appointment with her to go over and sign the paperwork later in the week. What else should he have done?

[12] Ibid.

Profile Discussion
Ethically, the professional should ask probing questions to determine the reasons why the senior has decided to take an action. Obviously Mrs. Wong had a need, and she came to the conclusion that the "solution" that will meet her need is to create an irrevocable living trust with the grandson as beneficiary. However, it could very well be that she has incorrectly defined her need, or that there are other options, rather than an irrevocable trust, that will meet her need. It may be there are consequences to this decision that she has not thought of – either good or bad. Frank should have asked Mrs. Wong to briefly describe her need, and/or asked her the reasons for establishing this trust, or what she hopes to accomplish by doing so. He could then have given Mrs. Wong whatever information she needed to make an informed decision based on her value assumptions and on accurate reality assumptions.

Erroneous Thinking

Following are some very common examples of erroneous thinking: beware of making these mistakes yourself.

Error	Description and Example
Unclear meaning	Using terms that are vague or incomplete. For example, when discussing long-term care with a senior, have you defined it? The senior could be thinking "nursing home" when you are meaning home health care, family care, assisted living, and/or nursing home.
Hasty generalization	Jumping to a conclusion without specific evidence. For example, assuming that "all seniors are forgetful."
Emotional appeals	Using language that can cause an emotional reaction to an issue. For example, taking advantage of a senior's fear or concern, such as loss of independence.
Imaginary results	Creating a bogus issue or promise that is not based in facts. For example, stating to a senior, *"If you don't purchase this annuity, it's almost certain you'll be forced into a very low standard of living in your later years."* People want the same or a higher standard of living in their later years, but the question is, what are the facts that say an annuity would give them this? Or, *"If you buy this insurance policy, and you die before your spouse, she'll be financially secure for the rest of her life."* A senior would want to ensure his wife is financially secure after his death, but the question is whether a life insurance policy would do this. Again, what are the facts?
What should be versus what is	Just because something should be true doesn't mean it is true. For example, thinking that a senior's children should be – and are -- unselfish, devoted, and caring – when the facts may prove otherwise.
Either-Or choice	Mistakenly limiting yourself to only two choices. For example, a senior either has full mental capacity, or he does not. This example does not take into consideration the possibility that the senior may have **intermittent** capacity.

Error	Description and Example
Begging the question	Trying to prove a conclusion is true simply by re-stating the conclusion in different words, without offering a reason to support the conclusion. For example, *"It's worth $300 a month to have disability insurance because if you pay $300 a month, you'll receive a portion of your monthly income if you become disabled."* This sentence begs the question because it repeats that $300 will pay for a disability policy, and only describes what a disability policy does. No advantages, benefits, reasons or facts are given to support the conclusion that $300 a month is a fair and reasonable amount to pay in a monthly disability premium.
Looking for the perfect solution	A partial solution may be the best option. For example, if a client can't afford the "Cadillac" of long-term care policies, having $50 a day to put toward long-term care may be much better than having nothing.
False cause	Assuming that one event caused another, without any proof. For example, Harry, 85, hired a home health care worker three days ago. When his daughter visits on the fourth day, she sees that Harry has bruises on his arm. She concludes that the new home health care aide is abusing Harry, without evidence of that.

Mental Traps

For 50 years, psychologists and researchers have been studying the way our minds function when we make decisions. They tell us that we develop unconscious routines to cope with the complexity inherent in ethical decisions. Some of these routines take the form of biases; others appear simply as irrational inconsistencies in our thinking - and most are hard-wired into our thinking process. Your best protection against these flaws is awareness, and you can also help your clients avoid them in making decisions. These mental traps are:

- Anchoring
- The status quo
- Sunk costs
- Seeing what you want to see
- Focusing on dramatic events [13]

Anchoring

In considering a decision, the mind gives disproportionate weight to the first information it receives. Initial impressions, ideas, estimates or data "anchor" subsequent thoughts. Think about the decision problem on your own before consulting others, to avoid becoming anchored by their ideas. Be careful to avoid anchoring other people from whom you seek information or advice. Tell them as little as possible about your own ideas, because if you say too much, you may simply get back your own preconceptions (which have now become your advisors' anchors).

