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AND
ALTERNATIVE FUNDING

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of state-approved continuing education.

for

ILLINOIS INSURANCE PRODUCERS

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Introduction

With the 76 million members of the Baby Boom generation planning retirement in the coming years, the issue of long-term care is likely to become more pressing with each passing day. There are, of course, large-scale economic concerns related to this matter, what with politicians and pundits arguing back and forth about how the government will react to the inevitable strain on public health programs like Medicare and Medicaid. But there are also plenty of personal worries attached to it that have little to do with fiscal debates.

While the Baby Boomers have been blessed with parents whose generation has lived longer than its predecessors, that longevity has come at a cost. Many Americans in their 50s and 60s have been forced to acknowledge the physical, emotional and financial effects of long-term health problems, even while they, themselves, remain healthy. They have wrestled with the choice to put their fathers in nursing homes and have witnessed the intensive care an elderly person often requires. They have seen mothers spend a lifetime of savings on health care and ultimately need public aid. They have lost countess hours trying to secure adequate care for an older relative and have often made major sacrifices in order to personally look after the sick.

The Baby Boomers have loved their parents enough to confront these disheartening situations, and they love themselves and their children enough to want to avoid repeating those sad events when their own health declines. They will obviously never be able to bypass the aging process, but they hope to go through it as comfortably as possible, both for their own sake and the sake of the friends and family they might leave behind.

When LTC producers consider these increasingly common situations, they might conclude that they have a social responsibility to reach out to older people and make them aware of potentially beneficial products like long-term care insurance. However, that ethics-based responsibility should not be used as an excuse to pursue selfish professional goals. Indeed, insurance products can save people from having to experience financial devastation, but some tragic tales over the years have featured elderly people who not only had insurance but, in fact, had owned multiple policies. These stories prove it is not good enough to merely purchase insurance products. Instead, a person must buy the proper product based on his or her goals, needs and financial means.

The truth is that the financial products geared toward older people are some of the most complex items offered by banks, lenders and insurance companies. Making sense of all the available options and ultimately making the best choice are tasks that can confuse even the best-educated and the most-alert consumers, regardless of age. Understanding these products is made even more difficult by those insurance workers, bank employees and financial planners who either take advantage of people's age-related fears and make sales in bad faith or are nearly as uninformed about product suitability as their clients.

We have even reached a point in our society where some insurance regulators advise older consumers to be suspicious of anyone who gives senior seminars or claims to have earned such special designations as "senior adviser." These warnings incorporate some gross oversimplifications, but they are not entirely groundless thanks to the unethical conduct that has been showcased by some agents, brokers, financial planners and bank executives. To the detriment of the many trustworthy and knowledgeable senior specialists in business today, these people treat older clients as if everyone who is at or near retirement age is identical. These salespersons might insist, for example, that LTC insurance is a necessity for everyone they meet.

No matter how much salespersons want to believe in age-related stereotypes and lean on those generalizations to market goods and services to older clients, the number of current or soon-to-be seniors is simply too large for a one-size-fits-all approach. Among the 35 million current seniors and the 76 million Baby Boomers, some will be concerned about immediate health issues and will need help supplementing their Medicare benefits. Others will be thinking about a more distant future and be wondering how they will be capable of affording an extended stay in a nursing home or some other care-focused facility. Some seniors will want to protect as many personal assets as possible in order to pass those valuables on to loved ones or charities when they die. Another group might not have any obvious heirs or many assets and might only be interested in enhancing their income so that they can pay for basic necessities like food, housing and prescription drugs.

As a licensed LTC insurance producer in Illinois, you do not need to be convinced that an LTC policy can help consumers cope with some of those concerns. You already know how the right policy can assist people in protecting personal assets and addressing health care costs. Since you already understand the general purpose of LTC insurance, the first half of this course will stick to the specifics of a typical policy. We will summarize the basics of coverage in order to help you refresh your memory, and we will point out a few nuances in policy language that might be more important to consumers than they initially realize.

The course's second half sets LTC policies aside and stresses that those products are only one of many options for adults who want a head start on managing their long-term physical needs. Alternatives like Medicaid assistance, viatical settlements, life settlements and reverse mortgages are explained in ways that balance their positive appeals and their potentially unfavorable features. The intent here is not to prove that these alternatives are better or worse than LTC insurance. Rather, it is to suggest that different problems call for different solutions. Like LTC insurance, these products and programs have their proponents and their detractors. Yet each of them serves as proof that the competition for older people's attention is constantly evolving and becoming more intense.

In a crowded, diverse market, the seniors of today and tomorrow do not need to be exposed to pushy salesmanship and fear-infused half-truths about LTC planning. Seniors require honest answers and analysis from professionals they can trust. By continuing your LTC education via this and similar courses, you are not just satisfying a state-mandated rule. You are proving your commitment to finding those answers and earning that trust.

Reviewing Long-Term Care Insurance

Though mainly thought of as a senior citizen's product, LTC insurance can help consumers fill holes in health coverage at any age. In general, LTC policies absorb the costs of skilled, intermediate and custodial care that a chronically ill or recovering patient requires beyond 90 days. Since debuting in the 1970s, LTC policies have evolved from pure "nursing home insurance" into flexible risk management tools that allow policyholders to receive health services in other settings, including in assisted-living facilities, life centers and private homes.

The next several sections of this text will touch on the basic components of all legally recognized LTC policies in Illinois. In time, we'll go back and define the differences between skilled, intermediate and custodial care and explain residential options for LTC patients. But before going any further, we will first review the kinds of situations in which coverage will not apply.

Standard Exclusions

Above all else, LTC producers must know what kinds of care insurance companies may exclude from LTC policies, and they must communicate these uncovered risks to potential clients. Federal and state governments generally do not require insurers to cover LTC that is associated with the following circumstances:

- **Pre-existing conditions**: Any limitations on coverage for pre-existing conditions must be explained within the policy under an independent paragraph titled "Pre-existing Condition Limitations." Insurers in Illinois may not use a definition of "pre-existing condition" that is any more restrictive than "the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care or treatment. Or a condition for which medical advice was recommended by, or received from a provider of health services, within six months preceding the effective date of coverage for an insured person."

  While applicants are nearly guaranteed to be affected by this exclusion if they have pre-existing cases of AIDS, multiple sclerosis, muscular dystrophy, cirrhosis or Parkinson's disease, many carriers will grant coverage for other pre-existing health problems—such as diabetes or heart conditions—as long the policyholder agrees to pay out of pocket for all treatment related to the condition over a specified timeframe. For example, an insured might need to pay for the first six months of diabetic care before the insurer becomes responsible for handling those costs.

  When this sort of waiting period is used, it must apply to all pre-existing conditions. An insurer cannot dictate one waiting period for a particular condition and a different waiting period for another condition.

- **Mental illnesses or nervous disorders**: This exclusion typically does not apply to organic forms of mental illness. An insurance company cannot deny coverage for Alzheimer's disease unless the disease was a pre-existing condition. People with a non-covered mental illness or nervous disorder might still qualify for Social Security disability benefits.

- **Drug addiction**: This exclusion applies to alcoholism, as well as to dependence on illegal substances.

- **Acts of war**: Treatment for injuries sustained in an incident that is deemed an "act of war" by insurers and the federal government might not be covered, even if the injured person is a civilian.

- **Self-inflicted injuries**: This exclusion applies to suicide attempts, as well as to serious yet non-life-threatening incidents.

- **Military injuries**: The Department of Veterans' Affairs is usually responsible for giving cash grants to military personnel who are injured during active duty.

- **Aviation injuries**: This exclusion applies when the insured was not a paying passenger in an aircraft.

- **Care covered by other insurance**: This exclusion applies to treatment that would otherwise be covered by either private or public insurance plans, including Medicare and workers compensation. Illinois specifically permits LTC insurance companies to exclude coverage for any treatment that could be handled through an individual's existing health insurance plan or through any of the person's additional LTC policies.

Benefit Triggers

If care is not specifically excluded by an LTC policy, buyers and sellers need to understand what must occur for insurance coverage to begin.

