



RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

Accelerated Life Benefits Technical Advisory Workgroup

*Final Recommendations Report with
Proposed Legislation
January 15, 2013*

Table of Contents

Executive Summary	3
Purpose	3
Membership and Meetings	4
Background	6
Recommendations	8
APPENDIX A:	12
Final Proposed Legislation from Technical Advisory Workgroup	12
APPENDIX B:	16

Executive Summary

As part of the General Appropriations Act passed by the Legislature during the 2012 legislative session, the Agency for Health Care Administration was directed to establish a technical advisory Workgroup to examine issues relating to life insurance and long-term care benefits.

“From the funds in Specific Appropriation 224, the Agency for Health Care Administration, in coordination with the Department of Children and Families and the Office of Insurance Regulation, shall establish a technical advisory Workgroup by August 1, 2012, to examine methods to allow an insured under a life insurance policy or the contract holder of an annuity, to convert the policy or annuity to a long-term care benefit. The Workgroup shall also examine the feasibility and benefits of mandating life insurance companies to include an offer of accelerated death benefits as a means to fund long-term care institutional services in their standard policies. The advisory Workgroup must include, but is not limited to, representatives from nursing home providers, life insurance companies, and life insurance agents. Members of the Workgroup shall serve without compensation. The agency shall submit a report of findings and activities of the Workgroup, including recommendations and proposed legislation, no later than January 15, 2013.” (House Bill 5001, 2012)

This report provides an overview of the Workgroup’s activities and their final recommendations for consideration. With the submission of this report, the Workgroup has completed its objective and will disband.

Purpose

As stated in Specific Appropriation 224, the purpose of establishing this Workgroup was to assist in developing:

- The method to allow an insured under a life insurance policy or the contract holder of an annuity to convert the policy or annuity to a long-term care benefit.
- The feasibility and benefits of mandating life insurance companies to include an offer of accelerated death benefits as a means to fund long-term care institutional services in their standard policies.

With the submission of this report, recommendations and draft legislation included, the Workgroup has accomplished this purpose.

Membership and Meetings

The Workgroup members were appointed by the Secretary of the Agency for Health Care Administration (Agency) on July 1, 2012, and included representatives from nursing home providers, life insurance companies, and life insurance agents. When choosing appointees, priority was given to individuals whose primary interest, experience, or expertise lay with those who could be directly affected by the new program. Members of the Workgroup were appointed to serve, without compensation, until all recommendations were made or until January 15, 2013, whichever came first.

Voting Members of the Workgroup

- Scott Berlin, New York Life Insurance Company –*Insurance Company Representative*
- Doug Burr, Health Care Navigator –*Nursing Home Association Representative*
- Michael Freedman, Coventry First –*Life Settlement Representative*
- Robert Glowacki, Transamerica life Insurance –*Insurance Company Representative*
- Jack McRay, AARP –*Consumer Representative*
- Jeff Sadler, Life Insurance Agent –*Life Insurance Agent*
- Jennifer Ziolkowski, Opis Management Resources –*Nursing Home Association Representative*

Along with the appointment of the voting Members, Chris Chaney, Legislative Affairs Director for the Agency for Health Care Administration (Agency) was appointed and served as the Facilitator for this Workgroup from July 1, 2012 until August 30, 2012. Eric Lingswiler, Chief of the Agency's Division of Health Quality Assurance, Bureau of Managed Health Care served as the Facilitator for this Workgroup from September 1, 2012 to present.

State of Florida staff

- Chris Chaney, Legislative Affairs Director, Agency for Health Care Administration
- Eric Lingswiler, Chief of Bureau of Managed Health Care, Division of Health Quality Assurance, Agency for Health Care Administration
- Danielle Pigott, Medicaid Director's Office, Agency for Health Care Administration
- Jim Walker, Division of Life and Health Product Review, Office of Insurance Regulation
- Michelle Robleto, Deputy Commissioner, Life and Health, Office of Insurance Regulation
- Carrie Strickland, ACCESS Florida Program Office, Department of Children and Families
- Dorthene Baker, ACCESS Florida Program Office, Department of Children and Families

The Workgroup held four meetings between July 31, 2012 and January 4, 2013. During the last meeting, some members expressed the desire to hold an additional meeting through a conference call. However, due to the constraints of the statutorily mandated report submission and the need to publicly notice all meetings of the Workgroup, the meeting was unable to be held as requested at the January 4, 2013 meeting.