[13] Hammond, John S., Ralph L. Keeney, and Howard Raiffa. Smart Choices. Boston, MA: Harvard Business School Press, 1999

The Status Quo

Your clients inherit 100 shares of a blue-chip stock that they would never have bought themselves. They could sell the shares and reinvest the money for a minimal commission and no tax consequences. What do they do? Most decision makers tend to make decisions that perpetuate the current situation. The status quo is comfortable, and they avoid taking action that would upset it. In any given decision, the status quo may indeed be the best choice – but shouldn't be the choice just because it IS the status quo. You would serve your clients well by reminding them of their objectives and help them examine how they would be served by the status quo.

The Sunk Costs

Almost everyone has had the experience of facing an expensive repair to an aging car that you have already put significant money into for earlier repairs. Considering this decision, you could probably sell the car. But you decide to fix what's wrong, not wanting to "lose" the money you already spent on the car. That's the wrong reason for the choice! What matters is the current condition of the car and the economic pros and cons of repairing versus selling.

People tend to make choices in a way that justifies past choices. Our past decisions create what economists call "sunk costs" – old investments of time or money that are now unrecoverable. But people are unwilling to admit to a mistake (consciously or not) and wind up compounding the error. Remember the wise words of the noted investor Warren Buffet: "When you find yourself in a hole, the best thing you can do is stop digging."[14]

Seeing What You Want to See

The following profile illustrates this mental trap:

Profile
Sylvia and Greg have been concerned that the stock market has gone too high, and they have almost decided to sell most of their portfolio and invest the cash in a money market mutual fund. But before they call their broker, they decided to do one more thing. They call their friend Chris, whom they know sold out her portfolio last week, to find out her reasoning. She makes a strong case for an imminent stock market decline. What do they do?

Profile Discussion
Hopefully, Sylvia and Greg's conversation with Chris isn't the deciding factor, because it is a "confirming-evidence trap." This happens when you seek out information that supports your existing point of view, while avoiding information that contradicts it. It is the same as if a detective seeks evidence to support his supposition that the "butler did it," ignoring evidence that points to another suspect. This mistake affects where you go to collect evidence, and how you interpret the evidence you do receive. To counteract the tendency to see only what supports your decision, get someone you respect to play devil's advocate – to argue against the decision you're contemplating. And be honest with yourself about your motives: are you really gathering information to help you make a smart choice, or are you just looking for evidence confirming what you think you'd like to do?

[14] Ibid.

Focusing on Dramatic Events

What's the probability of a fatality from a plane crash versus a car accident? Most people know that statistically your chances of dying from an auto accident are higher than from a plane crash, but did you know your chances of being in a fatal plane crash are one in 10,000,000?[15]

Because people base their opinions on experience (what they can remember), they can be overly influenced by dramatic events that leave a strong impression on their memory. To minimize this error, wherever possible try to get statistics. Examine your assumptions so you are not being overly influenced by distortions of memory.

Lack of Emotional Intelligence

As you learned in Chapter 4: The Ethical Decision Making Process, it takes self-discipline to follow the most ethical road. There are certain skills that are necessary to achieve self-discipline, and they are: emotional awareness, emotional management, and emotional self-direction. Taken together, these skills comprise what is today called **emotional intelligence.**

- **Emotional awareness** is being cognizant of your feelings at a given moment and being able to name them (having an emotional vocabulary to express feelings).
- **Emotional management** is the ability to control the behaviors that often spring from emotions, such as angry words or impulsive actions.
- **Emotional self-direction** is the ability to delay gratification and to motivate yourself to take actions that will achieve the goal or result you desire.

Emotional intelligence is very different from technical expertise or book learning. A person can be a poor performer academically and be highly evolved in terms of emotional intelligence. IQ doesn't change much after our teen years, but emotional intelligence is learned—and continues to be learned—throughout our lives and from our experiences.

Emotional intelligence abilities include: being able to motivate oneself and persist in the face of frustrations; to control impulse and delay gratification; to regulate one's moods and keep distress from swamping the ability to think; to empathize and to hope.[16] Emotional competencies are essential to walking an ethical path—and they can be improved upon.