Back in the days when LTC insurance was synonymous with nursing home insurance, some policyholders received no benefits unless the cause of their health problems resulted in a three-day hospital stay. Limiting coverage in that way is now illegal throughout much of the United States, including in Illinois. More commonly, policy benefits go into effect when the insured can no longer perform specific "activities of daily living" (ADLs). Though insurers have the right to add additional ADLs as benefit triggers, Illinois requires its LTC policies to contain at least the following six ADLs:

- **Bathing**: Including the ability to move in and out of a shower or tub, clean oneself and dry oneself
- **Dressing**: Including the ability to put on clothing and any medical accessories, such as leg braces
- **Eating**: Including the ability to chew and swallow food and use utensils
- **Transferring**: Including the ability to move in and out of beds, cars and chairs
- **Toileting:** Including the ability to get to a restroom and perform related personal hygiene
- **Continence:** Including the ability to control the bladder and bowel muscles and perform related personal hygiene

Most LTC policies feature ADL-related triggers that are contingent on the insured's inability to perform at least two of the six standard activities. Illinois does not allow ADL triggers to be contingent on the insured's inability to perform four or more ADLs.

The ADL concept is not a terribly difficult one for buyers to grasp, but they and their trusted advisers sometimes forget to view ADLs from both a physical and mental perspective. Suppose, for example, that a woman in the 1980s insisted on an LTC policy that did not exclude care for Alzheimer's patients. Nothing in her chosen policy specifically mentioned the disease, but the policy's ADLs were limited to the standard physical tasks mentioned above. Years later, the woman was diagnosed with the disease and needed to be looked after. But because the ailment did not prevent her from independently performing various physical tasks, the LTC policy gave her and her family no financial relief.

Maybe her insurance salesperson knew all along about the deficiencies in the policy and was more concerned about a commission than about customer satisfaction. Or maybe, like the woman, the seller simply did not have a thorough-enough understanding of the policy to form a clear picture of the uninsured risk. Either way, the buyer made a very costly error.

Insurers and state governments have tried to rectify these kinds of situations by including multiple benefit triggers within LTC policies. Though not required to do so by law, some carriers include triggers that are based on a person's inability to perform specified "instrumental activities of daily living" (IADLs), which might involve mental capabilities as well as physical ones. Common IADLs are as follows:

- Taking medication at prescribed times
- Cooking
- Performing housework

- Driving
- Paying bills
- Balancing check books
- Shopping
- Using a telephone

In order to more firmly ensure coverage for physically healthy but mentally inhibited policyholders, Illinois requires all LTC policies to feature "cognitive impairment" as a benefit trigger. This term could make coverage mandatory for Alzheimer's treatments, but it might also apply to less-specific ailments that have caused patients to lose their memory, misjudge place and time, or struggle to reason.

A few policies contain a benefit trigger that allows policyholders to receive covered care for general reasons of "medical necessity," as agreed to by the insurer and a licensed physician. This trigger, rarely addressed by LTC salespersons in trade publications, could sometimes work in the policyholder's favor if he or she can still perform specified ADLs but suffers from a cognitive impairment that is difficult to diagnose. On the other hand, this trigger may be too vague in some cases and could prompt disagreements between insurers and physicians about what kind of care is truly "medically necessary."

The definition of "medical necessity" is the basis for coverage of treatment within nearly any health insurance plan. Several court cases over the years have involved the differing interpretations of the term among patients, doctors and insurers. Depending on one's point of view, "medical necessity" might relate to the following kinds of care:

- Only care that keeps the patient alive
- Any care that is designed to ease a person's pain
- Any care that improves the quality of a patient's life

Perhaps in an attempt to lessen the likelihood of legal battles over medical necessity, Illinois has enacted LTC insurance laws that require insurers to define such potentially vague words as "customary" and "reasonable" within coverage forms and policy summaries. Also, all benefit triggers must be listed and explained within a policy under an independent paragraph titled "Limitations or Conditions on Eligibility for Benefits." This paragraph must also include the identity of the person who will decide when and if benefits have been triggered. In some cases, the insured's private physician may be the one to evaluate cognitive impairment and the ability to perform ADLs. In other situations, a medical professional employed by the insurance company is responsible for making these determinations.

Benefit Periods and Elimination Periods

When consumers are receptive to the idea of purchasing LTC insurance, they are likely to ask themselves, "How much coverage should I buy?" The amount of coverage that is purchased will be represented in direct and indirect ways by the policy's "benefit period" and "elimination period."

The benefit period addresses how long coverage will last. This figure is often discussed in terms of time, with most benefit periods lasting a few years. The time element within the benefit period arises because many policies pay for LTC on a day-by-day basis. This may be done through an indemnity system or an expense-incurred system.

In an indemnity system, the policyholder receives a specific amount of money for each day's care, no matter how much the caregiver charges. For example, a policy might pay the insured party $100 each day to cover LTC expenses over a span of two years. In an expense-incurred arrangement, services are rendered, receipts or bills are passed along to the insurer, and money is paid based on the caregiver's specific charges.

Elimination periods are essentially LTC insurance deductibles that are expressed chronologically rather than as concrete dollar amounts. These features spell out how long an insured person must pay for LTC services before a policy's benefits will begin. Some LTC policies have no elimination period and allow the insured to receive benefits immediately after being deemed an LTC patient. Most policies, though, feature an elimination period that ranges from one month to six months.

The LTC producer can do the customer a great ethical service by explaining exactly how the insurer treats elimination periods. For example, it may be important for people with a 30-day elimination period to know how an insurer treats intermediate care that a patient receives only once-a-week. Does the elimination period include the remaining six days of the week, meaning that coverage would kick in after a month? Or will the elimination period not be over until 30 weeks have passed?

Since costs for LTC services can vary significantly from one region to the next, insurance producers and their clients should research prices in the prospective insured's area before choosing benefit periods and elimination periods.

Residential Options for LTC

The place where an insured person hopes to receive LTC services should play an immensely important role in the analysis of a proposed policy. Most early LTC insurance policies did not give the buyer many residential options, usually limiting coverage to stays in nursing homes. Many of today's LTC policies cover what can generally be referred to as "community care benefits," which allow insureds to receive care in nursing homes, their own homes, assisted-living centers and other environments.

Given choices, some clients will prefer coverage that can be utilized in as many settings as possible. Others will want to limit their options so that they do not end up paying for benefits they would never care to use. Basic summaries of the many residential options for LTC appear in the next several sections.

Nursing Homes

Probably the most commonly recognized LTC option and almost certainly the most expensive one, a nursing home is designed to provide the most intensive medical care and assistance that can be rendered outside of a hospital environment. In addition to performing custodial and intermediate care (which may or may not be done by a medical professional), nursing homes can offer skilled care (which should only be performed by medical professionals) on a 24-hour basis.

Nursing home costs (averaging somewhere near $75,000 per year for a private room in 2008) will often include meals and supervised activities. According to a report from Duke University's Center for Demographic Studies, the number of nursing home patients has decreased in this country, with more elderly people opting for care at home or in an assisted-living facility.

Assisted-Living Facilities

Assisted-living facilities are very popular among the senior community, at least in part because they offer some necessary medical and personal assistance while still preserving enough of the individual freedoms that a person might lose in a nursing home. Residents in assisted-living communities are typically free to come and go as they please, are given meals at specified times and can ask for assistance with ADLs at any time throughout the day. Some skilled care, however, might not be available unless a health care practitioner is making a scheduled visit to the premises.

The cost of assisted-living care can be considerably lower than the price of services at a nursing home. A 2008 study conducted by MetLife found that the average cost of residing at an assisted-living facility was roughly half the cost of residing in a nursing home.

From an LTC insurance perspective, assisted-living facilities must be approached with care. Many LTC policies will cover treatment that is rendered in these environments, but "assisted-living" is a surprisingly generic term with definitions that can vary from state to state or from one facility to another. Illinois, for example, did not begin to specifically license assisted-living facilities until the year 2000, and though many policies base coverage on a facility's licensure by the state, others might have stricter or looser conditions for covered care. For these reasons, neither the insurance producer nor the insurance customer should assume that all businesses that label themselves as "assisted-living" centers will be reimbursed for services through an LTC policy.

Life Centers

If clients wish to remain in one place no matter how dependent they might become on caregivers, they might want an LTC policy that specifically covers assistance received at a "life center." A life center (also known as a "continuing care community" or "life care community") typically serves a wide range of seniors in need of varying levels of supervision and medical assistance, all in one large facility or in neighboring buildings. Life centers house largely independent seniors and provide them with meals, activities and housekeeping services. They also serve assisted-living residents by helping with ADLs and can take care of patients who need full-fledged nursing home assistance.

With most life centers operating as non-profit organizations (many are affiliated with religious groups), residents are generally assured of receiving quality care no matter how low their assets might drop over the course of several years. In return for this later-day security, life center residents will often make a major down payment for their care when they enter a facility and will also pay monthly fees similar to those paid by assisted-living or nursing home residents. If a life center resident dies or moves to another facility, a portion of the entry fee might be refundable, but this would likely depend on the length of the person's stay at the center.

