

ADVISORY WORK GROUP REPORT

SENATE CONCURRENT RESOLUTION 104

Options to Fund
Long-Term Care Benefits
February 1, 2013



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REPORT TO THE LEGISLATURE REQUIRED BY SCR 104 OF THE 2012 REGULAR SESSION

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As directed by **Senate Concurrent Resolution 104** (Appendix-1), the Louisiana Department of Insurance established an advisory work group to examine options, both existing and those that may become available, to allow an insured under a life insurance policy or contract holder of an annuity to fund long-term care benefits. The SCR 104 Advisory Work Group's charge was to study, examine, evaluate, and make recommendations and findings on the feasibility of combining life insurance and annuity benefits with long-term care benefits as a means to fund long-term care.

Membership

The SCR 104 Advisory Work Group was comprised of the following members:

- Robert Wooley, a Baton Rouge attorney who represents the life settlement industry, designee of the Commissioner of Insurance.
- Hugh Eley, assistant secretary, Office of Aging and Adult Services of the Department of Health and Hospitals (DHH), designee of the secretary of the DHH.
- Joseph Donchess, executive director of the Louisiana Nursing Home Association.
- John Lancaster, president of Baton Rouge-headquartered Guaranty Income Life Insurance Company, designee of the executive director of the Louisiana Insurers' Conference.
- Miriam Krol, vice president, long-term care, American Council of Life Insurers (ACLI), designee of the ACLI; Bob Glowacki, vice president of Transamerica, attended as Ms. Krol's designee.
- Beverly Armstead, designee of the executive director of the Governor's Office of Elderly Affairs.
- Scott Berlin, senior vice president of New York Life Insurance Company, selected by the top ten writers of insurance, annuities and long-term care insurance in Louisiana.
- Danny Ford, lobbyist for the National Association of Insurance and Financial Advisors of Louisiana (NAIFA-LA) and owner of Gulf South Strategic Media LLC, designee of NAIFA-LA's executive director.

The Commissioner of Insurance designated John Lancaster the chairperson of the SCR 104 Advisory Work Group.

Background

An aging population of baby boomers who began reaching 65 on January 1, 2011, presents the potential for enormous burdens on the Medicaid system that currently provides substantial last resort funding for both facility and community based long-term care. The charge of this committee is to explore the feasibility of utilizing life insurance and annuity benefits to supplement the state's expenditures for long-term care.

Because annuity benefits, by definition, are an income stream that individuals can spend however they see fit, including long-term care if needed, the Advisory Work Group concentrated its efforts on how life insurance benefits may be used to fund long-term care needs of life insurance policy owners.

Life insurance is an asset (resource) that the Medicaid applicant may otherwise lose entirely when seeking to qualify for Medicaid.

As of January 1, 2012, to qualify for Medicaid, the applicant must reduce his asset holdings to include his home (capped at value of \$525,000), his car (if used for employment, medical treatment or daily activities) and \$2,000 in cash or cash equivalents (including life insurance with a cash value), and his monthly income as an individual must be less than \$2,094. Life insurance that has no cash surrender value does not count against the insured's eligibility, but limits on income allowance may not allow policyholders to continue to pay the premium to keep the policy in force. Applicants may also retain up to \$10,000 in burial funds or equivalent insurance policies and remain eligible for Medicaid. (See Appendix-2 for Louisiana Medicaid Eligibility Guidelines.)

According to a U.S. Government Accountability Office study in 2007, the rate of surrender or lapse of life insurance policies among Medicaid applicants in order to reach Medicaid eligibility is 38 percent; however, this number is not exclusively attributable to applicants who need to receive long-term care.

In 2012, the average annual costs of long-term care were the following¹:

Type of Setting	National Average	Louisiana Average
Nursing Home Semi Private Room	\$ 81,030	\$ 53,655
Nursing Home Private Room	\$ 90,520	\$ 57,305
Assisted Living Facility	\$ 42,600	\$ 34,704
Home Health Aide (4 hrs/day; 5 days/week)	\$ 21,840	\$ 18,770

¹ MetLife Mature Market Institute, Market Survey of Long-Term Care Costs, 2012.
https://www.metlife.com/mmi/research/2012-market-survey-long-term-care-costs.html?WT.ac=PRO_Pro3_PopularContent_5-18491_T4297-MM-mmi&oc_id=PRO_Pro3_PopularContent_5-18491_T4297-MM-mmi#keyfindings

The 2012 national costs for nursing home care were 3.7 percent higher than the 2011 costs; DHH reported that Louisiana's increases in Medicaid costs in recent fiscal years result from increases in other areas. Between FY 2009 and FY 2012, Louisiana Medicaid payments for long-term care for elderly and persons with physical disabilities remained essentially flat. Current projections do estimate an increase in FY 2013.

Options Considered by the Advisory Work Group

1. Mandate that all life insurance policies be settled so that the settlement proceeds can be used to fund long-term care benefit needs.
2. Encourage broader use in the marketplace of Long-Term Care Partnership Policies.
3. Adopt statutes, similar to those passed in Indiana and Kansas, that utilize an agency within the Department of Health and Hospitals to coordinate the collateral assignment of benefits, so that persons owning life insurance policies who apply to Medicaid for long-term care benefits would make an irrevocable collateral assignment of the proceeds of their life insurance policy to the state. In turn, the state would continue paying the premium to keep the policy in force until the Medicaid recipient dies. Upon the death of the Medicaid recipient, the state would recoup its costs of providing Medicaid benefits and its costs of paying premium from the death benefit of the policy; any excess funds available from the policy would be paid to the Medicaid recipient's named beneficiaries. Laws in both states recognize the Medicaid eligibility guidelines, which permit each Medicaid recipient to hold assets in the amount of \$10,000 for the purpose of paying funeral and burial expenses. This report will refer to this option as the "public option."
4. Adopt a statutory framework that would regulate private sector settlement of life insurance policies whose business model is to purchase the irrevocable assignment of the proceeds of a life insurance policy by providing escrowed funds to pay ongoing expenses for long-term care, thus delaying eligibility for Medicaid. The report will refer to this as the "private option."
5. Consider legislation similar to the legislation under consideration by the Florida Accelerated Life Benefits Technical Advisory Workgroup, which proposes to include both the public option described in Option 3 above and the private option, as described in Option 4 above. (See Appendix-3 for Florida Workgroup's Proposed Legislation.)
6. Pursue an education initiative so that life insurance policyholders/owners have more information available regarding the alternatives to lapsing or surrendering their life insurance policies.
7. Authorize by law the Department of Health and Hospitals to provide, as part of the Medicaid application process for long-term care, written notice to Medicaid applicants of life insurance policy options, as provided by statute or rule.

Feasibility of Options Considered

1. The first option to require all life insurance policies to be settled so that the settlement proceeds can be used to fund long-term care benefit needs was immediately rejected for the following reasons:
 - a. Such a mandate is not necessary because the owner of any life insurance policy already has the right to settle his policy.
 - b. The new requirement may address needs of future aging populations, but it does not affect (and cannot affect) existing contracts or address the current and upcoming financial needs.
 - i. Insurance companies' reserves are based on the exposure created by their existing contract language. Statutorily imposing language or conditions that alter existing contracts will affect insurer solvency.
 - ii. Statutorily imposing language or conditions on existing contracts will likely face legal challenge.
 - c. Mandating the insertion of a settlement feature into life insurance policies could raise the cost of life insurance policies by an undetermined amount and make life insurance less affordable, causing an undetermined number of Louisianans to forego the purchase of life insurance and leave their families more financially at risk upon their demise.
2. The second option is in regard to the Long-Term Care Partnership Program. A Long-Term Care Partnership Program was established in 2009 in Louisiana. It operates under the direction of DHH in consultation with the Louisiana Department of Insurance. Under the Long-Term Care Partnership Program, individuals who purchase long-term care insurance policies that meet certain requirements specified in the federal law can apply for Medicaid under special rules for determining financial eligibility and estate recoveries. These special rules generally allow the individual to protect assets equal to the insurance benefits received from a Partnership Policy so that such assets will not be taken into account in determining financial eligibility for Medicaid and will not subsequently be subject to Medicaid liens and recoveries.

The Louisiana Department of Insurance reports that few Partnership Program policies exist and that more Partnership policies could be available, but some insurers have elected not to seek Partnership certification for long-term care policies issued prior to the establishment of the Long-Term Care Partnership Program.

DHH supports this option as this method has already been set up on a federal level for individuals to purchase long-term care insurance in a manner that helps them become Medicaid eligible without reducing their resources or offsetting their transfers.

The Long-Term Care Partnership Program is protective of the assets of individuals, but it provides limited relief from the impending Medicaid funding burdens as aging baby

boomers approach the demographic group that uses long-term care. (See Appendix-4 for LDI Bulletin 09-13.)