Profile
Bonnie is an insurance agent who primarily sells life and health insurance, and long-term care (LTC) insurance. Her career in insurance began only three years ago, and she is still building her business and, at times, struggling with cash flow. Lately, she has had several referrals to senior clients who are interested in LTC policies, and she is meeting with Mr. and Mrs. Feldman today. Bonnie has developed an outline that she uses to educate her clients about the several LTC policies that she sells, including their similarities and differences. Her notes also include a list of questions that she asks her clients in order to help them plan and make the right choices.

[15] Ibid.

[16] Goleman, Daniel. Emotional Intelligence. New York, New York, Bantam Books, 1995

Profile (cont.)
The Feldmans both seem intelligent and alert, and Bonnie begins to go through her interview. After she explains the 90-day elimination period, and Mr. and Mrs. Feldman indicate they understand, Bonnie tries to explain the chronic illness certification requirements of the policy. But Mrs. Feldman keeps getting the two concepts confused. Finally, Bonnie hands her the Buyer's Guide and suggests that she read through it, so Bonnie can go on to her next appointment. Bonnie has found that she feels frustrated when meeting with seniors. They are taking much more of her time than younger clients, and more thought and effort to explain things clearly and make sure they understand. She is also feeling stressed, because it is beginning to seem like she is just not going to come out as well in terms of being paid for her time. Her patience really wears thin sometimes. On the other hand, it looks like LTC insurance is the fastest-growing part of her business. Some of her LTC clients, it is true, are only in their 50s and 60s, but the older clients are frustrating because she has to do everything more slowly and thoroughly. What should Bonnie do?

Profile Discussion
Bonnie is using one of the skills that make up emotional intelligence: identifying and labeling her feelings. She realizes she is frustrated, and can gauge how intense her frustration is. She has had less success, however, in controlling her impatience, and in reducing the stress that these situations cause her. Bonnie must realize that working with seniors generally takes time, patience, sensitivity, empathy, and a desire to develop relationships that will often not result in an immediate paycheck – but that offer rich rewards in addition to eventual income. If she chooses to continue to do business with seniors, she would benefit from using some problem-solving steps such as setting goals, identifying alternative actions, and anticipating the consequences. She clearly needs to develop more patience and understanding of the perspectives of others. If she cannot or will not become more patient, she should consider limiting the number of senior clients she works with and pursue other avenues of production.

Chapter 5 Summary

It is very tempting to rationalize a less-than-ethical decision. *"Everyone's doing it,"* or *"How can it be unethical? I didn't break any laws,"* are typical justifications for unethical behavior. Becoming aware of the common rationalizations is the first step to avoiding them.

Critical thinking is another skill that is essential to ethical behavior. If you have not developed the ability to question assumptions, identify poor logic, and understand a different perspective, you may have difficulty choosing the most ethical course of action.

In addition, automatic mental flaws – irrational thinking – can get in the way of ethical decision making. Beware of the traps of anchoring, status quo, sunk costs, seeing what you want to see, and focusing on dramatic events – and help your clients do so too.

A lack of emotional intelligence can make it very difficult to succeed in maintaining ethical relationships with seniors. Poor impulse control can lead to impatience, unethical advice, conflicts of interest, or the failure to sufficiently educate clients so they can make an informed decision. Having emotional competency means being aware of and able to control your emotions.

Test Your Comprehension

1. Why do you think people sometimes rationalize unethical behavior?
2. How do you evaluate the validity of information (one of the skills of critical thinking)?
3. One of the psychological traps that seniors may fall into when making decisions is the "status quo" trap. Why is this?
4. Explain emotional awareness, emotional management, and emotional self-direction.

Test Your Comprehension Answers

1. Sometimes individuals make an unethical choice without realizing at the time that they are facing an ethical issue. Then, in retrospect, if they realize they have behaved unethically, they feel guilty or embarrassed, and need to justify that behavior to themselves (and/or others). If individuals make a decision to behave unethically, even though they are aware that it is not the best decision, they feel the need to defend the decision with an excuse. In either case, they are demonstrating a lack of character and integrity.
2. In order to evaluate the validity of information, ask the following questions:
   - Is it fact or opinion?
   - If fact, is it supported by evidence? How good is the evidence? Is there proof?
   - If opinion, how much expertise or training does the person have on the subject about which he has an opinion? Is there good reason to believe that he is relatively free of distorting influences (bias and prejudices) or personal gain?
3. Seniors often make decisions based on the trust they have developed in their relationship with an advisor. The trust relationship becomes even more important than a given decision, and so the senior is reluctant to make a change. Seniors also can experience feelings of embarrassment, inadequacy, or inability to trust their own instincts and feel safer sticking with the status quo.
4. Emotional *awareness* is being cognizant of your feelings at a given moment and being able to name them (having an emotional vocabulary to express feelings).