Home Care

For reasons of comfort, convenience, pride and familiarity, most Americans would understandably prefer to receive LTC in their own home rather than in a nursing facility. Federal and state insurance laws have enhanced home care coverage over the years and have provided some consumer protection to buyers. Though coverage limits under the same policy may differ for institutionalized care and home care, an LTC insurer must offer home care coverage that is equal to at least one-half of the value of the policy's institutionalized coverage.

Unlike in the past, an Illinois LTC insurer cannot force a policyholder to first receive care at a nursing home before at-home benefits may go into effect.

In a possible address to patients with at-home custodial needs, lawmakers do not allow Illinois insurers to sell policies that limit coverage solely to medical services or to services performed by licensed or registered nurses.

Adult Day Care

An important yet often overlooked provision in LTC policies with home care benefits is coverage for respite services available at an adult day care center. On one hand, this might seem more like a family benefit than a policyholder benefit, since it ensures that home-based caregivers have opportunities to conduct personal business, spend time with other loved ones or merely take a breather from their nursing responsibilities. At the same time, however, one could argue that this respite care ultimately benefits the patient, because any reduction in stress experienced by family caregivers is likely to keep the chronically ill individual in the comforts of home for a longer period of time.

More than 3,000 adult day care centers operate in the United States, with many of them catering specifically to people with special needs, such as people with physical impairments, people with cognitive impairments, people with chronic conditions and people recovering from illnesses or injuries. For roughly $60 to $80 per day, adult day care centers will usually feed visitors, dispense medication at prescribed times and engage the person in group activities. Some centers also offer counseling services for caregivers.

Mandatory LTC Policy Provisions

In spite of the many coverage options available to consumers, some provisions in LTC policies are non-negotiable and have been mandated by Illinois law in order to promote consumer protection throughout the local LTC market. Mandatory provisions for all LTC policies recognized by the state are as follows:

- **Skilled, intermediate and custodial care**: Skilled care should only be administered by a medical professional. Custodial care and some intermediate care may be administered successfully by non-medical professionals. An insurer must offer coverage that is not limited to skilled nursing care. An insurer cannot offer to cover a lower level of care in a facility only after the patient receives a higher level of care.
- **Renewals**: Years ago, some insurers only offered guaranteed renewable LTC policies to elderly customers. Illinois now requires all LTC policies sold in the state to be guaranteed renewable regardless of the policyholder's age or health status.

  Insurers can only use the term "guaranteed renewable" within the context of a policy with benefits that will not change as long as the buyer pays premiums on time. The term does not apply to policies that feature guaranteed premium rates. Consumers must be alerted to the meaning of "guaranteed renewable" and to the possibility of premium increases somewhere on an LTC policy's first page.

  If a policy's benefits and its premiums are both guaranteed, insurers may use a term such as "non-cancelable."

- **Inflation protection**: Although the American Association of Retired Persons has said only 40 percent of LTC policyholders opt for this feature, all LTC insurers in Illinois must offer inflation protection that annually increases the policy's daily benefit by at least 5 percent. Some insurers might offer additional inflation protection, but, based on Illinois law, inflation protection exceeding 5 percent can be cancelled because of

the insured's age, the benefits received from the policy or the length of time the policy has been in effect. Inflation protection of only 5 percent cannot be cancelled under those circumstances.

Insurance producers must include a visual representation of how inflation protection might impact the policy over a 20-year period, either within the policy summary or as an attachment to the policy summary. Furthermore, an applicant who does not want inflation protection must actively refuse it by signing a waiver that states:

"I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of this policy with and without inflation protection. Specifically, I have reviewed plan(s) (fill in the blank), and I reject inflation protection."

- **Non-forfeiture benefits**: An offer of non-forfeiture benefits must be made to LTC insurance applicants in Illinois. Non-forfeiture provisions allow the insured to receive LTC benefits even after the policyholder has stopped paying premiums and cancelled the coverage. In exchange for keeping premiums that had already been paid toward the LTC policy, the insurer typically agrees to cover a reduced amount of care at no additional cost. For example, an insurer might keep all paid premiums but allow the insured to receive an $80 daily indemnity for future LTC rather than the $150 daily indemnity that the policy would have provided if the insurance had been maintained.

  LTC policies that are eligible for federal tax breaks can only contain non-forfeiture benefits that are triggered when the insured dies, cancels the entire policy or utilizes the non-forfeiture benefits specifically to rid oneself of unwanted coverage or reduce the cost of insurance.

- **Free-look periods**: Some states, including Illinois, require all LTC policies to feature a 30-day "free-look period," during which a new policyholder can reconsider an insurance purchase and receive a full refund of any paid premiums with no questions asked. An explanation of the free-look period must exist either on the policy's first page or on an attachment to the first page.

Additional Policy Provisions

Over the years, competitive LTC insurers have included additional benefits within their policies which may be available at no extra cost or may be offered to the buyer in exchange for higher premiums. Some of the most popular additional benefits that are not mandated by state or federal law are as follows:

- **Alternative plan of care**: In essence, this benefit is a recognition on the insured's and the insurer's behalves that LTC options could grow as scientists make medical breakthroughs and as businesses providing LTC adapt to new consumer demands. Generally, this provision allows care that is not mentioned in the policy to be covered as long as the insured, the health care provider and the insurance company all agree it is a valid component of modern LTC.

- **Ambulance benefits**: Some LTC policies will cover medically necessary transportation to hospitals. From a buyer's standpoint, this provision might be irrelevant in some circumstances. Though the government has reduced the amount of money it pays to ambulance service providers in recent years, Medicare might still cover an ambulance trip in a senior emergency or in cases when an ill or injured person is confined to a bed. In some communities, residents pay for ambulance services through local taxes, thereby allowing ambulance charges for the uninsured to be written off.

- **Bed reservation**: Though laws may differ among states, some LTC facilities have the right to put a bed back on the market if a resident is absent from the community for an extended period of time. The bed reservation benefit allows the insured to take a long vacation, stay with family or friends for a while, or endure a long stay at a hospital or other health care facility without losing personal space in an LTC facility.
- **Future purchase option**: Viewed in some contexts as a cheaper alternative to inflation protection, this benefit allows the policyholder to increase LTC benefits later in life without needing to medically qualify for the additional coverage. This option does not, however, prevent insurers from basing premiums for the upgraded policy on an insured's age at the time of the upgrade.
- **Home modification**: An option particularly suited to an insured who intends on receiving LTC in a private home, this benefit covers property improvements that address the needs of a sick or injured person. Covered modifications and products might include the installation of wheelchair ramps, shower chairs and bars used for support in bathrooms.
- **Non-cancelable coverage**: Rare at the time of this writing, non-cancelable policies are one step ahead of being guaranteed renewable. These insurance contracts guarantee that benefits will remain the same as long as premiums are paid and that those premiums will not rise above a certain amount.

Cancellations and Denied LTC Claims

In spite of their unpleasantness, situations do arise in which insurance companies decide they must cancel a client's policy or deny a policyholder's claim. With a few exceptions, LTC insurers may cancel policies if they can reasonably contend that a policyholder did not complete an application honestly.

Illinois allows insurers to contest active policies and otherwise valid claims if applicants misrepresented facts to the point of affecting the coverage given to them, but the policies must have been in effect for less than six months. In cases of policies that have been in effect for a period between six months and two years, companies may only contest policies and claims on the basis of misrepresentation if the applicant misrepresented facts that pertain to an allegedly abused policy benefit. In disputes involving policies older than two years, the state says insurers can contest policies and claims on the basis of misrepresentation only if the applicant knowingly and intentionally misrepresented facts that relate specifically to one's health.

An insurer may also cancel policies due to non-payment of premiums, but exceptions apply in these situations, too. Illinois LTC insurers must offer a feature called "reinstatement for cognitive impairment," which allows a person to regain a policy that was cancelled on account of non-payment of premiums if the policyholder was cognitively impaired at the time of a premium due date. Methods for determining cognitive impairment and the definition of a cognitive impairment in these circumstances cannot be any more restrictive than the methods and definition used to trigger benefits.

When cognitive impairment is determined to have occurred, reinstatement is possible within five months after a cancellation. Reinstatement for cognitive impairment does not excuse the policyholder from eventually having to pay any premiums that led to the initial cancellation.