3. The third option is to pass legislation similar to the enactments in Indiana and Kansas to permit the state to become an assignee under a person's policy as it assumes the obligation of paying the premium. (See Appendix-5 for Indiana & Kansas Laws.) The Advisory Work Group considers this a viable option and offers it to the Louisiana legislature for consideration. The Advisory Work Group recommends that the legislature consider these factors in its deliberation of this public option:
 - a. Passage of the referred legislation occurred in Indiana in 2011 and in Kansas in 2012. Because the legislation in each state is new, implementation is a work in progress.
 - b. This solution offers the beneficiaries the potential for receiving part of the death benefit from the policy after the insured's death.
 - c. Current Louisiana law permits Medicaid to recover assets from estates to cover Medicaid costs. Under existing law, DHH will collect proceeds from a life insurance policy where the agency is aware of it and the proceeds are part of the estate.
 - d. This option would require some changes to DHH Medicaid Eligibility procedures to capture additional information and could require additional staff to process premium payments. It would work best if structured similarly to the current procedure Medicaid Eligibility applies to annuities, where the client provides proof that the state has been made the beneficiary of the annuity, a process provided for in the Deficit Reduction Act of 2005.
 - e. Without more information about the average cost of insurance, the average length of stay in a nursing home, or at what point the payout exceeds the cost if the policy does not go full term, it would be difficult to determine if the public system would be cost neutral to the state.
 - f. Collection of data by DHH to help determine these costs could not feasibly begin until late 2014, at which time DHH would have modified its applications and database systems.
4. The fourth option is to design a statutory and regulatory framework, similar to what governs the viatical settlement industry, to assure the protection of consumers who choose to settle their insurance policy in order to obtain a payment source for their long-term care. The Advisory Work Group recommends that the legislature consider these factors in its deliberations of the private option:
 - a. The statutory framework should impose the viatical settlement requirements of La. R.S. 22:1791 et seq., including adequate market conduct, pricing and reserving standards on those doing business as brokers of life insurance policies for the limited purpose of funding long-term care. Proper regulatory safeguards must be in place for protection of the interests of the consumer and the state. This shall require

that all marketing materials, including benefit projections, sales brochures, and sample contracts utilized by the viatical settlement provider, its brokers and agents, must be filed with and approved by the Louisiana Department of Insurance. Further, all pricing and valuation materials, including actuarial memoranda and pricing methodologies, must be filed with and approved by the Louisiana Department of Insurance. The Louisiana Department of Insurance shall conduct periodic market examinations and financial audits of each viatical settlement provider issuing viatical settlement contracts to provide long-term care benefits to a viator.

- b. When the personal resources are exhausted, Medicaid becomes the default payor for long-term care.
 - c. This option will work only if the eventual Medicaid recipient learns of this option prior to disposing of the asset in another manner.
 - d. This option enables Medicaid and Medicaid beneficiaries to capture maximum value for life insurance contracts.
5. The fifth option is to consider legislation, similar to the legislation under consideration by the Florida Accelerated Life Benefits Technical Workgroup, which proposes to include both the public option as described in Option 3 above and the private option described in Option 4 above. (See Appendix-3 Florida Workgroup's Proposed Legislation.) The Advisory Work Group believes that the Florida proposal represents an appropriate balance of the public and the private options.
6. The sixth option is an education initiative. Generally, life insurance policyholders lack awareness of the alternatives that may exist in lieu of lapsing or surrendering a life insurance policy. To supplement private marketing efforts, the legislature could direct education initiatives by state government.
7. The seventh option is to authorize DHH to provide written notice to Medicaid applicants of their options regarding settling their life insurance policies. The Advisory Work Group recommends that the legislature consider these factors in its deliberations of requiring this disclosure by DHH:
 - a. A requirement for DHH to provide written notice regarding the settlement of life insurance policies should be limited to Medicaid applicants in need of long-term care. This is a more targeted approach than the NCOIL Life Insurance Consumer Disclosure Model Law, which would require regulated entities to provide the notice to certain policyholders. (See Appendix-6 NCOIL Model on Disclosures.) The contents of this required disclosure should be standard for all such applicants and limited to what is determined by law or rule.
 - b. Medicaid shortfalls can be reduced if more people utilized their life insurance assets for long-term care and delayed or eliminated their reliance on Medicaid.

Summary Statement of SCR 104 Advisory Work Group

With the baby boomers entering retirement age, the expectation is that there is a large population segment financially unprepared to fund their declining years. This lack of preparation will be costly to the state as the number of long-term care Medicaid beneficiaries grows and becomes a larger burden to state budgets. Availability of Medicaid for long-term care may be a factor in low consumer interest in purchasing long-term care insurance products. Mandating the use of life insurance death benefits as a funding mechanism for long-term care benefits in Louisiana may negatively influence younger consumers' interest and ability in buying life insurance products, whose price will increase to accommodate the new mandated benefit. At the same time, such a mandate would do nothing to relieve Medicaid budget woes, as those aging into a need for long-term care are unlikely to be purchasers of new life insurance policies containing this benefit, since it would be especially costly for them.

The Advisory Work Group is encouraged by the current draft of Florida's proposed legislation and believes that it may represent an appropriate balance between the public and private options discussed in this report.

The Advisory Work Group commends the Legislature for its interest in the important public policy area of preparing both the state and its citizens for what lies ahead, in terms of the fiscal effects to the state and individuals' need to cope with the burdens of aging. The SCR 104 Advisory Work Group hopes that the insights provided will be of some assistance as this public policy debate advances.

Appendices

Appendix 1: SCR 104 of the 2012 Regular Session

Appendix 2: Louisiana Medicaid Eligibility Guidelines

Appendix 3: Florida Workgroup's Proposed Legislation

Appendix 4: LDI Bulletin 09-13

Appendix 5: Indiana and Kansas Laws

Appendix 6: NCOIL Model on Disclosures

Appendix 1: SCR 104 of the 2012 Legislative Session

Regular Session, 2012

ENROLLED

SENATE CONCURRENT RESOLUTION NO. 104

(Substitute of SCR No. 66 by
Senator Buffington)

BY SENATOR BUFFINGTON

A CONCURRENT RESOLUTION

To establish an advisory work group within the Department of Insurance to examine options that may be available to allow an insured under a life insurance policy or contract holder of an annuity to fund long-term care benefits.

WHEREAS, a need exists to fund long-term care benefits; and

WHEREAS, a study is necessary to determine the options available today and those that may be available in the future to combine life insurance and annuity benefits with long-term care benefits for the purpose of addressing the long-term care needs of the insured and contract holder; and

WHEREAS, the study of those issues is best undertaken by an advisory work group within the Department of Insurance, with the assistance of the Department of Health and Hospitals and others knowledgeable in the subject matter areas associated with those issues; and

WHEREAS, the advisory work group shall study, examine, evaluate, and make recommendations and findings on the feasibility of combining life insurance and annuity benefits with long-term care benefits as a means to fund long-term care.

THEREFORE, BE IT RESOLVED that the Legislature of Louisiana does hereby establish the advisory work group within the Department of Insurance to examine options that may be available to allow an insured under a life insurance policy or contract holder of an annuity to fund long-term care benefits.

BE IT FURTHER RESOLVED that the membership on the advisory work group shall consist of the following:

- (1) The commissioner of the Department of Insurance, or his designee.
- (2) The secretary of the Department of Health and Hospitals, or his designee.

(3) The executive director of the Louisiana Nursing Home Association, or his designee.

(4) The executive director of the Louisiana Insurers' Conference, or his designee.

(5) A representative of the American Council of Life Insurers, selected by the council members, or such person's designee.

(6) The executive director of the office of elderly affairs in the office of the governor, or his designee.

(7) A company representative from one of the ten top writers of insurance, annuities, and long-term care benefits in the state of Louisiana selected by such writers.

(8) The executive director of the National Association of Insurance and Financial Advisors of Louisiana, or his designee.

BE IT FURTHER RESOLVED that the names of the members of the advisory work group shall be submitted to the commissioner of the Department of Insurance no later than September 1, 2012.

BE IT FURTHER RESOLVED that the commissioner of the Department of Insurance shall convene the first meeting of the advisory work group no later than September 15, 2012.

BE IT FURTHER RESOLVED that the commissioner of the Department of Insurance shall designate the chairperson of the advisory work group from the membership of the working group.

BE IT FURTHER RESOLVED that the advisory work group shall provide for the manner and frequency of its meetings at its first meeting, and it shall be staffed by the Department of Insurance.

BE IT FURTHER RESOLVED that the advisory work group shall meet as necessary and shall report its findings to the legislature no later than February 1, 2013.

BE IT FURTHER RESOLVED that the advisory work group shall terminate upon the date of submission of its report or February 1, 2013, whichever occurs first.

BE IT FURTHER RESOLVED that a copy of this Resolution be transmitted to the commissioner of the Department of Insurance, the secretary of the Department of Health and Hospitals, the executive director of the Louisiana Nursing Home Association, the executive

SCR NO. 104

ENROLLED

director of the Louisiana Insurers' Conference, and the executive director of the office of elderly affairs in the office of the governor.

PRESIDENT OF THE SENATE

SPEAKER OF THE HOUSE OF REPRESENTATIVES

Effective 01-01-2012 SUBJECT TO CHANGE AS PER CHANGES IN POLICY, LAWS OR FEDERAL REGULATIONS

LOUISIANA MEDICAID GUIDELINES FOR LONG TERM CARE PAYMENT

Individual must meet the following eligibility factors:

- is a resident of Louisiana
- is a U.S. Citizen or Qualified alien
- has or will apply for an SSN
- has countable monthly income below the LTC Special Income Limit or “SIL” (3 times the monthly Supplemental Security Income (SSI) benefit rate
- has countable resources of less than \$2000
- meets one of the following conditions:
 - pregnant, or
 - under age 18, or
 - at least age 65, or
 - blind (vision 20/200 or less), or
 - disabled as established by receipt of Social Security disability benefits or a BHSF Medical Eligibility Team Decision.

If all of these requirements are met the OAAS Office of Aging and Adult Services evaluates functional and medical data provided by the applicant and/or medical professionals to determine if the individual meets the level of care for long term care services. This includes nursing homes and home and community-based services. In the case of nursing home admissions, in some situations, additional information is reviewed by the Office of Behavioral Health or the Office for Citizens with Development Disabilities to ensure that the placement is appropriate for the diagnosis.