   Emotional *management* is the ability to control the behaviors that often spring from emotions, such as angry words or impulsive actions.

   Emotional *self-direction* is the ability to delay gratification and to motivate yourself to take actions that will achieve the goal or result you desire.

Chapter 5 Review Questions

1. Assuming that all seniors are sedentary is making a(n)
   a. emotional appeal.
   b. false cause.
   c. hasty generalization.
   d. either-or choice.
2. In critical thinking, we must find what is true versus what we take for granted. In doing so, the critical thinker is examining his or her
   a. value assumptions.
   b. simplistic arguments.
   c. principles and beliefs.
   d. reality assumptions.
3. Hugh wants to impress his clients, a married couple, with the importance of having long-term care (LTC) insurance. Hugh describes situations where seniors without LTC were financially devastated. The clients react by buying LTC insurance that is very hard for them to afford. By taking advantage of his clients' fears, Hugh used a(n)
   a. emotional appeal.
   b. hasty generalization.
   c. false cause.
   d. reality assumption.

Answers to Chapter 5 Review Questions

1. c
2. d
3. a

Chapter 6
Making New and Better Decisions

There's only one corner of the universe you can be certain of improving, and that's your own self.
—Aldous Huxley

Chapter Objectives

Upon completing Chapter 6, you will be able to:

- Reassess your comfort level and responses to ethical dilemmas
- Use the Ethical Issues chart to remind yourself of common ethical dilemmas and correct responses to them
- Use the Personal Action Plan to further develop ethical decision-making skills

Introduction

This final chapter in the course will give you the opportunity to re-assess your comfort level with ethical dilemmas, and also contains tools that you can use to continue to develop your competence and confidence in your ethical decision-making skills.

Profile
Mr. and Mrs. Carder were clients of Al's for many years, and last year Mr. Carder passed away. Mrs. Carder is now 88 years old, frail but of sound mind. She was totally dependent upon her husband to make all the financial decisions, and now because she trusts Al completely, has somewhat transferred her dependency to him. Al knows the Carders' daughter, Susan, lives a few hours away with her husband and family. Al urges Mrs. Carder to bring Susan in for a meeting so he can *"make sure she can pass along her investment philosophy to her family members and that they understand it."* Actually, what Al is doing is trying to encourage family members to take more of an interest in Mrs. Carder's financial welfare, because she needs more help than Al can ethically give her. This is fine with Mrs. Carder, but unfortunately, Susan seems to be too busy to get involved. At Al's next meeting with Mrs. Carder, as he tries to explain the documentation necessary for a transaction, she says *"I'm sorry, Al. I seem to be so stupid about these things – but truly, finances are just not something I learned about. Why can't I just sign the forms? I trust you, and you know what direction I want to go."* What should Al do?

Profile Discussion
Fortunately, Al is a caring, thorough professional. He is willing to give Mrs. Carder all the time she needs to absorb the information, and has a way about him that is respectful and helps her to preserve her dignity and self-esteem. He chooses to tell Mrs. Carder that he will explain part of the paperwork today, and makes arrangements to meet again next week to review what she has learned and go over the rest of the information before she signs anything. He makes Mrs. Carder feel comfortable asking virtually any question about her finances. When they have finished conducting their business, Mrs. Carder says, *"Al, you have been so patient with me and I really appreciate it. I never feel like you are in a rush or that you think I'm hopeless. You have answered all my questions, thank you so much."*

Self-Assessment

At the very beginning of this course, you were presented with a self-assessment to determine how you feel when you find yourself in an ethical dilemma that requires a decision. Now that you have almost completed the course, score yourself again to reassess your comfort level with sensitive situations. This time, a discussion of the best ethical responses to each scenario are provided after the self-assessment.

Instructions: The six scenarios below describe ethical dilemmas that professionals who serve seniors could easily encounter. Each scenario requires an ethical response or action by the professional. At the end of each scenario, give yourself:

- 1 point for each Yes answer
- 0 points for each No answer

Total your points in the space provided after the last scenario.