Due to the mental lapses that are possible among the cognitively impaired and the inability among some policyholders to manage their finances, Illinois LTC insurers must make room on an application for the name of at least one third party who will receive notice of any

unpaid premiums or policy penalties. This “third-party notice” provision does not make the third party legally responsible in any way for payment of premiums, and applicants may decline third-party notice by signing a waiver. At least once every two years, an insurer must alert LTC policyholders to the fact that they can add or remove the names of people who are set to receive the notice.

Fair Warnings to LTC Producers and Insurers

In order to demonstrate legally and ethically acceptable market conduct, LTC insurance companies and their sales associates must periodically submit information to state regulators.

Among other company responsibilities, Illinois LTC insurers (other than those solely selling coverage as a rider to a life insurance policy) must develop suitability standards that are used to determine whether a given customer is an appropriate candidate for a policy. These standards, at a minimum, need to relate to a potential client’s finances, other insurance policies, and reasons for interest in LTC coverage. Companies are required to submit these suitability standards to the state upon request and are responsible for training sales representatives to give factually accurate presentations without over-insuring customers. In annual reports to the state insurance commissioner, an insurance company must disclose the following information:

- The number of people it deemed unsuitable for LTC coverage
- The company’s annual LTC lapse and replacement rates
- The rates of denied policy claims by class

LTC producers are held accountable for their individual LTC lapse and replacement rates. By June 30, each company must identify affiliated sales representatives whose lapse and replacement rates are among the highest 10 percent in the organization and report them to the state.

This disclosure to the state does not automatically spell trouble for the named individuals and does not necessarily signify any wrongdoing. However, the state wants to be sure that producers are not engaging in the following activities, which are illegal in Illinois:

- “Twisting” or “churning,” which occurs when a producer convinces consumers to cancel an insurance policy or other financial agreement and replace it with a new one that does not serve a beneficial purpose
- Using high-pressure tactics
- Distributing marketing material that is technically a solicitation for insurance but is designed or formatted to appear otherwise
- Misrepresenting facts

Any Illinois insurance producer who is found to be in non-compliance with any aspect of LTC insurance laws or regulations can be punished with a fine of up to $10,000 or three times the sum of the person’s commissions from improperly sold, serviced or canceled policies, whichever amount is greater.

Alternative Funding for LTC and LTC Insurance

Insurance professionals know their clients care about protecting personal assets and about making sure loved ones are financially secure. Why else do people purchase optional health and life insurance and often buy more coverage for their cars or homes than laws or

mortgage agreements demand? With the probability of needing long-term care rising and with the cost of that care getting higher and higher, logic suggests LTC insurance ought to be an incredibly popular product among the general public.

That logic, though, has proven to be faulty in some respects. While certainly noteworthy compared to figures from several years ago, growth in the LTC insurance market has generally either been big but temporary, or steady but unremarkable. Americans seem to be more aware of the fact that the insurance exists, but most of them aren't making it an integral part of their retirement strategies.

Consumers' somewhat timid response to LTC insurance is rooted in more than just the common tendency to avoid thoughts of old age and incapacitation. In many cases, it is influenced greatly by the growing number of options for LTC planning that may or may not involve insurance policies. Instead of being attracted to the positives of LTC insurance, aging adults might be turned off by the price of coverage and decide that government assistance through Medicaid will ultimately be a better solution to their health needs. Perhaps a medical condition prevents a person from qualifying for a decent LTC policy and makes a life settlement or viatical settlement a more realistic source of financial assistance. Or maybe a senior is concerned about possibly spending money on insurance that might never be necessary and would rather exchange home equity for cash in a reverse mortgage arrangement.

Like the insurance policies you reviewed in the first portion of this course, these alternatives for LTC funding all have potentially positive and potentially negative features for seniors and other consumers. As an LTC insurance producer, you might find that understanding these positives and negatives will help you grasp what you're competing against and allow you to develop a comprehensive risk management plan that is tailor-made for each client's unique situation.

Among the products, programs and financial arrangements that will be mentioned in the rest of this material, some may be suitable for people who are not interested in obtaining LTC insurance. Others can be suitable both on their own terms and as sources of funding for an excellent yet expensive LTC policy. In any case, it ought to be clear that LTC insurance is a great choice for many, but not the only choice for all.

Truths and Myths About Medicaid

Some insurance producers who are intent on making LTC sales regardless of product suitability tend to distort facts and try to manipulate consumers through fear by implying that, unless a senior has LTC coverage, he or she will eventually run out of money and end up either on the street or in a substandard facility with inferior caregivers.

The truth about LTC insurance and government assistance is this: If seniors can initially afford LTC insurance, they almost certainly are taxpayers who are generally entitled to share in the benefits provided through public programs such as Medicaid once their personal assets drop below a certain amount. Although the very popular Medicare program does not provide much coverage for LTC expenses, necessary health costs are commonly paid through Medicaid.

Instead of being made to fear destitution, seniors and their families deserve to know the facts about what Medicaid will pay toward LTC. They should also make themselves aware of the sometimes difficult process an individual must go through in order to become eligible for help.

Many Americans worry about the effects Medicaid assistance might have on the quality and availability of their health care. This concern is valid in the sense that once people are approved for Medicaid, they risk losing some personal choices in regard to their treatment and living conditions. For obvious reasons, the government is unlikely to pay for a private room in a selective assisted-living center with the most luxurious living quarters, the best meals and the most extensive list of exciting group activities.

It is also true that individual states have reimbursed care providers and LTC facilities in ways that could impact the availability of some services to low-income citizens. According to Consumer Reports, some states' Medicaid programs pay facilities and caregivers the same amount of money with minimal regard to the degree of rendered care, while other states have higher reimbursement rates for advanced care. Some Medicaid critics have suggested that the equal payment systems discourage facilities from accepting patients in need of high-level care and have also argued that the higher reimbursement rates for advanced care discourage facilities from accepting relatively low-maintenance patients.

Yet to use Medicaid as a scare tactic in an LTC insurance presentation would involve making gross overgeneralizations and might inadvertently dissuade government officials and the public from focusing on some of the program's specific flaws. Medicaid has been known to pay for nearly half of all LTC in this country, and though individual cases of patient neglect and poor treatment deserve our attention, denouncing the totality of public assistance for LTC would imply that nearly half of today's nursing home and life center residents do not receive proper attention from staff and do not receive decent medical treatment from trained professionals.

Relying on fear and misinformation also tends to involve ignoring the legal and ethical ways for citizens to receive Medicaid benefits and still possibly avoid becoming forgotten victims with few choices. People who worry about not getting into a quality facility once they go on Medicaid can do themselves a great favor by researching reputable facilities' Medicaid acceptance policies ahead of time and moving into a favored environment while they still possess a significant amount of financial assets.

Many onsite LTC providers (particularly those affiliated with religious organizations) accept Medicaid payments for seniors who are already permanent residents of their facility. The government might not pay an amount equal to what the facility charges, and seniors transitioning from private payment to Medicaid might need to give up such luxuries as a private room. However, many of these organizations can make up for the smaller reimbursements with the money they make from their privately billed residents and generally will not order a Medicaid patient to leave the premises when space is available. Many medical professionals who are employed on a daily basis by these businesses and non-profit organizations are not told which patients are paying their own way and which ones are receiving government aid. So the standard of day-to-day medical care at the same facility is unlikely to change based on one's finances.

Still, it is important to note that many other senior communities do not accept Medicaid, and the ones that do take it usually try to limit the number of public-aid patients they will serve. If a senior lives in a facility that does not accept Medicaid and suddenly needs LTC assistance from the government, he or she might have to move to a different facility that accepts government payments and has an available bed.

Medicaid Eligibility

The most obvious downside to Medicaid, and one of the main reasons why many people purchase LTC insurance, is that a person must be nearly wiped out financially in order to

qualify for benefits from the need-based program. Exact eligibility requirements differ among states, but, in general, a Medicaid recipient can only possess a few thousand dollars in personal assets and still receive public assistance.

Under most circumstances, a person's private home and car are exempt from Medicaid eligibility requirements, meaning that the government cannot force someone to sell or surrender these items before he or she can receive public aid. Under the Deficit Reduction Act of 2005, however, a home's exempt status does not apply if equity exceeds either $500,000 or $750,000, depending on state choice.

Nearly all of the income that is earned by a Medicaid beneficiary is supposed to go toward medical expenses, but some states enforce more-lenient income requirements than others. At a minimum, Medicaid beneficiaries are allowed to keep at least $30 each month, which the person can use to pay for non-covered expenses like phone and television services. A Medicaid beneficiary may also keep some funds that have been earmarked for funeral costs.