INCOME ELIGIBILITY

- 1) An individual is categorically eligible if their monthly countable income is below the individual SIL (\$2,094 as of 1-1-2012) and his/her resources are \$2,000 or less. For a couple (both spouses seeking nursing home care), their combined income is compared to the couple SIL (\$4,188). Resources are compared to the couple resource limit of \$3,000. If ineligible as a couple, eligibility is considered for each individually using the individual limits. (See spousal impoverishment provisions’ section if there is a community spouse.)
- 1) If an individual is ineligible solely because his countable income is over the SIL, he/she may be considered under the Medically Needy Program. Under MNP, his income must be less than the Medicaid rate for that particular facility, or the individual may be certified on a month by month basis if the individual’s monthly income is over the Medicaid facility rate but below the monthly MNIES (\$100 urban, \$92 rural) after subtracting the Medicaid facility fee, any ongoing monthly medical expenses (i.e., Medicare Part B premium) or any nonrecurring medical expenses (i.e., prescriptions that are not paid by any medical plans).

Effective August 1, 1997 service limits apply to MNP. The following services are no longer covered services under the MNP program: dental or dentures, alcohol and substance abuse clinic, mental health clinic, home and community based services, home health (nurse aide and physical therapy), case management, mental health rehabilitation, psychiatric inpatient hospital for persons under age 22, sexually transmitted diseases, and tuberculosis clinic.

RESOURCE/ASSETS ELIGIBILITY AND DESCRIPTION

Resources/assets include items such as cash, funds in checking and savings accounts, investments (mutual funds, CD's stocks, bonds, etc.) life insurance, real estate and personal belongings. Resources/assets are counted as of the first moment of the first day of the month. Outstanding checks do not reduce the amount of available funds reported by the financial institution.

Items that may be exempt from countable resources in the eligibility determination process under certain conditions:

Home property may be exempt, up to \$525,000, if the individual is keeping his home available should his condition permit him to return home, or if his spouse and/or dependents live in it.

One vehicle per household, regardless of its value, if used for employment, medical treatment or daily activities.

Fully paid burial spaces for individual and immediate family members.

Life insurance which has no cash surrender value.

Cash surrender value of all life insurance policies whose total face value does not exceed \$10,000 (this limit is for certain groups including LTC and Medicare Savings Programs).

Up to \$10,000 (for LTC and Medicare Savings Programs) in burial funds. First, the face value of the two above excluded types of insurance policies are applied to the \$10,000 (for LTC and Medicare Savings Programs) burial exclusion. If the \$10,000 (for LTC and Medicare Savings Programs) maximum has not yet been reached, then any other irrevocable burial arrangements are used to reach the \$10,000 (for LTC and Medicare Savings Programs) limit before allowing other funds to be set aside and designated for burial.

NOTE: In order for a pre-need funeral contract to be excluded as a countable resource, it must be an irrevocable contract and include an itemized list of services commensurate with the value of the pre-payment. For a burial contract funded by life insurance to be considered an excluded resource for Medicaid eligibility purposes, the owner must have signed an amendment irrevocably waiving his/her rights under the policy to surrender the policy for cash, to obtain a loan against the policy and to change the ownership.

LOOK BACK RULE

Transfers of resources for less than fair market value must be examined if they occurred within the 60 months before application or at any time after the application. The look back period is 60 months for transfers which occur on or after 2-8-2006.

For transfers occurring on or after 8-10-93 thru 2-7-06, the look back period is 36 months preceding the date of Medicaid application (60 months for trust situations). For transfers occurring on or after 2-8-06 the look back period is 60 months from the date an individual applies and is determined eligible except for the transfer. Any transfer after application must also be examined. If it is determined that resources were transferred for less than fair market value, the applicant is ineligible for vendor payment to the nursing facility for a specified period. The uncompensated value of the item transferred or donated determines how long Medicaid won't pay the nursing home fee. The period the restricted coverage is determined by dividing the uncompensated value by the average private cost of nursing home care at the time of application. For applications on or after 11-1-07, the average private pay cost used is \$4,000. Example: $\$60,000/\$4000 = 15$ months; $\$300,000/\$4,000 = 75$ months or 6.25 years). For transfers occurring on or after 8-10-93 thru 2-7-06 the penalty period begins with the month of transfer. For transfers occurring on or after 2-8-06 the penalty period begins when an individual applies for benefits and is found eligible except for the transfer.

SPOUSAL IMPOVERISHMENT RULES

NOTE: APPLIES ONLY TO INSTITUTIONALIZED INDIVIDUALS WHO HAVE A COMMUNITY SPOUSE (SPOUSE LIVING AT HOME IN THE COMMUNITY)

Spousal impoverishment provisions allow individuals residing in medical institutions for a continuous period of institutionalization (at least 30 consecutive days), to allocate resources to a legal community spouse in the eligibility determination process. For individuals institutionalized 1-1-2010 or later, the spouse at home can retain resources up to \$ 113,640.00 (1-1-2012 Spousal Resource Standard). All resources owned separately by either spouse and all resources owned jointly by the couple are considered in determining countable couple assets. The individual in the nursing home may retain up to \$2,000 in resources. If the total countable resources exceeds \$115,640.00 (\$113,640 + \$2,000) the individual is ineligible. If the total countable resources are below that amount then the couple has to sign an agreement to transfer allocated resources to the spouse at home before the first renewal of eligibility.

Whereas, resources can be allocated to establish eligibility under the spousal impoverishment provisions, income cannot. The spousal impoverishment income provisions apply only in the post eligibility determination of cost of care (see Patient Liability Section). Beginning 1-1-2010 income of the institutionalized individual can be allocated to the spouse at home subject to the maximum of \$2,841. The community spouse's own income is first applied to the maximum needs limit. The institutionalized spouse can only contribute enough of his /her income to bring his/her community spouse's income up to the \$2,841 limit (assuming that much income exists).

PATIENT LIABILITY

Once an individual is determined eligible for Medicaid long term care services, a post eligibility computation is done to determine the amount the individual must contribute from his income toward his cost of care. The only deductions allowed from the Medicaid recipient's income are: \$38 per month for personal care needs, any medical/health insurance premiums and any spouse/dependent maintenance needs. All remaining income must be contributed toward the cost of care at the facility. This remaining income is referred to as the patient liability (PLI). If the patient liability is less than the facility fee, Medicaid will make a vendor payment to the facility for the balance of the facility fee at the approved Medicaid reimbursement rate and the individual is eligible for the full range of Medicaid long term care services.

If the patient liability is equal to or greater than the facility fee, Medicaid will not make a vendor payment. The individual is fully liable for the facility fee, but is eligible for all other Medicaid long term care services.

ESTATE RECOVERY

Mandated by the Omnibus Reconciliation Act of 1993 (Section 13612 (a)) which amended Section 1917 (b) of the Social Security Act (42 U.S.C. 13960) requires that states seek recovery of Medicaid payments for certain services.

Act 1190 of the 1995 Regular Session of the Louisiana Legislature, provides for an estate recovery program whereby the Department of Health and Hospitals, Bureau of Health Services Financing shall seek recovery from a Medicaid recipient's estate for the total amount of Medicaid payments to the providers of nursing facility services, home and community based services and related hospital and prescription drug services made on behalf of recipients age 55 or older when these services were received.

MEDICARE SAVINGS PROGRAMS

NOTE: Individuals do not have to be institutionalized to be eligible for the following programs.

For Medicare beneficiaries whose monthly income is at or below \$931 (\$1,260 for a couple) and whose resources are below \$6,940 for an individual and \$10,410 for a couple as of 4-1-12 under the Qualified Medicare Beneficiary (QMB) Program, Medicaid will pay the Medicare Part A and Part B premiums and deductibles and may provide the coinsurance for other Medicare-covered services if the medical services provider accepts the individual as a Medicaid patient.

For Medicare beneficiaries who meet QMB resource requirements, but whose income is slightly higher, up to or below \$ 1,117 for an individual (\$1,513 for a couple) as of 4-1-12, under the Specified Low-Income Medicare Beneficiary (SLMB) program, Medicaid will pay only the Medicare Part B premium.

Appendix 3: Florida Workgroup's Proposed Legislation

An act relating to the Medicaid eligibility and life insurance policies

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 409.90255, Florida Statutes, is created to read:

409.90255 – Life insurance asset. –

(1) ELIGIBILITY -- The department, in determining eligibility for Medicaid, is authorized to treat life insurance owned by an applicant as follows:

(a) The value of a life insurance policy that is in force and owned by an applicant or a recipient who meets the state's nursing home level of care shall not be considered as a resource or asset in determining the applicant's or recipient's eligibility for Medicaid if the applicant or recipient makes an irrevocable election to name the state as a beneficiary of the life insurance policy for an amount that is not greater than the amount of Medicaid benefits provided to the recipient plus any premiums or other costs incurred by the agency to the insurer that issued the life insurance policy, or collaterally assigns the life insurance policy to the state under a written agreement submitted to and recorded by the issuing company of the life insurance policy, or irrevocably assigns the ownership of the policy to the state.

(b) No Medicaid benefits may be authorized or provided until the designation of the state as an irrevocable beneficiary or the collateral assignment in favor of the state or written acknowledgement of irrevocable assignment by the insurer is completed and accepted by the department as part of the application process.

(c) Any designation of the state as an irrevocable beneficiary or any collateral assignment or an irrevocable assignment in favor of the state is void if the application for Medicaid benefits is not approved.

(2) To the extent allowed by federal law, the agency may use federal or state funds under the Medicaid program to pay premiums plus any other costs related to an in force life insurance policy that is owned by an applicant or a recipient who:

(a) meets the state's nursing home level of care;

(b) has made an irrevocable election to name the state as a beneficiary of the life insurance policy for an amount that is not greater than the amount of Medicaid benefits provided to the recipient and the premiums or expenses paid by the agency to the insurer that issued the life insurance policy; or

(c) collaterally assigned the life insurance policy to the state under a written agreement submitted to and recorded by the issuing company of the life insurance policy

(3) Any life insurance policy that is in force and under which the state is named as an irrevocable beneficiary or that has been collaterally assigned to the state may not be sold, assigned, or the ownership transferred to any person or entity. This restriction exists as long as the policy names the state as an irrevocable beneficiary or as long as the policy is collaterally assigned to the state.