If you know what to say or do to resolve the ethical dilemma, type your answer in the space provided.

A discussion of the best ethical responses and actions in each scenario are provided after this self-assessment.

1. **Your area manager** comes into the office, very pleased with himself and crowing about having sold a large investment to one of his senior clients. Both he and you know this particular investment is not beneficial to the client. If you say anything to this manager, you risk the loss of some good leads, and territory assignments are coming up, too – you could be assigned a rotten territory if he's mad at you. If you mention this to your manager's boss, it would be even worse, because your interference will get right back to him.

   Will you say anything, and, if so, to whom? Why or why not?

	Yes	No
I know what to do to resolve this dilemma	_____	_____

   My resolution is:

   _____
   _____
   _____
   _____

	Yes	No
I would probably take this action to resolve this dilemma	_____	_____

2. **Your neighbor, a** long-time client, gives you a referral to her older cousin who can use your services, but who is very reticent about his financial situation. You have some products that would be beneficial, and that would also mean good commissions for you. Your neighbor knows how secretive the cousin is, and happily tells you all she knows about the cousin's financial dealings. You worry about hearing all these personal, confidential financial details from your neighbor, but the information really will help you serve the cousin better (and make the deal). Besides, if you ask the neighbor not to talk about her cousin's business, it will hurt her feelings.

   What do you do? Or, do you do nothing? Why or why not?

	Yes	No
I know what to do to resolve this dilemma	_____	_____

   My resolution is:

   _____
   _____
   _____
   _____

	Yes	No
I would probably take this action to resolve this dilemma	_____	_____

3. **You are meeting** with your clients, Mr. and Mrs. Jones, in their home. They are quite advanced in years, and you have been doing business with them for a long time. Although Mr. Jones has always been a little forgetful, in this meeting you notice that he is behaving in ways that he never has before - ways that resemble the behaviors that you witnessed when your grandfather suffered from Alzheimer's disease. Mrs. Jones seems completely oblivious to the changes in her husband, remaining as cheery and composed as ever. If she doesn't recognize his symptoms, saying something could really upset her.

   What, if anything, would you say to Mrs. Jones? Why or why not?

	Yes	No
I know what to do to resolve this dilemma	_____	_____

   My resolution is:

   _____
   _____
   _____
   _____

	Yes	No
I would probably take this action to resolve this dilemma	_____	_____

4. **Your clients, Francine** and Natalie, partners in their 60s, have been discussing the purchase of an insurance policy with you. They believe the coverage is important; however, they are not very secure financially and express concern over the premiums – at present, they can afford them, but if the premiums increase by very much they will be unable to pay them and thus will lose the coverage. You agree with their need for the insurance, and you also know that premiums will be increased in four months– but you don't know by how much. It could be a small, affordable raise, or it could be a significant jump, as past premium increases have been both types.

   Do you discuss the future increase with your clients? Why or why not? What do you recommend to them?

	Yes	No
I know what to do to resolve this dilemma	_____	_____

   My resolution is:

   _____
   _____
   _____
   _____

	Yes	No
I would probably take this action to resolve this dilemma	_____	_____

5. **You have been** working with your retired clients, Mr. and Mrs. McGee, for many months, and although they seem to trust you and communicate freely with you, they have been unable to make a final decision about your product. You have tried several times to "close the deal" and Mr. McGee repeatedly promises to move forward, even setting dates to do so, but then always comes up with more delay and excuses. You truly believe you have fully informed them, given them alternatives, discussed consequences, and sought and answered all of their questions. You are at a loss to explain why they are "stuck." Then one afternoon, as you are sipping the coffee they have served you in the living room, you overhear an argument in the kitchen. Mrs. McGee is browbeating, criticizing, and verbally abusing her husband. She accuses him of making poor choices, costing them financial losses, being stupid, lazy, and undependable. You can hardly believe what you are hearing. But it is now clear to you why Mr. McGee keeps putting you off – he is afraid of giving his abusive wife further ammunition to use against him – and so avoids making a decision.

   What, if anything, do you do? Why or why not?