Meeting agendas were constructed from Workgroup member recommendations, with supporting documentation provided through collaboration between Workgroup members and State of Florida staff.

Meetings were open for public comments and questions with a specified amount of time on the agenda. All comments and questions were limited to the specific items on the agenda for each meeting. Also, public stakeholders were given the opportunity to present testimony on agenda items when appropriate and/or when asked upon by the Workgroup.

The Workgroup continued to meet until all recommendations were made, as determined by a consensus vote of Workgroup members.

Background

According to the National Clearinghouse for Long Term Care Information, an “Accelerated Death Benefit” is a feature included in some life insurance policies that allows the policy holder to receive a tax-free advance on his or her life insurance benefit.¹ The amount received while the policy holder is still alive is then subtracted from the amount that will be paid to the policy holder’s beneficiaries upon their death. The Interstate Insurance Product Regulation Commission adopted standards for Accelerated Death Benefits policies in February of 2007, and defined “Accelerated Death Benefits” in those standards to mean “the advance payment of some or all of the death proceeds payable under a life insurance policy:

- To the owner, during the lifetime of the insured at the time of a qualifying event;
- That reduced the death benefit otherwise payable through a present value payment or imposition of a lien upon the death benefits; and that are payable upon the occurrence of any single qualifying event with respect to the insured resulting in the payment of a benefit amount fixed at the time of acceleration.”²

¹ “Accelerated Death Benefits,” 08 Jan. 2013 http://www.longtermcare.gov/LTC/Main_Site/Paying/Private_Financing/Life_Insurance.aspx#ADB

² “Standards for Accelerated Death Benefits,” http://www.insurancecompact.org/rulemaking_records/record_stndrds_acceldeathbens.pdf

Life insurance policy holders also may have the option for a viatical settlement. According to the Securities and Exchange Commission website, a viatical settlement allows an investor to invest in another person's life insurance policy.³ The investor purchases the policy at a price that is less than the death benefit of the policy, and when the policy holder dies, the investor collects the death benefit.

In some cases, utilization of accelerated death benefits or viatical settlements impacts a policyholder's eligibility for Medicaid coverage of long-term care services. Money collected through an Accelerated Death Benefits policy or a viatical settlement could be considered as income, which might impact Medicaid eligibility for some policy recipients.

Several states have moved forward to investigate or implement policies which would allow those in need of long-term care services to convert their life insurance policies, through the mechanism mentioned above, into a Medicaid long-term care benefit option.

Currently, Florida considers the cash value of a life insurance policy as an asset for the purposes of determining Medicaid eligibility. According to information provided by Chris Orestis, President and Co-Founder of Life Care Funding Group, during his presentation to the Workgroup during its November 7, 2012 meeting, it has been a standard practice for Medicaid applicants to abandon a life insurance policy if it is within the legally required five year look back spend down period.⁴ Mr. Orestis proposed that allowing consumers to convert life insurance plans into long-term care insurance plans (which are a qualified Medicaid spend down) would benefit both the consumer and the state Medicaid program by delaying the time at which the policy holder might require Medicaid coverage for long-term care services.

³ "Viatical Settlements," 08 Jan. 2013, <http://www.sec.gov/answers/viaticalsettle.htm>

⁴ "1630.0553 - Life Insurance (MFAM)," 08 Jan. 2013, <http://www.dcf.state.fl.us/programs/access/docs/esspolicymanual/1630.pdf>

In January of 2012, the Florida Health Care Association contracted with the Center for Economic Forecasting and Analysis to prepare an analysis of the impact of conversion of life insurance policies to long-term care benefit plans in Florida. The objective of the research was to “examine utilizing life insurance policy assets as a means of private funding in order to pay for long-term health care needs and allow for policy holders to use a life insurance policy converted to a long-term care benefits plan as a qualified spend down for Medicaid eligibility”.⁵ In its conclusion, the report found that allowing these conversions would benefit elders and adults in Florida who become self-care limited by approximately \$138 – 157 million (net) annually.

Recommendations

Recommendations were made by the Workgroup and appear in the proposed legislation included as Appendix A. Each element of the Workgroup’s statutory scope and a brief summary of the recommendations included in the draft legislation to address each element are outlined below.

1. Examine the methods to allow an insured under a life insurance policy or the contract holder of an annuity to convert the policy or annuity to a long-term care benefit.
2. Examine the feasibility and benefits of mandating life insurance companies to include an offer of accelerated death benefits as a means to fund long-term care institutional services in their standard policies.