Until the passage of the Spousal Impoverishment Act in 1988, Medicaid required married couples to jointly spend down their shared assets before either the husband or wife could benefit from the program. In some extreme cases, a relatively healthy spouse who wanted to remain above the poverty line opted to divorce an unhealthy spouse who was in need of Medicaid assistance.

The Spousal Impoverishment Act typically allows a healthy spouse to keep one-half of any jointly held assets up to a certain dollar amount without disqualifying an unhealthy spouse for Medicaid benefits. Income earned solely by a healthy spouse does not factor into an unhealthy spouse's Medicaid eligibility. Any jointly held assets that have been structured within a certain timeframe to reduce a Medicaid applicant's share in them could result in denied aid. Each state has the right to allow exceptions to Medicaid eligibility rules in cases of undue hardship.

Medicaid Planning

Families who are focused on asset protection must be aware of the legal issues involved with a popular estate concept called "Medicaid planning." For years, some financial advisers have made their livings by helping clients take advantage of loopholes in the Medicaid system through asset transfers and other financial maneuvers, all designed to allow people to become eligible for public aid without giving up much of their money. These financial plans have become common enough for the government to deem them abusive and enforce increasingly strict laws that close many of those loopholes.

In general, the government audits financial statements dating back three to five years (referred to as the "look-back period") before a person applied for Medicaid. If these statements show that a person transferred or surrendered personal assets for less than fair market value, the state may refuse to provide Medicaid benefits for a period equal to the amount of time it would take the person to spend down those assets. For institutionalized care, this waiting period is calculated by dividing the total value of unlawful transfers by the monthly average cost of nursing home care in the area. Waiting periods for care that is rendered outside of an institutional environment cannot last longer than the waiting period for institutionalized care.

Medicaid rules regarding asset transfers do not apply when the transferred asset is a home and the recipient is the person's spouse, a minor son or daughter, a blind or disabled adult child or an adult child who lived in the home for at least two years prior to the person's move to a nursing facility and acted as the person's caregiver during that time. Nor do these rules generally apply when assets were transferred completely to a spouse or to trusts set up for a

spouse, a disabled son or daughter or another disabled individual under the age of 65. Other kinds of trusts (particularly those that provide money for Medicaid recipients) might cause eligibility problems.

Initially, the laws passed to restrict Medicaid planning were instituted with penalties and criminal charges that mainly affected the person seeking public aid. These rules have since been revised in ways that transfer significant liability for unlawful Medicaid planning to the financial advisers who are behind the criminal acts.

Reverse Mortgages

An increasingly common option for seniors in search of money for LTC insurance is a "home-equity conversion loan," also known as a "reverse mortgage." In this kind of arrangement, a homeowner receives a lump sum, a line of credit or, most likely, a steady flow of payments from a financial institution for as long as the person lives on the property. In exchange for providing these payments, the institution receives a portion of the proceeds from the eventual real estate sale plus interest when the homeowner dies or relocates. Reverse mortgages are structured to ensure that the amount of money owed to the lender does not exceed the property's value, and any proceeds left over from a sale after the lender has been repaid will go to the senior's chosen beneficiary.

The size of the payouts to the homeowner will be based on the property's value and the person's life expectancy at the time the application is completed. Obviously, a lender who agrees to pay the applicant a monthly fee throughout occupancy does not want to end up paying more money over several years than the lender is contractually able to receive upon sale. Perhaps with this in mind, most mortgage lenders, as well as the Department of Housing and Urban Development, reserve reverse mortgage opportunities solely for homeowners who are at least in their 60s.

Individual lenders may have their own policies regarding closing costs, interest rates and additional fees. In most cases, the homeowner remains responsible for insurance costs and property taxes.

Annuities and LTC Benefits

Provisions related to LTC can sometimes be found in annuity contracts. At its most basic level, an annuity is a contract whereby an individual or group invests money with an insurance company and expects that the money will be returned at a later date, either in a lump sum or in periodic installments over several years. Income created through an annuity might be necessary in the immediate future when personal savings, Social Security checks and other sources of money do not adequately cover a retired person's expenses. Or it might be one component of a working person's long-term retirement plan.

Almost every annuity can be categorized in three different ways, depending on how the corresponding funds are invested, how the owner pays for the annuity, and when the owner expects to use funds from the annuity as an income stream. An annuity may be fixed or variable, deferred or immediate, and bought with either a lump sum or in multiple installments. We will now briefly review two of those three groupings and examine how they relate to consumers' financial goals and risk tolerances.

Fixed and Variable Annuities

People who care more about saving money than engaging in high-risk, high-return ventures tend to prefer fixed annuities over variable annuities because fixed annuities contain fiscal guarantees. The traditional fixed annuity guarantees a return of all the money given to the insurance company and also credits interest to the investor's account. The insurer usually

promises minimum investment returns near 3 percent or 4 percent, though contractually guaranteed rates will almost certainly be above those numbers during the annuity's early years.

The risk to owners of fixed annuities is minimal because the insurance company invests their money in conservative long-term bonds. The consumer generally shoulders no responsibility for the annuity's performance. However, people who purchase fixed annuities could lose some of their principal if catastrophes or poor management make an insurer insolvent.

Variable annuities increase in popularity when the financial markets are noticeably strong. They appeal to investors who are willing to risk losing some or even all of their principal if the insurance company agrees to give them opportunities for potentially large returns.

Variable annuities feature few or no guarantees, but the interest credited to variable accounts can greatly exceed the returns that are promised in fixed contracts. The owner shoulders the responsibility of investing his or her money in mutual funds made available to the insurer's clientele, and the owner's account balance will go up or down based on the funds' performances.

Unlike those who buy fixed annuities, people who purchase variable annuities have their money protected from an insurance company's creditors. However, variable annuity owners must pay various fees (typically on an annual basis) that do not factor into fixed annuity purchases.

Immediate and Deferred Annuities

The annuity shopper's choice between an immediate or deferred annuity will depend on when the person plans to receive payments from the insurance company. A deferred annuity suits investors who do not need additional income at the time of purchase but envision needing money years into the future. Deferred annuities go through an "accumulation period," during which the owner's account is expected to grow without affecting the person's tax situation.

When people buy a deferred annuity, their goal at that moment is to watch their principal expand for several years. Presumably at a much later date, they will cash in their deferred annuity for either a lump-sum payout or divided payouts that will be disbursed throughout someone's remaining lifetime. At the earliest, a deferred annuity contract might allow the owner to begin receiving regularly scheduled payouts one year after the sale date.

An immediate annuity creates an income stream for the owner soon after the sale date. In general, the owner starts receiving payouts within one year of entering into the contract. Most immediate annuities can begin returning money to a person within 30 days.

Although immediate annuities allow for growth of an investor's principal, these products do not go through a traditional accumulation period, since money is being taken out of them at the same time that they are growing in value. Opportunities for tax deferrals with an immediate annuity are relatively minimal because federal taxation on the income begins at the same time as the payouts.

LTC Waivers and Riders

One of the drawbacks to buying any annuity is that the owner may have to pay a steep surrender charge to the insurer if he or she wants access to the invested funds after only a few years. However, many annuities feature a "crisis rider" or "crisis waiver," which can be used to support the annuitant during specific financial emergencies, such as those involving a disability, a chronic health problem or unemployment.

Though some crisis waivers only waive surrender charges for annuity withdrawals that are below a certain dollar amount, others let the owner make a clean break with the insurer without penalization. A crisis rider, on the other hand, can do more than just eliminate a surrender charge. It might increase payouts if an annuitant experiences a crisis, or it might trigger benefits under an insurance policy that has been made part of the annuity contract. In the latter case, the owner would basically be getting a discount for buying two insurance products at once.

Considering the annuity's status as a popular product for older consumers and retirees, it makes sense for these contracts to feature LTC crisis waivers and riders that can help pay for institutional or at-home treatment. But annuities that contain LTC benefits must be evaluated and purchased with care. The laws associated with full-blown LTC insurance policies might not apply to LTC crisis waivers, which merely nullify surrender charges and do not force the insurance company to pay directly for anyone's health expenses. LTC riders that merely increase the size of annuity payouts might not need to meet various statutory requirements either, because they too do not force the insurance company to cover care. Like crisis waivers, they merely put annuity owners in a potentially better position to handle LTC costs on their own.

Viatical Settlements and Life Settlements

Viatical settlements allow terminally ill individuals to sell their life insurance policies to investors in exchange for money. Although a person who sells a life insurance policy through a viatical settlement company will almost certainly be medically ineligible for LTC insurance, money received from a settlement can be used to cover anything the person needs, including long-term medical care.