(4) Upon the death of the insured who is the subject of the policy, proceeds that exceed the amount of Medicaid benefits provided to a recipient plus premiums and other costs incurred by the agency shall be paid to a beneficiary named by the applicant or recipient.

(5) LONG-TERM CARE; LIFE POLICY TRANSFER—The owner of a life insurance policy with any face amount in excess of \$10,000, may enter into a viatical settlement contract pursuant to Part X of Chapter 626, Florida Statutes in exchange for guaranteed periodic payments to the Florida Medicaid program, which payments shall be used solely to provide Medicaid covered long-term care services at the effective date of the contract, for the viator, only when the viatical settlement contract complies with the requirements of Part X, Chapter 626, Florida Statutes. The contract must contain the following:

(a) The lesser of five percent (5%) of the face amount of the life insurance or \$5,000 is reserved as death benefit payable to the viator's estate or beneficiary;

(b) The balance of payments required under the contract unpaid at the death of the viator must be paid to the viator's estate or a named beneficiary;

(c) A schedule evidencing the total amount payable to the viator, the number of payments and the amount of each payment required to be paid under the contract; and

(d) All proceeds must be held in an irrevocable state or federally insured account.

(6) For purposes of this section only, all marketing materials, including benefit projections, sales brochures, and contracts, utilized by the viatical settlement provider and its brokers, must be filed with and approved by the Office of Insurance Regulation; further, all pricing and valuation materials, including actuarial memoranda and pricing methodologies, must be filed with and approved by the Office of Insurance Regulation.

(7) The Office of Insurance Regulation shall conduct periodic market examinations and financial audits of each viatical settlement provider issuing viatical settlement contracts to provide long-term care benefits to a viator.

(8) The Department of Children & Family Services must provide, as part of the application for Medicaid, written notice of the life insurance policy options provided in subsections (5) a through d of this section.

(9) The Office of Insurance Regulation, The Department of Children & Family Services and the Agency for Health Care Administration are authorized to promulgate jurisdictionally appropriate rules to implement this act.

(10) The agency is instructed to seek any state plan amendments or federal waivers that may be required to implement this act.

(11) As used in this section, "value" includes: The face value of a life insurance policy; the cash value of a life insurance policy; and the value received pursuant to subsection (5) of this section.

Section 2. This act shall take effect upon becoming law.



LOUISIANA DEPARTMENT OF INSURANCE

JAMES J. DONELON
COMMISSIONER**BULLETIN NO. 09-13**

TO: ALL INSURERS AND PRODUCERS TRANSACTING LONG-TERM CARE BUSINESS IN THE STATE OF LOUISIANA

FROM: JAMES J. DONELON, COMMISSIONER OF INSURANCE

RE: IMPLEMENTATION OF THE LOUISIANA LONG-TERM CARE PARTNERSHIP PROGRAM IN LOUISIANA

DATE: DECEMBER 28, 2009

The purpose of Bulletin No. 09-13 is to provide guidance regarding the implementation of the Louisiana Long-Term Care Insurance Partnership Program (hereinafter sometimes the Partnership Program).

Background and Purpose

The Partnership Program operates under the direction of the Louisiana Department of Health and Hospitals in consultation with the Louisiana Department of Insurance, and Bulletin No. 09-13 is a collaboration of and is jointly issued by both departments. Federal enabling legislation pertaining to the Partnership Program is set forth in the Deficit Reduction Act of 2005, Pub. L. 109-171 (DRA), and implementing procedures are described in guidance issued by the Centers for Medicare and Medicaid Services (CMS). See State Medicaid Director's Letter (SMDL #06-019) dated July 27, 2006, issued by CMS.

Under the Louisiana Long-Term Care Partnership Program, individuals who purchase long-term care insurance policies that meet certain requirements specified by the DRA (Partnership Policies) can apply for Medicaid under special rules for determining financial eligibility and estate recoveries. In the case of group insurance, each certificate that meets the DRA's requirements constitutes a Partnership Policy. These special rules generally allow the individual to protect assets equal to the insurance benefits received from a Partnership Policy so that such assets will not be taken into account in determining financial eligibility for Medicaid and will not subsequently be subject to Medicaid liens and recoveries.

The Louisiana Long-Term Care Partnership Program is effective October 1, 2009.

A. Asset Protection Provided.

Under the Louisiana Long-Term Care Partnership Program, the asset eligibility, adjustment, and recovery provisions of the Louisiana Medicaid plan are applied by disregarding an amount of assets, above and beyond the asset disregard or allowance otherwise provided under the Medicaid plan, equal to the amount of insurance benefits received from a Partnership Policy. This disregard of assets is referred to herein as the Asset Disregard.

The Asset Disregard applies to all insurance benefits received from a Partnership Policy. Thus, for example, the Asset Disregard applies to insurance benefits paid on a reimbursement, cash benefit basis, indemnity insurance basis, or on a "per diem or other periodic basis without regard to the expenses incurred during the period to which the payments relate" (within the meaning of section 7702B(b)(2)(A) of the Internal Revenue Code of 1986 (26 U.S.C. 7702B(b)(2)(A))). Similarly, the Asset Disregard applies to all insurance benefits received from a Partnership Policy regardless of whether such insurance benefits are in respect of costs for long-term care that would not be covered by Medicaid. The Asset Disregard as of any date equals the insurance benefits that have been received to that date from a Partnership Policy, even if additional insurance benefits may be received in the future from such Partnership Policy.

If a policy is received after the effective date of the Louisiana Long-Term Care Partnership Program in exchange for a policy issued before such date and the new policy qualifies as a Partnership Policy, the Asset Disregard will apply only with respect to insurance benefits received under such new Partnership Policy and thus will not include insurance benefits, if any, received under the predecessor policy.

Partnership Policies that cover more than one insured are treated as separate Partnership Policies, each of which covers a single insured. With respect to each such insured, the Asset Disregard equals the insurance benefits received from the Partnership Policy on account of such insured having become a chronically ill individual (within the meaning of section 7702B(c)(2) of the Internal Revenue Code of 1986 (26 U.S.C. 7702B(c)(2))).

The Asset Disregard does not include return of premium payments made upon the termination of a Partnership Policy because of cancellation or death since such payments do not represent insurance benefits.

Eligibility for benefits under Medicaid is subject to other eligibility requirements, such as applicable income limitations and home equity limitations.

B. Partnership Policies.

A Partnership Policy is a long-term care insurance policy (including a certificate issued under a group insurance contract) that satisfies all of the following requirements:

1. Qualified under Federal tax law.

The policy must be a qualified long-term care insurance contract as defined in section 7702B(b) of the Internal Revenue Code of 1986 (26 U.S.C. 7702B(b)). Thus, a qualified long-term care insurance contract that provides insurance benefits on a reimbursement, cash benefit basis, indemnity insurance basis, or on a "per diem or other periodic basis without regard to the expenses incurred during the period to which the payments relate," within the meaning of section 7702B(b)(2)(A) of the Internal Revenue Code of 1986 (26 U.S.C. 7702B(b)(2)(A)), will be a Partnership Policy if it satisfies the DRA's other requirements applicable to Partnership Policies, as described herein. Similarly, a long-term care insurance rider or other provision of an insurance contract (such as a rider to a life insurance contract or, after December 31, 2009, a rider to an annuity contract) that constitutes a qualified long-term care insurance contract under section 7702B(e) of the Internal Revenue Code of 1986 (26 U.S.C. 7702B(e)) will be a Partnership Policy if it satisfies the DRA's other requirements applicable to Partnership Policies, as described herein.

2. Issue date.

The policy must not be issued earlier than the effective date of the Louisiana Long-Term Care Partnership Program. The issue date is the effective date of coverage under the policy. Thus, for example, in the case of a certificate issued under a group insurance contract, the effective date of coverage with respect to such certificate is the issue date of the certificate.

A policy received in an exchange after the effective date of the Louisiana Long-Term Care Partnership Program is treated as newly issued and thus is eligible for Partnership Policy status. For purposes of applying the Medicaid rules relating to the Partnership Program, the addition of a rider, endorsement, or change in schedule page for a policy may be treated as giving rise to an exchange.

3. State of residence.

The policy must cover an insured who was a resident of the State when coverage first became effective under the policy. In the case of an

exchange, this requirement shall be applied based on the coverage of the first long-term care insurance policy that was exchanged.

A certificate covering an insured who is a resident of Louisiana may qualify as a Partnership Policy even if the situs of the group insurance contract under which such certificate is issued is in another State.

4. Consumer protection requirements.

The Federal consumer protection ~~requirements~~ of section 1917(b)(1)(C)(iii)(III) of the Social Security Act (42 U.S.C. 1396p(b)(1)(C)(iii)(III)) must be met with respect to the policy. (See also the certification process with respect to this requirement described in C below.)

5. Inflation protection.

With respect to inflation protection, if the policy is sold to an individual who:

- (a) has not attained age 61 as of the date of purchase, the policy must provide compound annual inflation protection;
- (b) has attained age 61 but has not attained age 76 as of the date of purchase, the policy must provide some level of inflation protection; and
- (c) has attained age 76 as of the date of purchase, the policy may (but is not required to) provide some level of inflation protection.

In each of these three situations, no particular rate for inflation protection is required. Thus, inflation protection increases include but are not limited to increases at a rate less than five percent or at a rate determined by an index-based formula.

For purposes of applying this inflation requirement, the date of purchase means the effective date of coverage under the policy. Thus, for example, the date of purchase of a certificate issued under a group insurance contract means the effective date of coverage under such certificate. In the case of an exchange, the date of purchase is the effective date of coverage under the new policy, *i.e.*, the determination is made without regard to any predecessor policy. If the insured and the policyholder or certificate holder under a policy are different, the insured should be considered the individual to whom a policy is sold for purposes of applying the inflation protection requirements.