The Workgroup proposed a public and private model by where a recipient could use the intrinsic value of a life insurance contract to assist with the costs associated with long-term care services, through the Medicaid services delivery system, utilizing funds from the public option, or through the private model option, using a viatical settlement, distributed by an authorized fiduciary. As a result, the proposed model does not include mandatory requirements which would have dictated specific action to insurers from the

⁵ Dr. Martijn Niekus, Center for Economic Forecasting and Analysis, The Florida State University, presented the PowerPoint “Conversion of Life insurance Policies to Long-Term Care Benefit Plans in Florida,” 31 July 2012.

state, thus preserving a more open and amenable market place. Accelerations of the death benefit for life insurance are usually limited to life expectancy durations of one year or less. This limitation is imposed due to the actuarial difficulties in accurately pricing accelerations that exceed one year's duration. To further complicate the acceleration scenario, accelerated death benefits are considered a health benefit in Florida, requiring the insurer to hold Certificates of Authority for health as well as life insurance. Therefore the model proposed by the Workgroup does not include an option relating to accelerated death benefits contracts.

The public and private model proposed would allow for the assignment of a life insurance policy to the state as a pathway to Medicaid eligibility for those who meet nursing home level of care criteria and would, alternatively, allow for viatical settlements to be entered into through which guaranteed payments would be made to the Florida Medicaid program to cover the costs associated with Medicaid services received by the policy holder.

Break down of legislation

Eligibility –The Workgroup decided that a public and private model would be the most beneficial, which would allow the applicant to use the value of an in force life insurance policy to offset the costs of long-term care services.

The value of a life insurance contract would not prohibit an applicant from being considered for Medicaid eligibility if that applicant agreed to irrevocably assign the benefits of that contract to the state or if they entered into a viatical settlement through which payments would be made to the Medicaid program to cover the costs associated with their Medicaid services.

The legislation provides two models which allow the applicant to draw on the value of their life insurance contract; a public model and a private model. The public model leverages current state agencies and allows them to transfer the value of a life insurance contract to offset the cost of a long-term care confinement.

The state acts as a fiduciary intermediary converting assets held in a life insurance contract to periodic payments offsetting the cost of long-term care confinement.

Any applicant that meets the state nursing home level of care could qualify for this public model assistance. The legislation provides safeguards which require that the assets of the life insurance contract are used solely to offset the cost of long-term care confinement with any residual value being returned to the original beneficiary of the life insurance contract.

One of the disadvantages of the public model is its requirement of the state to become a fiduciary in the area of life insurance contracts. This will also increase the workload of the Office of Insurance Regulation.

The private model allows an applicant for Medicaid to be determined eligible even though they may own a life insurance contract which would otherwise disqualify them from eligibility.

This private model allows for a viatical settlement of a life insurance contract with payments to be used solely to provide Medicaid covered long-term care costs. This proposed legislation uses current viatical statutes and adds protections for the state and the viator (the owner of the life insurance contract who enters into a settlement arrangement for the sale of that contract). The protections for the state require the benefits of the viatication be used to offset the cost of long-term care confinement and provide additional safeguards for the Medicaid applicant.

This proposed legislation would require that all marketing material associated with this program be reviewed and approved by the Office of Insurance Regulation prior to use. The legislation requires periodic market conduct examinations by the Office of Insurance Regulation.

Note: Further analysis is needed regarding the potential fiscal impact to the state regarding the financial transactions outlined in the draft legislation included as Appendix A.

As previously mentioned in the Membership and Meetings portion of this report (see bottom of page 4), the conference call mentioned in the last meeting, January 4, 2013 was not held. Workgroup Members' contributions that could not be approved due to those constraints are included in this report as Appendix B.

APPENDIX A:

Final Proposed Legislation from Technical Advisory Workgroup

A bill to be entitled

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.

APPENDIX B:

Additional Workgroup Recommendations to Proposed Legislation

A bill to be entitled
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. Such irrevocable election, collateral assignment or irrevocable assignment to the state must be executed between the owner of the policy and the state and must be on a form promulgated by the agency.

(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. In addition to any requirements in Part X, Chapter 626, Florida Statutes, any viatical settlement contract entered into with respect to this section 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 of the viatical settlement contract 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 of the viatical settlement provider, must be filed with 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 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.