Life settlements are similar to viatical settlements but do not involve insureds who are terminally ill. Money obtained through a life settlement may be used by an aging consumer as he or she chooses. For healthier seniors, a life settlement might even provide money that can be used to purchase a comprehensive LTC policy.

Viatical and life settlements have helped many ill or elderly people receive some much-needed income during difficult times, but they are very controversial and are sometimes not even understood by the people who try to make money off of them. Upon reading the remaining pages in this book, you'll be able to explain how these financial arrangements work and why they raise some ethical questions.

Where Did Viaticals Come From?

It may be easy to view a secondary market for life insurance as a purely American creation; just one extreme example of what a modern market economy can produce.

Yet the practice of selling one's life insurance to strangers has its origins across the ocean in England, where economically poor individuals who suffered from serious illnesses could auction off their life insurance policies to the highest bidder at least as early as the 19th century. U.S. authorities who knew about these auctions and considered them despicable aimed to keep them out of our country by promoting non-forfeiture laws on a state level beginning in the 1860s.

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

When they look back on the state of life insurance as it was 20 years ago, multiple industry experts note that a person who wanted to sell an in-force yet unwanted policy usually had to deal with a "monopsony;" an environment in which people who market their goods and services can only do business with one buyer. That lone potential purchaser in those days was effectively the same company that issued the policy, and the "take or leave it" offer from that buyer was never greater than the policy's cash surrender value.

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

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

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

None of this boded well for people who were dying of AIDS during the late 1980s. As the disease attacked their immune system and made them too sick to remain in the workforce, many AIDS patients lost their income and employer-sponsored health insurance and struggled to pay for medical treatment that could have prolonged their lives.

Those who were fortunate enough to hang onto their health coverage often found that their medical plans would not pay for the latest experimental drugs and therapies that scientists were developing to combat the new health crisis. Rather than being able to concentrate on enjoying their last days as much as possible, the terminally ill often spent their time worrying about how they were going to pay for medical attention and still have enough money for such essentials as housing, food and utilities.

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

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

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

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

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

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

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

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

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

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

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

How Do Viatical Settlements Work?

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

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

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

The Front-End Viatical Process

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

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

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

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

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

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

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

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

Brokerage Companies and Settlement Companies

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

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

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

Viatical Brokers

Viators have the option of either using a broker to handle a viatical transaction or contacting settlement companies on their own. Many viators choose to utilize brokerage services, not only to avoid the work of negotiating with settlement companies but also because an experienced broker will at least have a general idea of which settlement companies might be most likely to show an interest in purchasing a particular policy.

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

Verifying Information and Obtaining Consent

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

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

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

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

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

Because viatical settlement companies ultimately become irrevocable beneficiaries on the policies they purchase, any pre-existing irrevocable beneficiaries must actively renounce their policy rights in order for a settlement to be valid. Though not legally required to do so, most companies will also refuse to bid on policies unless revocable beneficiaries consent to a potential sale.

This standard practice exists as a deterrent to possible legal action that might otherwise be brought by an insured's angry family members or other interested parties. To date, this legalistic safeguard seems to have worked well enough. Research conducted during the development of this course found no major lawsuits filed by preexisting beneficiaries against viatical companies.

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

The viatical company will need permission to contact the insurer that issued the policy so that it can confirm this information and investigate any possible barriers to a smooth transfer of ownership. Although the insurance company may charge a fee for verifying this information, the National Association of Insurance Commissioners (NAIC) has proposed standard legislation that would forbid insurance companies from charging higher verification fees to viatical companies than to other inquirers. The NAIC has also supported giving insurers 30 days to respond to inquiries in order to investigate possible fraud.

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

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

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

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

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

Determining the Size of Settlements

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

Life Expectancies

The main consideration among these variables is the insured person's remaining life expectancy. As morbid as it may seem, neither settlement companies nor their investors are

keen on working with applicants who have several years left to live. Long life expectancies diminish investment returns for settlement companies and their investors because the people who fund the viatical settlement need to pay a longer stream of premiums to the insurer to keep the policy active. Overly healthy applicants might also tie up investors' money for an unacceptably long time, since no one in the viatical business gets a return on an investment until insured people die.

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

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

Policy Premiums

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

When the viatical industry began, some settlement companies required the viator to pay premiums on a viaticated life insurance policy for at least one year after the settlement date. However, it is now standard industry practice for settlement companies and their investors to handle payment of all premiums until the insured person dies. According to the Atlanta Journal-Constitution, a settlement company will reserve enough money to fund a viaticated policy for a period of time equal to the insured's life expectancy multiplied by 1.5.

Health of the Insurer

Like any savvy insurance customer, a viatical settlement company wants to ensure that the life insurer that issued a policy will be financially strong enough to honor eventual claims. Devastating occurrences, such as natural disasters and terrorist attacks (not to mention poor business planning), have been known to place some insurers into insolvency, thereby preventing policyholders from receiving benefits in full and in a timely manner. State guaranty funds may help a failed insurer's clients receive some policy benefits, but these funds usually cap the amount available to policy owners at $100,000 or so.

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

Age of the Policy

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

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

Policy Loans

Potential viators should not forget about any outstanding loans they have on their life insurance policy. Policy loan provisions are an important and attractive feature of permanent life insurance, but the insurer's ability to subtract the amount of outstanding loans from the death benefit makes them an undesirable element in a viatical transaction.

Because interest on policy loans can further decrease the death benefit if the loan is left unpaid, a settlement company will want to satisfy the terms of any existing lending agreement between the insurer and the insured immediately after buying someone's coverage. When bidding for a policy with an unpaid loan attached to it, the company will look at all other underwriting factors first, come up with a specific settlement amount, deduct the unpaid balance on the loan from that settlement amount, and offer the result to the viator.

Economic Influences

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

The Settlement Contract

Soon after accepting a final bid from a settlement company, the viator receives the settlement contract. The settlement contract is a legal document that spells out the rights of the viator and the settlement company. It explains, ideally in a clear manner, the following information:

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

Before the contract becomes a binding agreement, the viatical settlement company must typically make several important disclosures to the viator and remind the seller of various important facts. Though far from uniform across the country, the following reminders and

disclosures have been suggested, endorsed or implemented by various states, the NAIC and/or viatical trade groups:

- A reminder of the amount of death benefits that beneficiaries will lose in the event of the settlement
- Disclosure of the fact that the settlement may result in a stranger owning an insurance policy on the insured person's life
- Disclosure of the fact that viaticating a joint life insurance policy or any other policy that covers multiple individuals may cause multiple individuals to lose their coverage
- Disclosure of the fact that viaticating the policy will probably force the insured to lose rider benefits, including those applicable to long-term care and accidental death
- Disclosure of the fact that a settlement could have a negative effect on the viator's eligibility for Medicaid and other need-based government programs
- Disclosure of the fact that settlement proceeds may be accessible to a viator's creditors
- A reminder that there are other opportunities for financial relief (including but not limited to accelerated death benefits from a life insurance company) besides viatical settlements
- Disclosure of the fact that, under some circumstances, settlement proceeds may be taxed by federal and state governments as income or capital gains

Transfer-of-Ownership Forms and Escrow Agreements

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

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

When the transfer-of-ownership forms are sent to the viator for completion, the settlement company is often required to move all money intended for the viator into an escrow account that is administered by an escrow agent. The settlement company usually picks the escrow agent, but it must limit its choice to a properly licensed entity that has nothing to gain from the sale of the viator's policy.

In addition to holding onto the money meant for a viatical settlement, the escrow agent may be asked to keep various documents safe while the viatical transaction is underway. Assuming the insurer approves the transfer of ownership from the viator to the settlement company, the escrow agent releases the settlement amount to the viator through a wire transfer, a certified check or a cashier's check.

Receiving Payments

The viator can expect to receive settlement funds no later than the date specified in the viatical contract. If the viator receives the money at a later date, the settlement may be considered null and void, and regulators might take legal action against the settlement company. NAIC model legislation calls for viators to receive their money from escrow agents

no later than three business days after the settlement company becomes aware of a successful transfer of ownership.

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

Some states' insurance and securities laws require that all viatical settlements in the area involve lump-sum payments to sellers. Though the viator's federal tax obligations may depend on the manner in which the settlement proceeds are spent, viators are not required to use their settlement money to fund any medical care.

Rescission Clauses

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

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

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

If the viator dies during the settlement's rescission period, the viatical company relinquishes its ownership rights, and the insurance company pays death benefits to the insured's chosen beneficiaries, as if the transaction had never occurred.