C. Certification Process.

Pursuant to section 1917(b)(5)(B)(iii) of the Social Security Act (42 U.S.C. 1396p(b)(5)(B)(iii)), a long-term care insurance policy shall be deemed to meet the consumer protection requirements of section 1917(b)(1)(C)(iii)(III) of the Social Security Act (42 U.S.C. 1396p(b)(1)(C)(iii)(III)) if the plan amendment provides that the Louisiana Commissioner of Insurance certifies, in a manner satisfactory to the Secretary of the U.S. Department of Health & Human Services (Secretary), that the policy meets such requirements. In addition, the State Medicaid Director's Letter (SMDL #06-019) dated July 27, 2006, issued by CMS, provides that the Louisiana Commissioner of Insurance must certify that a policy meets these consumer protection requirements in order for a policy to be a Partnership Policy.

In accordance with the safe harbor procedure specified in section 1917(b)(5)(B)(iii) of the Social Security Act (42 U.S.C. 1396p(b)(5)(B)(iii)), and subject to any guidance from the Secretary that may be issued providing otherwise, policies shall be considered certified pursuant to section 1917(b)(5)(B)(iii) of the Social Security Act (42 U.S.C. 1396p(b)(5)(B)(iii)) and therefore will be deemed to meet such consumer protection requirements if the issuer: (i) identifies the policy forms on which such policies are issued, and (ii) certifies that the consumer protection requirements of section 1917(b)(1)(C)(iii)(III) of the Social Security Act (42 U.S.C. 1396p(b)(1)(C)(iii)(III)) are met by such policies. As appropriate, the Louisiana Commissioner of Insurance shall, in turn, certify to the Secretary the compliance of such policies with such consumer protection requirements using the State Certification Form attached as Attachment A. An issuer's identification and certification of policies must be made to the Louisiana Commissioner of Insurance using the Issuer Certification Form attached as Attachment B. Copies of the Louisiana Commissioner of Insurance's certifications will be provided to the Louisiana Department of Health and Hospitals.

Issuers requesting to make use of a previously approved policy form as a Partnership Policy shall submit to the Louisiana Commissioner of Insurance the Issuer Certification Form set forth in Attachment B. This form shall be required for each policy form submitted for partnership qualification.

An issuer and the Louisiana Commissioner of Insurance may submit supplemental Issuer Certification Forms and State Certification Forms, respectively, that identify additional policy forms on which policies are issued that satisfy the consumer protection requirements of section 1917(b)(1)(C)(iii)(III) of the Social Security Act (42 U.S.C. 1396p(b)(1)(C)(iii)(III)). Copies of the Louisiana Commissioner of Insurance's certifications to the Secretary shall be provided to the Louisiana Department of Health and Hospitals and to the issuer of the policies subject to such certification.

If there is a change made by the Secretary, pursuant to section 1917(b)(5)(C) of the Social Security Act (42 U.S.C. 1396p(b)(5)(C)), in the provisions of the National Association of Insurance Commissioners' Long-Term Care Insurance Model Act or Regulation that apply to new policies covered by Partnerships, appropriate modifications will be made to the Issuer Certification Form to reflect the new requirements.

D. Partnership Disclosure Requirements:

- **Notice of Partnership Program.**

An issuer or its producer, soliciting or offering to sell a policy that is intended to qualify as a Partnership Policy, shall provide to each prospective applicant a Partnership Program Notice, attached as Attachment C, outlining the requirements and benefits of a Partnership Policy. A similar notice may be used for this purpose if filed and approved by the Louisiana Commissioner of Insurance. The Partnership Program Notice shall be provided with the required Outline of Coverage.

- **Notice of Partnership Policy Status.**

A Partnership Policy issued or issued for delivery in Louisiana shall be accompanied by the Partnership Status Disclosure Notice, attached as Attachment D, explaining the benefits associated with a Partnership Policy and indicating that at the time issued, the policy is a Partnership Policy. A similar notice may be used if filed and approved by the Louisiana Commissioner of Insurance. In the case of a group insurance contract, such Notice must be provided to the insured under a certificate upon the issuance of the certificate. In determining whether to provide this Notice with respect to a policy, the issuer of the policy may rely upon a statement by the policyholder, certificate holder or insured that the insured is a resident of Louisiana.

E. Limitation on Partnership Policy Specific Rules.

In accordance with section 1917(b)(1)(C)(iii)(VII) of the Social Security Act (42 U.S.C. 1396p(b)(1)(C)(iii)(VII)), and apart from the requirements described in Paragraph B above that are specified by the DRA, no requirement affecting the terms or benefits of a Partnership Policy may be imposed unless such requirement is imposed on long-term care insurance policies without regard to whether the policy is a Partnership Policy. This limitation does not affect the state of Louisiana's ability to generally regulate the terms and sale of long-term care insurance policies where the state of Louisiana imposes requirements without regard to whether policies are Partnership Policies.

F. Reporting Requirements.

Pursuant to section 1917(b)(1)(C)(iii)(VI) and (v) of the Social Security Act (42 U.S.C. 1396p(b)(1)(C)(iii)(VI) and (v), respectively), issuers of Partnership Policies must provide regular reports to the Secretary in accordance with regulations of the Secretary. Issuers shall make such regular reports as directed by 45 CFR Part 144 (and as may be amended).

Partnership Policies that cover more than one insured are treated as separate Partnership Policies, each of which covers a single insured. Thus, the reporting requirements described herein apply with respect to each such separate Partnership Policy.

G. Coordination Between Departments.

The Louisiana Department of Health and Hospitals must provide information and technical assistance to the Louisiana Department of Insurance on the role of the Louisiana Department of Insurance to assure that any individual who sells a Partnership Policy receives training and demonstrates evidence of an understanding of such policies and how they relate to other public and private coverage of long-term care.

H. Reciprocity.

Pending the issuance of guidance by the Secretary pursuant to section 6021(b) of the DRA, the Louisiana Long-Term Care Partnership Program shall provide reciprocity with respect to long-term care insurance policies covered under other State long-term care insurance partnerships (*i.e.*, Partnerships and Medicaid plan amendments approved as of May 14, 1993, providing for a long-term care insurance partnership).

In furtherance of this reciprocity, the amount of the Asset Disregard provided with respect to a policy purchased under the State long-term care insurance partnership of another State shall equal the Asset Disregard that would apply to a Partnership Policy covered directly by the Louisiana Long-Term Care Partnership Program. Such reciprocity shall be provided to all States that maintain a State long-term care insurance partnership that provides similar reciprocity for Partnership Policies issued under the Louisiana Long-Term Care Partnership Program. The provision of reciprocity under the Louisiana Long-Term Care Partnership Program does not affect eligibility requirements for Medicaid benefits that apply apart from those pertaining to permissible assets and resources.

After the issuance of guidance by the Secretary pursuant to section 6021(b) of the DRA, the Louisiana Department of Health and Hospitals, if it elects to be exempt from such standards, shall notify the Secretary in writing of such election within the period of time prescribed under such guidance.

I. Federal Long-Term Care Insurance Program

It is recognized that the enabling law for the creation of the Federal Long-Term Care Insurance Program (FLTCIP) set forth at 5 U.S.C. 9001-9009 provides for the preemption of state laws with respect to this program.

Therefore, where the Director of the U.S. Office of Personnel Management has certified that a certificate issued pursuant to the FLTCIP meets the requirements of section 1917(b)(1)(C)(iii) of the Social Security Act (42 U.S.C. 1396p(b)(1)(C)(iii)), such certificate shall be deemed to qualify for the Asset Disregard.

J. Producer Training

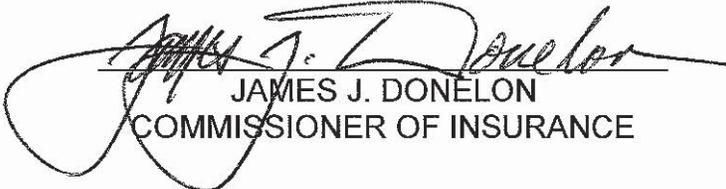
The DRA and the State Medicaid Director's Letter (SMDL #06-019) dated July 27, 2006, issued by CMS, require the Louisiana Commissioner of Insurance to provide assurance that any insurance producer who sells, solicits or negotiates "a policy under a Partnership receives training and demonstrates an understanding of Partnership policies and their relationship to public and private coverage to long-term care."

Issuers are to maintain records, subject to the state's record retention requirements, that verify that those insurance producers who sell, solicit or negotiate long-term care insurance products on their behalf have received the training required for Partnership Policies and that they demonstrate an understanding of the policies and their relationship to public and private long term care coverage.

For More Information, please contact:

Louisiana Department of Insurance
1702 N. 3rd Street
Baton Rouge, LA 70802
Telephone: (225) 342-1226
Website: www.lidi.state.la.us

Baton Rouge, Louisiana, this 28th day of December 2009.



JAMES J. DONELON
COMMISSIONER OF INSURANCE

Attachment A

STATE CERTIFICATION FORM

(relating to Qualified State Long-Term Care Insurance Partnership)

Under section 1917(b)(5)(B)(iii) of the Social Security Act (42 U.S.C. 1396p(b)(5)(B)(iii)), the State Insurance Commissioner of a State implementing a qualified State long-term care insurance partnership (Qualified Partnership) may certify that long-term care insurance policies (including certificates issued under a group insurance contract) covered under the Qualified Partnership meet certain consumer protection requirements, and policies so certified are deemed to satisfy such requirements. These consumer protection requirements are set forth in section 1917(b)(5)(A) of the Social Security Act (42 U.S.C. 1396p(b)(5)(A)) and principally include certain specified provisions of the Long-Term Care Insurance Model Regulation and Long-Term Care Insurance Model Act promulgated by the National Association of Insurance Commissioners (NAIC) (adopted as of October 2000 and referred to herein as the 2000 Model Regulation and 2000 Model Act respectively). These requirements apply to policies covered under a Qualified Partnership even if the State has not adopted all of such requirements with respect to its regulation of long-term care insurance.