	Yes	No
I know what to do to resolve this dilemma	_____	_____

   My resolution is:

   _____
   _____
   _____
   _____

	Yes	No
I would probably take this action to resolve this dilemma	_____	_____

6. **You have joined** the local branch of a company that is well-respected in your industry, and you have negotiated a very lucrative package of commissions and bonuses. After you work there a while, you begin to see some problems. Nothing like fraud or breaking the law, just a little carelessness, and especially some poor communication with senior clients. You don't believe anyone in the company is intentionally doing wrong, but you would like to see more accountability for quality work, and more emphasis on building relationships. This is how you conduct your business, and you are worried that mistakes, intense competition, and downright sloppiness will reflect badly on you.

   What would you do in this situation? Why or why not?

	Yes	No
I know what to do to resolve this dilemma	_____	_____

   My resolution is:

   _____
   _____
   _____
   _____

	Yes	No
I would probably take this action to resolve this dilemma	_____	_____

Total score: _____

Is your total score different from the first time you took this self-assessment?

Following are some new or additional responses to each scenario you may have considered, now that you've almost finished this course:

1. Silence in the face of unethical actions condones those actions. You could initiate a private discussion with the manager by asking if the client's situation or goals have changed, since based on what you know about them, this investment wouldn't be appropriate. (After all, you may not have - or be entitled to - all the pertinent information). If the manager indicates he knowingly recommended a product that is not in the client's best interest, then you should give serious thought to whether you want to continue to work in an organization that is managed by someone so unethical.
2. You kindly but firmly tell the neighbor that your professional ethics require you to be very careful about confidential information. You can tell her that although you appreciate her wanting to help, that you must keep discussions about the client's business strictly between you and the client. Explain that she would appreciate confidentiality if SHE were the client.
3. In private, you should tell Mrs. Jones that you are concerned about her husband's health, and ask her if she has noticed any changes in his behavior. If she says yes, suggest that he see his doctor for a checkup, and encourage her to be present and ask the doctor about his symptoms. If she says no, tell her why you are concerned – what you have observed – and suggest Mr. and Mrs. Jones both see his doctor and tell the doctor about these concerns. She should understand that physicians might not always be aware of Alzheimer's (or other dementia-related) behaviors if they don't occur in the doctor's presence. If Mrs. Jones seems upset during your discussion, reassure her that there can be many causes of Mr. Jones' problems, and it's best to find out all they can in order to avail themselves of early and proper treatment, if it is deemed necessary.
4. Francine and Natalie MUST have ALL the information that pertains to their prospective policy and its premiums, in order to make an informed decision. You must be open and frank with them, in order that they may choose what meets their goals and needs. That includes describing policy terms that may offer lower coverage for a smaller premium that they could afford in any event. The bottom line is that you make all options and all information available to them, as the choice is theirs.
5. Mr. and Mrs. McGee are both your clients. Has Mrs. McGee been included in all meetings and discussions? Do you believe Mr. McGee is competent? For both your clients' and your protection, it is important to do several things:
    - Document all of your recommendations and interactions with the McGees
    - If you have a concern about Mr. McGee's competency, ask the McGees if they would allow you to contact their family attorney and/or include him or her in your meetings and discussions
    - If you believe elder abuse exists, contact your state's elder protective service agency

- If you do not believe Mr. McGee has any problems with competency, and you are comfortable attributing Mrs. McGee's browbeating to marital discord, AND you have documented your interactions with these clients, then it may be time to accept that they are not ready to move forward with a transaction and move on to other clients whom you can actually help.

6. Yes, this scenario describes a lack of ethics—specifically because trusted advisors have a responsibility to be diligent and professional, to continue to improve their level of service, and above all to place the relationship with the senior client above any transaction. In order to provide honest, thorough and caring service to a senior client, good communication is critical.

   The lack of professional ethics present in this office could indeed reflect badly on you. You might offer to help develop guidelines, checklists, training, or some other intervention that will aid your colleagues in bringing their level of professionalism and ethics up to where it should be. If your suggestions are not received well and no improvement takes place, you should consider changing the office with which you are affiliated, to one that meets your high standards and serves senior clients ethically and well.

Examples of Ethical Issues

The issues presented in the six scenarios above include confidentiality, competency, senior autonomy, informed decisions, possible elder abuse, professional development, honesty, and more. These are simply illustrations of the conflicts and questions you may encounter in your capacity as a trusted advisor—and of the need for and challenge of making ethical decisions when working with seniors.