Contact With Viators

The relationship between the viator and the settlement company will continue, in some way, for as long as the insured individual remains alive. While finalizing the details of a viatical settlement, the viator must give his or her contact information to the settlement company. After the settlement has been legally completed, the company uses this contact information to periodically check up on the insured individual. In an arguably gruesome yet true reality of the viatical business, these regularly scheduled peeks into the insured's life essentially involve the settlement company asking if the person is either dead or at least close to death.

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

In general, viatical companies can contact viators no more than once every three months when the insured's remaining life expectancy is greater than one year. The NAIC has said companies should not be allowed to contact viators more often than once every month when the insured's remaining life expectancy is one year or less.

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

The responsibility for keeping tabs on the insured belongs to the settlement company rather than to a settlement company's investors. The settlement company can employ its own staff to conduct these checkups, or it can hire an independent third party to handle this aspect of its business. The company or the third party may conduct these periodic inquiries through the mail, over the telephone or over the internet. In addition to or in place of these inquiries, many established companies use Social Security databases to confirm an insured person's death.

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

The Back-End Viatical Process

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

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

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

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

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

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

More often than not, these investors technically do not become the owners of a viaticated policy, but they do earn themselves a piece of the policy's death benefit when the insured

person passes away. Barring some grossly inadequate underwriting by the settlement company, they receive a return of principal plus interest.

It is important to note here that, unlike many traditional investment vehicles, viatical investments offer simple, total interest rather than compounded, annual interest. It should also be noted that this simple, total interest is almost never guaranteed. Returns on viatical investments will depend almost entirely on the insured's date of death, with yields getting smaller and smaller the longer the person lives.

Are Viaticals Ethical?

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

People's occasionally questionable feelings toward the viatical industry are understandable, if not entirely warranted. After all, viatical companies and investors do not make any money until an insured person dies, and they make more money if the person dies sooner than expected. Investors might indeed hope that viators experience some dignity and some relief from financial stress as a result of a settlement, but one has to wonder how those investors would react if medical professionals developed a cure for a terminal disease.

Would their humanity cause them to be happy for affected viators and rejoice over the fact that the viators, their friends and their family would be spared from the grief that is associated with death? Or would their first instinct lead them to worry primarily about the substantial sum of money they will end up losing as a result of the cure?

With many investors having locked their retirement savings in viaticals, some critics believe the latter is the more likely response and that the industry is merely a corporate-built arena in which investors can gather and root for people's deaths.

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

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

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

Life insurers have consistently recognized that an individual most likely wants to remain unharmed and have therefore allowed a person to own a life insurance policy on his or her own life. Insurers have also recognized that a person's spouse, parents, employers and business partners often have financial and emotional reasons for wanting him or her to remain unharmed. Therefore, the parties in a familial or business relationship are often permitted to own insurance policies on one another's lives.

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

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

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

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

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

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

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

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

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

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

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

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

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

The NAIC has addressed the privacy issue by encouraging states to adopt legislation that would prohibit the sharing of insured’s personal, financial or medical information. Exceptions to this prohibition would include, but would not be limited to, the following circumstances:

- The sharing is necessary in order for the viator to obtain a settlement, and both the viator and the insured agree to the sharing.
- The sharing is necessary in order for the viatical company to secure adequate funding for the settlement, and both the viator and the insured agree to the sharing.
- The sharing is necessary in order for a settlement company to transfer a viaticated policy to another settlement company.
- The sharing is necessary in order for the viatical company to confirm the insured’s health.
- The sharing is necessary in order for the viatical company to comply with orders from the government.

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

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

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

- If the insured's remaining life expectancy is less than six months, the viator should receive a settlement equal to no less than 80 percent of the policy's death benefit.
- If the insured's remaining life expectancy is at least six months but less than one year, the viator should receive a settlement equal to no less than 70 percent of the policy's death benefit.
- If the insured's remaining life expectancy is at least one year but less than 18 months, the viator should receive a settlement equal to no less than 65 percent of the policy's death benefit.
- If the insured's remaining life expectancy is at least 18 months but less than 25 months, the viator should receive a settlement equal to no less than 60 percent of the policy's death benefit.
- If the insured's remaining life expectancy is greater than or equal to 25 months, the viator should receive a settlement that is at least the greater of the policy's cash surrender value and any applicable accelerated death benefits that would be available from the insurance company.

The NAIC has also said any viatical company that chooses to include the potential size of a settlement within its marketing material should have to use the average settlement for all its customers within the past six months.

It should be stressed that the contents of the NAIC's model regulation and model law, as summarized in parts of this material, are merely guidelines that lay the basic framework for the viatical laws in the individual states. Each state is free to adopt all or none of the NAIC's models.

Local governments have been especially hesitant to include the NAIC's minimum settlement amounts in their insurance codes. A survey of viatical-specific statutes in four states (California, Florida, Illinois and Indiana) showed that none of the four had instituted mandatory minimum amounts for settlements by the time of this writing.

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

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

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

When the U.S. House of Representatives Committee on Financial Services conducted a day-long hearing on alleged fraud in the viatical industry, hardly any of the attention was focused

on the plights of wronged viators. Rep. Sue Kelly even said, “The industry began, in large measure, as a noble means of allowing AIDS patients to pay their steep medical bills before death,” and Ohio Director of Insurance Lee Covington said, “While the nature of viatical transactions is dependent on the death of the viator, the social benefit of viaticals are extremely valuable for some terminally ill persons and some senior citizens.”

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

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

Tax Breaks, Fraud and Life Settlements

Triumphs and Setbacks for Viaticals

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

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

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

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

Assuming the company offering the settlement meets those requirements, viators can receive a tax-free viatical settlement if the person insured by the viaticated policy is a “terminally ill individual.” For tax purposes, the federal government defines “terminally ill individual” as “an individual who has been certified by a physician as having an illness or physical condition which can reasonably be expected to result in death in 24 months or less after the date of the certification.” As clarification, the government defines the term “physician” as “a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he performs such function or action.”

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

The term "chronically ill individual" means any individual who has been certified by a licensed health care practitioner as—

(i) being unable to perform (without substantial assistance from another individual) at least 2 activities of daily living for a period of at least 90 days due to a loss of functional capacity,

(ii) having a level of disability similar (as determined under regulations prescribed by the Secretary in consultation with the Secretary of Health and Human Services) to the level of disability described in clause (i), or

(iii) requiring substantial supervision to protect such individual from threats to health and safety due to severe cognitive impairment.

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

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

As you already know, most LTC insurers in the United States incorporate at least the following six activities of daily living into their benefit triggers:

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

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

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

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

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

To many viatical companies and legislators, the federal tax breaks available as a result of HIPAA seemed destined to breed positive results for businesses and government. In an ideal world, formerly hesitant policyholders were expected to hear about HIPAA's effect on viaticals, determine that this new and somewhat mysterious industry was legitimate and sell their unwanted insurance contracts for the kind of cash that would significantly reduce

people's dependence on such cash-strapped social programs as Medicaid. But several developments combined to dash those high hopes.

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

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

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

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

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

In numerous lawsuits, state regulators, the Securities and Exchange Commission (SEC) and individual investors accused viatical companies of various frauds. In some cases, money received from fresh investors was allegedly being used to pay off old investors, and no new policies were ever purchased. Sometimes, according to prosecutors, settlement companies did in fact purchase viaticated policies, but they employed doctors who would purposely downgrade an insured's projected life expectancy in order to make the person's policy more attractive to investors.

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

investors, who lost their principal when an insurer spotted a fraud and cancelled a dishonestly obtained policy.

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

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

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

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

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

NAIC documents also propose the following rules for advertisements:

- Advertisements should not include any "false or misleading" language, including but not limited to inaccurate mentions of guarantees, safety, security and high yields.
- Statistics used in advertising should be attributed to their source and should not be outdated.
- Advertisements should not lead people to believe that a company and its products are affiliated with the government.
- References to specific insurance companies should not be made without those companies' consent.

Yet not every state has adopted the NAIC models in their entirety or even at all. In 2007, more than 10 years after the NAIC approved its first edition of the Viatical Settlements Model Act, the trade publication Best's Review said some 12 states had neither enacted the proposed legislation nor passed similar laws. In fact, a debate has raged for at least a decade as to whether viatical companies should be regulated by the individual states or the federal government.

Regulation of Viatical Settlements

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

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

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

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

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

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

At the time of this writing, a few states had still not chosen to enact specific regulations for local viatical companies. The Life Insurance Settlement Association maintains a database of the applicable viatical laws and regulations in each state on its Web site, http://www.lisassociation.org.