This State Certification Form should be used by the State Insurance Commissioner to provide the certification under section 1917(b)(5)(B)(iii) of the Social Security Act. In providing this certification, the State Insurance Commissioner may reasonably rely upon the certification of issuers of the policies that is made in accordance with the Issuer Certification Form (see Attachment B). The Issuer Certification Form is not intended, however, to preclude the State Insurance Commissioner from requesting such further information from issuers of policies as the State Insurance Commissioner determines may be needed in order to reach a determination that such policies are in compliance with the provisions of the 2000 Model Regulation and 2000 Model Act that are applicable under section 1917(b)(5)(A) of the Social Security Act.

A State Insurance Commissioner may supplement its certification from time to time to include new policies that are certified.

I. POLICY FORMS COVERED BY CERTIFICATION

The policies to which this certification applies are those issued on the policy forms identified on the attached Exhibit 1 that are intended to be covered by the Qualified Partnership. Once a certification is issued with respect to a policy form under this State Certification Form, such certification will continue to apply to policies issued on such form that are intended to be covered by the Qualified Partnership until such time that: (a) the State Insurance Commissioner revokes such certification, or (b) there is a change made by the U.S. Secretary of Health and Human Services (Secretary), pursuant to section 1917(b)(5)(C) of the Social

Security Act (42 U.S.C. 1396p(b)(5)(C)), in the provisions of the NAIC's long-term care insurance models that apply to policies covered by the Qualified Partnership.

Any such change in requirements made pursuant to section 1917(b)(5)(C) of the Social Security Act (42 U.S.C. 1396p(b)(5)(C)) shall apply prospectively only (or in accordance with any effective date rule promulgated by the Secretary in connection with such change), so that policies issued prior to such change will be unaffected, *i.e.*, they will continue to be deemed to satisfy the requirements of section 1917(b)(5)(A) of the Social Security Act. For example, if a new requirement is imposed under section 1917(b)(5)(C) of the Social Security Act and the Secretary specifies that such change will apply to policies issued after a certain date, then partnership policies issued on or prior to such date on policy forms covered by this State Certification Form will be treated as certified and will be unaffected by such new requirement. Also, if the policy form is covered by a new State Certification Form that reflects a change in the long-term care insurance model requirements and the new State Certification Form is made effective as of the effective date of such change, then partnership policies issued under such policy form after such date also will be treated as certified.

II. CERTIFICATION

I hereby certify that, to the best of my knowledge and belief, the partnership policies issued on the policy forms identified in Exhibit 1 to this State Certification Form comply with the requirements of section 1917(b)(5)(A) of the Social Security Act (42 U.S.C. 1396p(b)(5)(A)).

Date

Name of State Insurance Commissioner
(or authorized delegate)

Signature of State Insurance Commissioner
(or authorized delegate)

Attachment A: Exhibit 1

(to State Certification Form)

Issuer: _____

Policy forms covered by certification:

Issuer: _____

Policy forms covered by certification:

Issuer: _____

Policy forms covered by certification:

Issuer: _____

Policy forms covered by certification:

Issuer: _____

Policy forms covered by certification:

Issuer: _____

Policy forms covered by certification:

Attachment B

ISSUER CERTIFICATION FORM

(relating to Qualified State Long-Term Care Insurance Partnership)

Under section 1917(b)(5)(B)(iii) of the Social Security Act (42 U.S.C. 1396p(b)(5)(B)(iii)), the State Insurance Commissioner of a State implementing a qualified State long-term care insurance partnership (Qualified Partnership) may certify that long-term care insurance policies (including certificates issued under a group insurance contract) covered under the Qualified Partnership meet certain consumer protection requirements, and policies so certified are deemed to satisfy such requirements. These consumer protection requirements are set forth in section 1917(b)(5)(A) of the Social Security Act (42 U.S.C. 1396p(b)(5)(A)) and principally include certain specified provisions of the Long-Term Care Insurance Model Regulation and Long-Term Care Insurance Model Act promulgated by the National Association of Insurance Commissioners (adopted as of October 2000 and referred to herein as the 2000 Model Regulation and 2000 Model Act respectively).

In order to provide each State Insurance Commissioner with information necessary to provide a certification for policies, this Issuer Certification Form requests information and a certification from issuers of long-term care insurance policies with respect to policy forms that may be covered under the Qualified Partnership of the State.

An insurance company may request certification of policies from time to time and, accordingly, may supplement this issuer certification form, *e.g.*, as it introduces new long-term care insurance policy forms for issuance.

I. GENERAL INFORMATION

A. Name, address and telephone number of issuer:

B. Name, address, telephone number, and email address (if available) of an employee of issuer who will be the contact person for information relating to this form:

C. Policy form number(s) (or other identifying information, such as certificate series) for policies covered by this Issuer Certification Form:

Specimen copies of each of the above policy forms, including any riders and endorsements, shall be provided upon request.

II. QUESTIONS REGARDING APPLICABLE PROVISIONS OF THE 2000 MODEL REGULATION AND 2000 MODEL ACT

Please answer each of the questions below with respect to the policy forms identified in section I.C above. For purposes of answering the questions below, any provision of the 2000 Model Regulation or 2000 Model Act listed below shall be treated as including any other provision of the 2000 Model Regulation or 2000 Model Act necessary to implement the provision.

Are the following requirements of the 2000 Model Regulation met with respect to all policies (including certificates issued under a group insurance contract) intended to be covered under the Qualified Partnership that are issued on each of the policy forms identified in section I.C above?

- Yes ___ No ___ N/A ___ A. Section 6A (relating to guaranteed renewal or noncancellability), other than paragraph (5) thereof, and the requirements of section 6B of the 2000 Model Act relating to such section 6A.
- Yes ___ No ___ N/A ___ B. Section 6B (relating to prohibitions on limitations and exclusions) other than paragraph (7) thereof.
- Yes ___ No ___ N/A ___ C. Section 6C (relating to extension of benefits).
- Yes ___ No ___ N/A ___ D. Section 6D (relating to continuation or conversion of coverage).
- Yes ___ No ___ N/A ___ E. Section 6E (relating to discontinuance and replacement of policies).
- Yes ___ No ___ N/A ___ F. Section 7 (relating to unintentional lapse).
- Yes ___ No ___ N/A ___ G. Section 8 (relating to disclosure), other than sections 8F, 8G, 8H, and 8I thereof.
- Yes ___ No ___ N/A ___ H. Section 9 (relating to required disclosure of rating practices to consumer).
- Yes ___ No ___ N/A ___ I. Section 11 (relating to prohibitions against post-claims underwriting).
- Yes ___ No ___ N/A ___ J. Section 12 (relating to minimum standards).
- Yes ___ No ___ N/A ___ K. Section 14 (relating to application forms and replacement coverage).
- Yes ___ No ___ N/A ___ L. Section 15 (relating to reporting requirements).
- Yes ___ No ___ N/A ___ M. Section 22 (relating to filing requirements for marketing).
- Yes ___ No ___ N/A ___ N. Section 23 (relating to standards for marketing), including inaccurate completion of medical histories, other than paragraphs (1), (6), and (9) of section 23C.
- Yes ___ No ___ N/A ___ O. Section 24 (relating to suitability).
- Yes ___ No ___ N/A ___ P. Section 25 (relating to prohibition against preexisting conditions and probationary periods in replacement policies or certificates).

- Yes ___ No ___ N/A ___ Q. The provisions of section 26 relating to contingent nonforfeiture benefits, if the policyholder declines the offer of a nonforfeiture provision described in section 7702B(g)(4) of the Internal Revenue Code of 1986 (26 U.S.C. 7702B(g)(4)).
- Yes ___ No ___ N/A ___ R. Section 29 (relating to standard format outline of coverage).
- Yes ___ No ___ N/A ___ S. Section 30 (relating to requirement to deliver shopper's guide).

Are the following requirements of the 2000 Model Act met with respect to all policies (including certificates issued under a group insurance contract) intended to be covered under the Qualified Partnership that are issued on each of the policy forms identified in section I.C above?

- Yes ___ No ___ N/A ___ A. Section 6C (relating to preexisting conditions).
- Yes ___ No ___ N/A ___ B. Section 6D (relating to prior hospitalization).
- Yes ___ No ___ N/A ___ C. The provisions of section 8 relating to contingent nonforfeiture benefits.
- Yes ___ No ___ N/A ___ D. Section 6F (relating to right to return).
- Yes ___ No ___ N/A ___ E. Section 6G (relating to outline of coverage).
- Yes ___ No ___ N/A ___ F. Section 6H (relating to requirements for certificates under group plans).
- Yes ___ No ___ N/A ___ G. Section 6J (relating to policy summary).
- Yes ___ No ___ N/A ___ H. Section 6K (relating to monthly reports on accelerated death benefits).
- Yes ___ No ___ N/A ___ I. Section 7 (relating to incontestability period).

In order for a policy to be covered under the Qualified Partnership of the State, the answers to all questions above should be "yes" (or "N/A" where all requirements with respect to a provision above are not applicable). If answers differ between policy forms (*e.g.*, a requirement would be answered "Yes" for one form and "N/A" for another), you should use separate Issuer Certification Forms for such policies.

III. CERTIFICATIONS:

1. I hereby certify that the answers, accompanying documents, and other information set forth herein are, to the best of my knowledge and belief, true, correct, and complete.