Use the following chart (from Chapter 4: The Ethical Decision Making Process) to remind yourself of the most common ethical questions that you may be presented with, and suggestions that will lead you to make the best decision.

Ethical Issue	Ethical Response
Confidentiality	**Who is your client?** Have you the client's permission to share any of her personal, financial, confidential information with any other individual? If not, do not!
Competency	**Specifically, what event is leading you to question the client's competency?** Know your client in order to know if he has been behaving inconsistently with past decisions and goals. It is unethical to continue with a transaction if you have a question about the client's competency. But you must obtain the client's permission to involve a family member or an advisor such as attorney, physician, or social worker in order to address the issue. Document your interactions with the client.
Conflict of interest	**Is there any possibility that your behavior or the choice you are making is not in the absolute best interest of your client?** Be aware of possible sources of a conflict of interest for you.
Informed decision	**Are you withholding any information, no matter how minor it seems?** Never, ever withhold any information from a client for any reason. Check for comprehension and solicit questions to make sure the client has all the facts she needs in order to make a completely informed decision. Document your interactions and remember that in the end, the choice is the client's.
Senior autonomy	**Do you always treat seniors with respect and seek to enhance their self-determination?** Do not, out of a misguided desire to help the client, try to make a decision for the client or take any action that the client is capable of taking for herself. Create an environment of understanding, patience and respect that encourages the senior to remain autonomous.
Setting expectations	**Do you and your senior client know what to expect from each other?** From the beginning of a relationship with a senior client, set the boundaries of your expertise and your advice. Let your client know what you expect from him. From the beginning of your relationship, establish an understanding with the client with regard to confidentiality, representation, and documentation.
Elder abuse or neglect	**Do you suspect elder abuse or neglect?** Know your responsibilities under your state's elder abuse statutes. Develop your network of senior advisors who can help you analyze a situation and determine what, if any, action to take.

Ethical Issue	Ethical Response
Time and patience	**Do you expect a senior client to respond as quickly as a younger client?** Understand older adults' cognitive changes and be as patient as you need to be when speaking, explaining, and developing the kind of relationship that is so important to the senior.
Stubborn/arbitrary client	**Is your client holding tightly to a viewpoint or a decision that you sincerely believe is not in her best interest?** Take enough time to explain and solicit questions about the issues. Document what information you have furnished and what your client's responses are. Decide whether you can ethically continue the transaction and if not, encourage the client to consult another advisor like a CPA or attorney.
Professional development	**What have you done lately to develop your professional skills?** Be on the lookout for more opportunities to learn and advance. Develop a network of ethical, competent colleagues from specialties other than your own and regularly get together with them.

A Professional's Pledge of Ethics

Preservation and promulgation of the highest standards of excellence in professionalism and ethics are essential to serving your clients. These are also principles that will maintain your reputation and success as a trusted advisor. Can you make the following pledge?

I will:

- Value my integrity above all. My word is my bond.
- Develop my practice with dignity and will be mindful in my communications with the public that what is permissible may not be professionally appropriate.
- Represent the interest of my client with vigor and will seek the most expeditious and least costly solutions to problems.
- Work continuously to attain the highest level of knowledge and skill in the areas in which I practice.
- Contribute time and resources to public service and charitable activities.
- Work to make the system more accessible, responsive and effective.
- Always engage seniors with courtesy and respect, striving to attain the highest degree of service.
- Honor the requirements, the spirit and the intent of the rules of professional conduct and will encourage others to do the same. [17]

[17] Used with permission from Beanna Whitlock, CSA, EA. Whitlock Tax Service, LLC, 6503 Pemwoods, San Antonio, TX 78240-2552. 800-465-2767.

Senior's Bill of Rights

As you have read, when serving seniors, there are many distinct considerations to be met in order to satisfy their special needs. The following Senior's Bill of Rights expresses the expectations that seniors rightfully have of their advisors:

When I retain an advisor, I am entitled to one who will:

1. Be capable of handling my issues.
2. Represent me zealously and seek any lawful means to present the merits of my issues or position.
3. Preserve my confidences, secrets or statements which I reveal in the course of our relationship.
4. Give me the right to make the ultimate decision on the objectives to be pursued in my issues.
5. Charge me a reasonable fee and tell me, in advance of being hired and upon my request, the basis for that fee.
6. Show me courtesy, respect and consideration at all times.
7. Exercise independent professional judgment in my behalf, free from compromising influences.
8. Inform me periodically about the status of my issues and, at my request, give me copies of documents prepared.
9. Exhibit the highest degree of ethical conduct.
10. Refer me to other qualified professionals if he or she cannot properly address the issue in my behalf.[18]

[18] Ibid.