Life Settlements

Faced with a souring public reputation and advances in AIDS treatment, the viatical companies of the late 1990s and early 21st century had to find a new way to survive. At first,

a few companies merely stopped buying policies from AIDS patients and shifted their focus toward potential viators with terminal cancer or other life-ending illnesses. But this strategy equated to a temporary patch for the industry's problems instead of a permanent fix. A groundbreaking cancer drug would have sent the industry back to the drawing board.

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

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

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

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

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

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

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

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

and other impersonal business entities having an interest in their life insurance policies than with unknown individuals having that same sort of interest.

Some states have regulated life settlements through their insurance and securities departments. In states that regulate viatical settlements as well as life settlements, an individual may or may not need to obtain separate licenses to market or facilitate both kinds of settlements.

Insurers' Reaction to the Secondary Market

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

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

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

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

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

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

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

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

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

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

Insurers have also frowned upon the life settlement industry's involvement with "wet paper," "wet ink" or "stranger-originated life insurance" (SOLI) policies. Similar to clean-sheeting, SOLI is life insurance that is bought by an individual at the suggestion of a life settlement company in exchange for money or gifts. When a policy becomes incontestable, the insured transfers ownership rights to the settlement company in accordance with a secret, preexisting agreement.

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

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

In 2007, the NAIC's Life Insurance and Annuities Committee endorsed a five-year waiting period that would be waived if the insured person gets divorced, is widowed, becomes terminally or chronically ill, retires or becomes disabled to the point of being unemployed. NAIC documents also suggest that individuals and settlement companies not be allowed to enter into a settlement agreement before a policy has been issued by an insurance company.

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

Accelerated Death Benefits

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

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

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

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

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

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

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

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

Conclusion

Insurance producers who embrace service to those who might need long-term care are likely to have plenty of opportunities for successful sales. These opportunities may seem more prevalent in the coming years because of the looming retirement of the Baby Boomers and the present circumstances of their parents' generation.

But it should be said that chances for knowledgeable professionals to prosper are likely to continue long after the Baby Boomers have gone. Although the tools, technology and products associated with insurance are bound to change, the concerns of society's aging population are likely to remain the same from one era to the next.

No generation wants to experience physical deterioration or disease, and no generation wants to have those problems made worse by financial struggles in old age. There will always be risks in the world; potential dangers that thoughtful adults will inevitably need to confront and manage. With a knowledgeable insurance professional at their side, consumers can tackle those great challenges with a reasonable degree of confidence.

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FINAL EXAM

1. Most LTC policies feature ADL-related triggers that are contingent on the insured's inability to perform at least _____ of the six standard activities.
   A. two
   B. four
   C. five
   D. one

2. In order to more firmly ensure coverage for physically healthy but mentally inhibited policyholders, Illinois requires all LTC policies to feature "_____" as a benefit trigger.
   A. inability to cook
   B. inability to pay bills
   C. cognitive impairment
   D. inability to use a telephone

3. The _____ addresses how long coverage will last.
   A. elimination period
   B. concept of medical necessity
   C. free-look period
   D. benefit period

4. _____are essentially LTC insurance deductibles that are expressed chronologically rather than as concrete dollar amounts.
   A. Elimination periods
   B. Benefit periods
   C. Activities of daily living
   D. Lapse rates

5. Under most circumstances, a person's_____ are exempt from Medicaid eligibility requirements.
   A. checking accounts
   B. stock holdings
   C. private home and car
   D. personal assets

6. Nearly all of the income that is earned by a Medicaid beneficiary is supposed to go toward _____.
   A. personal items
   B. medical expenses
   C. private nursing assistance
   D. health insurance premiums

EXAM CONTINUES ON NEXT PAGE

7. The_____ typically allows a healthy spouse to keep one-half of any jointly held assets up to a certain dollar amount without disqualifying an unhealthy spouse for Medicaid benefits.
   A. Spousal Impoverishment Act
   B. Deficit Reduction Act of 2004
   C. Health Insurance Portability and Accountability Act
   D. Medicare Act of 1965

8. When people buy a _____, their goal at that moment is to watch their principal expand for several years.
   A. reverse mortgage
   B. deferred annuity
   C. long-term care policy
   D. crisis rider

9. A(n) _____ creates an income stream for the owner soon after the sale date.
   A. variable annuity
   B. deferred annuity
   C. fixed annuity
   D. immediate annuity

10. In exchange for receiving the eventual death benefits created through a terminally ill person's life insurance policy, a viatical organization pays a major portion of the policy's _____ to the dying individual.
   A. cash surrender value
   B. dividends
   C. long-term care benefits
   D. face value

11. A policy owner who seeks out a viatical settlement is known as a(n) "_____."
   A. viator
   B. investor
   C. viatical settlement company
   D. chronically ill individual

12. A viator can sell _____.
   A. only a term life insurance policy
   B. only a universal life insurance policy
   C. nearly any kind of individual or group life insurance policy
   D. only a group life insurance policy

13. Viatical companies will usually only purchase term life policies if the policies can be converted to _____.
   A. permanent coverage
   B. an annuity
   C. LTC insurance
   D. accelerated death benefits

EXAM CONTINUES ON NEXT PAGE

14. When the policy that is up for sale involves group coverage, the viatical company will want a guarantee that the group's administrator will not _____ for any reason.
    A. increase the coverage
    B. cancel the coverage
    C. increase the premiums
    D. go out of business

15. In some states, terminally ill persons cannot enter into a viatical agreement unless they acknowledge they are doing so through _____.
    A. their own free will
    B. an attorney
    C. their estate
    D. a viatical broker

16. As a general rule, viatical settlements are made available to terminally ill individuals who have a remaining life expectancy of _____ or less.
    A. two years
    B. four years
    C. five years
    D. 15 years

17. Many settlement companies are hesitant to buy policies issued by life insurance companies that have not received decent marks from _____.
    A. consumer advocates
    B. insurance rating organizations
    C. viatical brokers
    D. respected trade magazines

18. Most companies in the secondary market will not purchase a policy that is less than _____ years old or that is still subject to any type of contestability period.
    A. four
    B. five
    C. eight
    D. two

19. If the viator dies during the settlement's _____, the viatical company relinquishes its ownership rights.
    A. suicide period
    B. contestability period
    C. rescission period
    D. benefit period

20. Since arriving in the United States a few decades ago, viatical settlements have continued to be one of the most _____ issues in the insurance and financial worlds.
    A. divisive
    B. unprofitable
    C. popular
    D. regulated

EXAM CONTINUES ON NEXT PAGE

21. HIPAA does not provide full tax breaks to viators when the person insured by a viaticated life insurance policy is expected to live longer than _____.
    A. three months
    B. six months
    C. two years
    D. the policy's beneficiary

22. Life settlements work like _____ with a few important exceptions.
    A. annuities
    B. dividends
    C. viatical settlements
    D. liability insurance

23. As with a viatical settlement, money received as part of a life settlement may be used by the viator _____.
    A. only for medical expenses
    B. only for LTC expenses
    C. only in the state where the settlement was reached
    D. as he or she pleases

24. _____ represent the number of people who discontinue their coverage before their life insurance policy matures.
    A. Premiums
    B. Lapse rates
    C. Cash surrender values
    D. Accelerated death benefits

25. Competition from the early viatical companies helped push the insurance industry into offering "_____."
    A. permanent life insurance
    B. long-term care dividends
    C. accelerated death benefits
    D. stranger-originated life insurance

END OF EXAM

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(Use Pen or Pencil To Darken Correct Choice For Each Question)

1. (A) (B) (C) (D)	6. (A) (B) (C) (D)	11. (A) (B) (C) (D)	16. (A) (B) (C) (D)	21. (A) (B) (C) (D)
2. (A) (B) (C) (D)	7. (A) (B) (C) (D)	12. (A) (B) (C) (D)	17. (A) (B) (C) (D)	22. (A) (B) (C) (D)
3. (A) (B) (C) (D)	8. (A) (B) (C) (D)	13. (A) (B) (C) (D)	18. (A) (B) (C) (D)	23. (A) (B) (C) (D)
4. (A) (B) (C) (D)	9. (A) (B) (C) (D)	14. (A) (B) (C) (D)	19. (A) (B) (C) (D)	24. (A) (B) (C) (D)
5. (A) (B) (C) (D)	10. (A) (B) (C) (D)	15. (A) (B) (C) (D)	20. (A) (B) (C) (D)	25. (A) (B) (C) (D)

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