Date

Name and Title of Officer of the Issuer

Signature of Officer of the Issuer

Attachment C

Partnership Program Notice Important Consumer Information Regarding the Louisiana Long-Term Care Insurance Partnership Program

Some long-term care insurance [policies] [certificates] sold in Louisiana may qualify for the Louisiana Long-Term Care Insurance Partnership Program (the Partnership Program). The Partnership Program is a partnership between state government and private insurance companies to assist individuals in planning their long-term care needs. Insurance companies voluntarily agree to participate in the Partnership Program by offering long-term care insurance coverage that meets certain State and Federal requirements. Long-term care insurance [policies] [certificates] that qualify as Partnership [Policies] [Certificates] may protect the [policyholder's] [certificate holder's] assets through a feature known as Asset Disregard under Louisiana's Medicaid program.

Asset Disregard means that an amount of the [policyholder's] [certificate holder's] assets equal to the amount of long-term care insurance benefits received under a qualified Partnership [Policy] [Certificate] will be disregarded for the purpose of determining the insured's eligibility for Medicaid. This generally allows a person to keep assets equal to the insurance benefits received under a qualified Partnership [Policy] [Certificate] without affecting the person's eligibility for Medicaid. All other Medicaid eligibility criteria will apply and special rules may apply to persons whose home equity exceeds [\$500,000]. Asset Disregard is not available under a long-term care insurance [policy] [certificate] that is not a Partnership [Policy] [Certificate]. Therefore, you should consider if Asset Disregard is important to you, and whether a Partnership Policy meets your needs. *The purchase of a Partnership [Policy] [Certificate] does not automatically qualify you for Medicaid.*

What are the Requirements for a Partnership [Policy] [Certificate]? In order for a [policy] [certificate] to qualify as a Partnership [Policy] [Certificate], it must, among other requirements:

- Be issued to an individual after October 1, 2009;
- Cover an individual who was a Louisiana resident when coverage first becomes effective under the [policy] [certificate];
- Be a tax-qualified [policy] [certificate] under Section 7702(B)(b) of the Internal Revenue Code of 1986;
- Meet stringent consumer protection standards; and
- Meet the following inflation requirements:
 - For ages 60 or younger - provides compound annual inflation protection
 - For ages 61 to 65 - provides some level of inflation protection
 - For ages 76 and older - no purchase of inflation protection is required

If you apply and are approved for long-term care insurance coverage, [carrier name] will provide you with written documentation as to whether or not your [policy] [certificate] qualifies as a Partnership [Policy] [Certificate].

What Could Disqualify a [Policy] [Certificate] as a Partnership [Policy] [Certificate]?

Certain types of changes to a Partnership [Policy] [Certificate] could affect whether or not such [policy] [certificate] continues to be a Partnership [Policy] [Certificate]. If you purchase a Partnership [Policy] [Certificate] and later decide to make *any* changes, you should first consult with [carrier name] to determine the effect of a proposed change. In addition, if you move to a state that does not maintain a Partnership Program or does not recognize your [policy] [certificate] as a Partnership [Policy] [Certificate], you would not receive beneficial treatment of your [policy] [certificate] under the Medicaid program of that state. The information contained in this disclosure is based on current Louisiana and Federal laws. These laws may be subject to change. Any change in law could reduce or eliminate the beneficial treatment of your [policy] [certificate] under Louisiana's Medicaid program.

Additional Information. If you have questions regarding long-term care insurance [policies] [certificates] please contact [carrier name.] If you have questions regarding current laws governing Medicaid eligibility, you should contact the Louisiana Department of Health and Hospitals.

Attachment D

Partnership Status Disclosure Notice

Important Information Regarding Your [Policy's] [Certificate's] Long-Term Care Insurance Partnership Status

This disclosure notice is issued in conjunction with your long-term care [policy] [certificate]:

Some long-term care insurance [policies] [certificates] sold in Louisiana qualify for the Louisiana Long-Term Care Insurance Partnership Program. Insurance companies voluntarily agree to participate in the Partnership Program by offering long-term care insurance coverage that meets certain State and Federal requirements. Long-term care insurance [policies] [certificates] that qualify as Partnership [Policies] [Certificates] may be entitled to special treatment, and in particular an Asset Disregard, under Louisiana's Medicaid program.

Asset Disregard means that an amount of the [policyholder's] [certificate holder's] assets equal to the amount of long-term care insurance benefits received under a qualified Partnership [Policy] [Certificate] will be disregarded for the purpose of determining the insured's eligibility for Medicaid. This generally allows a person to keep assets equal to the insurance benefits received under a qualified Partnership [Policy] [Certificate] without affecting the person's eligibility for Medicaid. All other Medicaid eligibility criteria will apply and special rules may apply to persons whose home equity exceeds [\$500,000]. Asset Disregard is **not** available under a long-term care insurance [policy] [certificate] that is not a Partnership [Policy] [Certificate]. **The purchase of a Partnership [Policy] [Certificate] does not automatically qualify you for Medicaid.**

Partnership [Policy] [Certificate] Status. Your long-term care insurance [policy] [certificate] is intended to qualify as a Partnership [Policy] [Certificate] under the Louisiana Long-Term Care Partnership Program as of the effective date of your [Policy] [Certificate].

What Could Disqualify Your [Policy] [Certificate] as a Partnership Policy? If you make any changes to your [policy] [certificate], such changes could affect whether your [policy] [certificate] continues to be a Partnership [Policy] [Certificate]. ***Before you make any changes, you should consult with [insert name of carrier] to determine the effect of a proposed change.*** In addition, if you move to a State that does not maintain a Partnership Program or does not recognize your [policy] [certificate] as a Partnership [Policy] [Certificate], you would not receive beneficial treatment of your [policy] [certificate] under the Medicaid program of that State. The information contained in this Notice is based on current State and Federal laws. These laws may be subject to change. Any change in law could reduce or eliminate the beneficial treatment of your [policy] [certificate] under Louisiana's Medicaid program.

Additional Information. If you have questions regarding your insurance [policy] [certificate] please contact [insert name of carrier.] If you have questions regarding current laws governing Medicaid eligibility, you should contact the Louisiana Department of Health and Hospitals.

Appendix 5: Indiana and Kansas Laws

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 12-15-1-21.7 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2011]:

Sec. 21.7. (a) To the extent allowed by federal law, the office may use federal or state funds under the Medicaid program to pay premiums and other expenses related to a life insurance policy that is in force and owned by an applicant or a recipient who:

(1) is:

(A) at least fifty-five (55) years of age; or

(B) permanently institutionalized; and

(2) has:

(A) made an irrevocable election to name the state as a beneficiary of the life insurance policy for an amount equal to:

(i) Medicaid benefits provided to the recipient under IC 12-15-5 or IC 12-14-17; plus

(ii) premiums or expenses paid by the office to the insurer that issued the life insurance policy; or

(B) collaterally assigned the life insurance policy to the state under a written agreement submitted to and recorded by the insurer that issued the life insurance policy.

(b) Any life insurance policy that is in force and under which the state is named as an irrevocable beneficiary or that has been collaterally assigned to the state may not be sold, assigned, or the ownership transferred to any person or entity. This restriction exists as long as the life insurance policy names the state as an irrevocable beneficiary or as long as the life insurance policy is collaterally assigned to the state.

(c) Life insurance policy proceeds that exceed the amount of Medicaid benefits provided to a recipient shall be paid to a beneficiary named by the applicant or recipient.

SECTION 2. IC 12-15-2-17 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2011]:

Sec. 17. (a) Except as provided in subsections (b) and (d), if an applicant for or a recipient of Medicaid:

(1) establishes one (1) irrevocable trust that has a value of not more than ten thousand dollars (\$10,000), exclusive of interest, and is established for the sole purpose of providing money for the burial of the applicant or recipient;

(2) enters into an irrevocable prepaid funeral agreement having a value of not more than ten thousand dollars (\$10,000); or

(3) owns a life insurance policy with a face value of not more than ten thousand dollars (\$10,000) and with respect to which provision is made to pay not more than ten thousand dollars (\$10,000) toward the applicant's or recipient's funeral expenses;

the value of the trust, prepaid funeral agreement, or life insurance policy may not be considered as a resource in determining the applicant's or recipient's eligibility for Medicaid.

(b) Subject to subsection (d), if an applicant for or a recipient of Medicaid establishes an irrevocable trust or escrow under IC 30-2-13, the entire value of the trust or escrow may not be considered as a resource in determining the applicant's or recipient's eligibility for Medicaid.

(c) Except as provided in IC 12-15-3-7, if an applicant for or a recipient of Medicaid owns resources described in subsection (a) and the total value of those resources is more than ten thousand dollars (\$10,000), the value of those resources that is more than ten thousand dollars (\$10,000) may be considered as a resource in determining the applicant's or recipient's eligibility for Medicaid.

(d) In order for a trust, an escrow, a life insurance policy, or a prepaid funeral agreement to be exempt as a resource in determining an applicant's or a recipient's eligibility for Medicaid under this section, the applicant or recipient must designate the office or the applicant's or recipient's estate to receive any remaining amounts after delivery of all services and merchandise under the contract as reimbursement for Medicaid assistance provided to the applicant or recipient after fifty-five (55) years of age. The office may receive funds under this subsection only to the extent permitted by 42 U.S.C. 1396p. The computation of remaining amounts shall be made as of the date of delivery of services and merchandise under the contract and must be the excess, if any, derived from:

- (1) growth in principal;
- (2) accumulation and reinvestment of dividends;
- (3) accumulation and reinvestment of interest; and
- (4) accumulation and reinvestment of distributions;

on the applicant's or recipient's trust, escrow, life insurance policy, or prepaid funeral agreement over and above the seller's current retail price of all services, merchandise, and cash advance items set forth in the applicant's or recipient's contract.

SECTION 3. IC 12-15-3-1, AS AMENDED BY P.L.246-2005, SECTION 104, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2011]:

Sec. 1. (a) Except as provided in subsections (b) and (c) and section 7 of this chapter, an applicant for or recipient of Medicaid is ineligible for assistance if the total cash value of money, stock, bonds, and life insurance owned by:

- (1) the applicant or recipient is more than one thousand five hundred dollars (\$1,500) for assistance to the aged, blind, or disabled; or
- (2) the applicant or recipient and the applicant's or recipient's spouse is more than two thousand two hundred fifty dollars (\$2,250) for medical assistance to the aged, blind, or disabled.