Personal Action Plan

Hopefully, through taking this course you have been able to identify any of your skill areas that you feel could use some development. The following pages offer a format that may be useful in planning and taking steps to strengthen your skills or learn something new. You are welcome to print and use the blank Personal Action Plan to help yourself move forward.

Example: **Personal Action Plan**

Skill to Develop: I need to have a system to use so I can consistently document my interactions with my senior clients.	
Resources: • Office supply stores for materials to organize my documentation (files, journals, etc.) • Colleagues who are good at documentation. • Professional organizers.	
Step 1: Visit office supply store to see what supplies they sell that would be helpful to me.	**Due Date** March 15
Step 2: Have coffee with my colleague(s) to ask them for tips and techniques they use in their documentation.	**Due Date** April 15
Step 3: Arrange for a consultation with a professional organizer to help me develop a system.	**Due Date** May 15

Information Needed: I need to learn more about what my responsibilities are under my state's Elder Abuse Statute.	
Source(s): Elder abuse websites – local, state and national; elder law attorney; agencies that protect against elder abuse.	
Step 1: Search the Web for information about Elder Abuse Statute.	**Due Date** March 10
Step 2: Telephone my elder law attorney and ask if she has any information I could use.	**Due Date** March 10
Step 3: Contact local or state agency for information.	**Due Date** March 10

Personal Action Plan

Skill to Develop:	
Resources:	
Step 1:	**Due Date**
Step 2:	**Due Date**
Step 3:	**Due Date**

Information Needed:	
Source(s):	
Step 1:	**Due Date**
Step 2:	**Due Date**
Step 3:	**Due Date**

Chapter 6 Review Questions

1. The owner of your financial planning firm recently hired his nephew, a new college graduate. The nephew is impatient, self-centered, aggressive, and about to make some seriously unethical choices. The owner seems unaware of his nephew's behavior. What should you do?
   a. Nothing. The owner must supervise his nephew's professional behavior.
   b. Speak to the nephew about his ethics. If he doesn't begin to make better choices, tell the business owner.
   c. Quit the company before your reputation is tarnished.
   d. Go straight to the business owner and ask what he is going to do about his unethical nephew.

2. Andrea volunteers for Meals on Wheels, and has become friends with a few seniors she visits regularly. Andrea's husband has just become a certified financial planner and is working hard to expand his client base. Is it ethical for Andrea to introduce her husband to some of these seniors?

   a. No, because the seniors might agree to do business with Andrea's husband just to please her.

   b. No, Andrea shouldn't recommend her husband because he is pretty inexperienced.

   c. Yes, as long as she doesn't benefit financially from the introduction.

   d. Yes, as long as she tells them the CFP she is introducing is her husband, and doesn't give her husband any confidential information she might have about the senior.

3. Over the last two years, Kevin's client Trudy has asked him to summarize information because she tires easily, wants to make quick decisions, and trusts him completely. Kevin has respected her wishes and simplified his explanations. Is this the right thing to do?

   a. Yes. This is respectful and giving good customer service.

   b. No. Kevin must present all information to Trudy so she can make informed decisions.

   c. Yes. Over the years, Trudy has learned a lot about investments and doesn't need as much detail.

   d. No. Kevin should ask Trudy to name a power of attorney to manage her estate.

4. Bruce calls you for advice, worried about his mother's continued safety living alone in her home. Bruce knows he could move her to a safer place but he doesn't want to uproot his mother against her will. You suggest that Bruce

   a. move his mother immediately, because her safety is at stake.

   b. have a geriatric care manager assess his mother and then decide, with her participation, how to meet her safety needs can be met.

   c. accept his mother's wishes and leave her where she is happy.

   d. meet with his mother's advisors and medical providers to convince her moving is best.

Answers to Chapter 6 Review Questions

1. b
2. d
3. b
4. b