(b) In the case of an applicant who is an eligible individual, a Holocaust victim's settlement payment received by the applicant or the applicant's spouse may not be considered when calculating the total cash value of money, stock, bonds, and life insurance owned by the applicant or the applicant's spouse.

(c) In the case of an individual who:

(1) resides in a nursing facility or another medical institution; and

(2) has a spouse who does not reside in a nursing facility or another medical institution;

the total cash value of money, stock, bonds, and life insurance that may be owned by the couple to be eligible for the program is determined under IC 12-15-2-24.

SECTION 4. IC 12-15-3-2 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2011]:

Sec. 2. (a) Except as provided in section 7 of this chapter, if the parent of an applicant for or a recipient of assistance to the blind or disabled who is less than eighteen (18) years of age owns money, stock, bonds, and life insurance whose total cash value is more than one thousand five hundred dollars (\$1,500), the amount of the excess shall be added to the total cash value of money, stock, bonds, and life insurance owned by the applicant or recipient to determine the recipient's eligibility for Medicaid under section 1 of this chapter.

(b) However, a Holocaust victim's settlement payment received by the parent of an applicant for or a recipient of assistance may not be added to the total cash value of money, stock, bonds, and life insurance owned by the applicant or recipient to determine the recipient's eligibility for Medicaid under section 1 of this chapter.

SECTION 5. IC 12-15-3-3 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2011]:

Sec. 3. Except as provided in section 7 of this chapter, if the parents of an applicant for or a recipient of assistance to the blind or disabled who is less than eighteen (18) years of age own money, stock, bonds, and life insurance whose total cash value is more than two thousand two hundred fifty dollars (\$2,250), the amount of the excess shall be added to the total cash value of money, stock, bonds, and life insurance owned by the applicant or recipient to determine the recipient's eligibility for Medicaid under section 1 of this chapter.

SECTION 6. IC 12-15-3-5 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2011]:

Sec. 5. Except as provided in section 7 of this chapter, the office may set the total cash value of money, stock, bonds, and life insurance that an applicant for or a recipient of Medicaid may own without being ineligible for Medicaid in cases not described in section 1 of this chapter.

SECTION 7. IC 12-15-3-7 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2011]:

Sec. 7. (a) As used in this section, "value" includes the following:

(1) The face value of a life insurance policy.

(2) The cash value of a life insurance policy.

(b) The value of a life insurance policy that is in force and owned by an applicant or a recipient who is at least fifty-five (55) years of age or permanently institutionalized may not be considered as a resource in determining the applicant's or recipient's eligibility for Medicaid if the applicant or recipient:

(1) makes an irrevocable election to name the state as a beneficiary of the life insurance policy for an amount that is not greater than:

(A) Medicaid benefits provided to the recipient under IC 12-15-5 or IC 12-14-17; plus

(B) premiums or expenses paid by the office to the insurer that issued the life insurance policy; or

(2) collaterally assigned the life insurance policy to the state under a written agreement submitted to and recorded by the insurer that issued the life insurance policy.

(c) Any designation of the state as an irrevocable beneficiary or any collateral assignment in favor of the state is void if the application for Medicaid benefits is not approved.

HOUSE BILL No. 2697

By Committee on Aging and Long-term Care

2-9

1 AN ACT concerning eligibility requirements for medicaid; allowing a
2 collateral assignment of the proceeds of life insurance policies.
3

4 *Be it enacted by the Legislature of the State of Kansas:*

5 Section 1. (a) The department of health and environment, in
6 conjunction with the department of social and rehabilitation services, shall
7 review and update its rules and regulations establishing eligibility
8 requirements for the Kansas program of medical assistance established in
9 accordance with title XIX of the federal social security act, 42 U.S.C. §
10 1396 *et seq.* Such review shall include the establishment of a procedure
11 which permits the holder of a life insurance policy which has a cash
12 surrender value to give the Kansas program of medical assistance
13 established in accordance with title XIX of the federal social security act a
14 collateral assignment of the proceeds of such life insurance policy. The
15 collateral assignment may be used by the insured in lieu of any
16 requirement that such life insurance policy be sold in order for the insured
17 to meet any property ownership limitation contained in any eligibility
18 requirement for participation in the Kansas program of medical assistance
19 established in accordance with title XIX of the federal social security act.
20 The collateral assignment shall be for an amount not to exceed the
21 proceeds of such policy necessary to reimburse the Kansas program of
22 medical assistance established in accordance with title XIX of the federal
23 social security act for any amount paid by such program for medical
24 benefits provided to the insured.

25 (b) The department of health and environment is hereby directed to
26 seek any necessary waivers from program requirements of the federal
27 government as may be needed to carry out the provisions of this section
28 and to maximize federal matching and other funds with respect to the
29 provisions of this section. If the department of health and environment
30 determines that one or more waivers from program requirements of the
31 federal government are needed to carry out the provisions of this section,
32 the department of health and environment shall implement the provisions
33 of this section only if such waivers to federal program requirements have
34 been obtained from the federal government.

35 (c) (1) Except as provided in paragraph (2), the review and update of
36 the rules and regulations establishing eligibility requirements for the

1 Kansas program of medical assistance established in accordance with title
2 XIX of the federal social security act, 42 U.S.C. § 1396 *et seq.*, shall be
3 completed and the revisions of such rules and regulations shall be adopted
4 in accordance with the rules and regulations filing act no later than 12
5 calendar months following the date of receipt of the waivers required
6 under subsection (b).

7 (2) If the department of health and environment determines that no
8 waivers are required to implement the provisions of subsection (a), the
9 review and update of the rules and regulations establishing eligibility
10 requirements for the Kansas program of medical assistance established in
11 accordance with title XIX of the federal social security act, 42 U.S.C. §
12 1396 *et seq.*, shall be completed and the revisions of such rules and
13 regulations shall be adopted in accordance with the rules and regulations
14 filing act no later than 12 calendar months following the effective date of
15 this act.

16 Sec. 2. This act shall take effect and be in force from and after its
17 publication in the statute book.

18



PRESIDENT: REP. ROBERT DAMRON, KY
PRESIDENT-ELECT: REP. GEORGE KEISER, ND
VICE PRESIDENT: SEN. CARROLL LEAVELL, NM
SECRETARY: SEN. VI SIMPSON, IN
TREASURER: REP. CHARLES CURTISS, TN

**NATIONAL CONFERENCE OF INSURANCE LEGISLATORS (NCOIL)
Life Insurance Consumer Disclosure Model Act**

Adopted by the NCOIL Executive Committee on November 21, 2010, and by the NCOIL Life Insurance & Financial Planning Committee on November 19, 2010.

Section 1. Short Title

This Act shall be known as the *Life Insurance Consumer Disclosure Model Act*.

Section 2. Definitions

- A. "Commissioner" means the *[insert title per individual state]* in this state.
- B. "Insurer" means the insurance company that issued the policy.
- C. "Insured" means an individual covered by a policy.
- D. "Person" means an individual or a legal entity.
- E. "Policy" means an individual life insurance policy owned by a person who is a resident of this state, regardless of whether issued, delivered, or renewed in this state.
- F. "Policy owner" means the owner of a policy.

Section 3. Notice to Policy Owner Required

- A. An insurer shall provide the written notice required by Subsection 3(B) to a policy owner, if an insured is age sixty or older or is known by the insurer to be terminally ill or chronically ill, and if:
 - 1. The policy owner requests the surrender, in whole or in part, of a policy;
 - 2. The policy owner requests an accelerated death benefit under a policy;
 - 3. The insurer sends notice to the policy owner that the policy may lapse; provided, however, that the insurer shall not be required to include the notice required by this paragraph to the policy owner more than one time within a twelve month period from the date of the first notice of lapse of the policy; or
 - 4. At any other time that the commissioner may prescribe by rule.
- B. The commissioner shall develop the written notice, promulgated by rule, to apprise policy owners of alternatives to the lapse or surrender of a policy and of the policy owner's rights as an owner of a policy related to the disposition of a policy. The notice shall be developed at no cost to insurers or other licensees and shall be written in lay terms.
- C. The written notice shall contain the following:
 - 1. A statement explaining that life insurance is a critical part of a broader financial plan;

2. A statement explaining that there are alternatives to the lapse or surrender of a policy;
3. A general description of the following alternatives to the lapse or surrender of a policy:
 - (a) accelerated death benefits available under the policy or as a rider to the policy;
 - (b) the assignment of the policy as a gift;
 - (c) the sale of the policy pursuant to a life settlement contract, including that a life settlement is a regulated transaction in this state *[as applicable]*
 - (d) the replacement of the policy pursuant to *[cite any regulation governing policy replacement]*;
 - (e) the maintenance of the policy pursuant to the terms of the policy or a rider to the policy, or through life settlement contract;
 - (f) the maintenance of the policy through loans issued by an insurer or a third party, using the policy or the cash surrender value of the policy as collateral for the loan;
 - (g) conversion of the policy from a term policy to a permanent policy; and
 - (h) conversion of the policy in order to obtain long-term care health insurance coverage or a long-term care benefit plan.
4. A statement explaining that life insurance, life settlements, or other alternatives to the lapse or surrender of the policy described in the notice may or may not be available to a particular policy owner depending on a number of circumstances, including the age and health status of the insured or the terms of a life insurance policy, and that policy owners should contact their financial advisor, insurance agent, broker, or attorney to obtain further advice and assistance.

Section 4. Penalties

A violation of Section 3(A) shall be deemed an unfair trade practice pursuant to state law and subject to the penalties provided by state law.