

ACCELERATED BENEFITS MODEL REGULATION

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Section 1. Purpose

The purpose of this regulation is to regulate accelerated benefit provisions of individual and group life insurance policies and to provide required standards of disclosure. This regulation shall apply to all accelerated benefits provisions of individual and group life insurance policies except those subject to the Long-Term Care Insurance Model Act, issued or delivered in this state, on or after the effective date of this regulation.

Section 2. Definitions

- A. “Accelerated benefits” covered under this regulation are benefits payable under a life insurance contract:
 - (1) To a policyowner or certificateholder, during the lifetime of the insured, in anticipation of death or upon the occurrence of specified life-threatening or catastrophic conditions as defined by the policy or rider; and
 - (2) That reduce the death benefit otherwise payable under the life insurance contract; and
 - (3) That are payable upon the occurrence of a single qualifying event that results in the payment of a benefit amount fixed at the time of acceleration.

- B. “Qualifying event” means one or more of the following:
 - (1) A medical condition that would result in a drastically limited life span as specified in the contract, for example, twenty-four (24) months or less;
 - (2) A medical condition that has required or requires extraordinary medical intervention, such as, but not limited to, major organ transplant or continuous artificial life support, without which the insured would die;
 - (3) A condition that usually requires continuous confinement in an eligible institution as defined in the contract if the insured is expected to remain there for the rest of his or her life;
 - (4) A medical condition that would, in the absence of extensive or extraordinary medical treatment, result in a drastically limited life span. Such conditions may include, BUT ARE NOT LIMITED TO, one or more of the following:
 - (a) Coronary artery disease resulting in an acute infarction or requiring surgery;
 - (b) Permanent neurological deficit resulting from cerebral vascular accident;

- (c) End stage renal failure;
 - (d) Acquired Immune Deficiency Syndrome; or
 - (e) Other medical conditions that the commissioner shall approve for any particular filing; or
- (5) Other qualifying events that the commissioner shall approve for a particular filing.

Section 3. Type of Product

Accelerated benefit riders and life insurance policies with accelerated benefit provisions are primarily mortality risks rather than morbidity risks. They are life insurance benefits subject to [insert sections referencing life insurance provisions].

Section 4. Assignee/Beneficiary

Prior to the payment of the accelerated benefit, the insurer is required to obtain from an assignee or irrevocable beneficiary a signed acknowledgement of concurrence for payout. If the insurer making the accelerated benefit is itself the assignee under the policy, no acknowledgement is required.

Section 5. Criteria for Payment

- A. Lump Sum Settlement Option Required. Contract payment options shall include the option to take the benefit as a lump sum. The benefit shall not be made available as an annuity contingent upon the life of the insured.
- B. Restrictions on Use of Proceeds. No restrictions are permitted on the use of the proceeds.
- C. Accidental Death Benefit Provision. If any death benefit remains after payment of an accelerated benefit, the accidental death benefit provision, if any, in the policy or rider shall not be affected by the payment of the accelerated benefit.

Section 6. Disclosures

- A. Descriptive Title. The terminology “accelerated benefit” shall be included in the descriptive title. Products regulated under this regulation shall not be described or marketed as long-term care insurance or as providing long-term care benefits.
- B. Tax Consequences. A disclosure statement is required at the time of application for the policy or rider and at the time the accelerated benefit payment request is submitted that receipt of these accelerated benefits may be taxable and that assistance should be sought from a personal tax advisor. The disclosure statement shall be prominently displayed on the first page of the policy or rider and any other related documents.
- C. Solicitations.
 - (1) A written disclosure including, but not necessarily limited to, a brief description of the accelerated benefit and definitions of the conditions or occurrences triggering payment of the benefits shall be given to the applicant. The description shall include an explanation of any effect of the payment of a benefit on the policy’s cash value, accumulation account, death benefit, premium, policy loans and policy liens.
 - (a) In the case of agent solicited insurance, the agent shall provide the disclosure form to the applicant prior to or concurrently with the application. Acknowledgment of the disclosure shall be signed by the applicant and writing agent.
 - (b) In the case of a solicitation by direct response methods, the insurer shall provide the disclosure form to the applicant at the time the policy is delivered, with a notice that a full premium refund shall be received if the policy is returned to the company within the free look period.

Drafting Note: States may wish to consider a 30-day free look period for direct response solicitation.

- (c) In the case of group insurance policies, the disclosure form shall be contained as part of the certificate of coverage or any related document furnished by the insurer for the certificateholder.
- (2) If there is a premium or cost of insurance charge, the insurer shall give the applicant a generic illustration numerically demonstrating any effect of the payment of a benefit on the policy's cash value, accumulation account, death benefit, premium, policy loans and policy liens.
 - (a) In the case of agent solicited insurance, the agent shall provide the illustration to the applicant prior to or concurrently with the application.
 - (b) In the case of a solicitation by direct response methods, the insurer shall provide the illustration to the applicant at the time the policy is delivered.
 - (c) In the case of group insurance policies, the disclosure form shall be contained as part of the certificate of coverage or any related document furnished by the insurer for the certificateholder.
- (3) Disclosure of Premium Charge.
 - (a) An insurer with financing options other than as described in Section 10A(2) and (3) of this regulation shall disclose to the policyowner any premium or cost of insurance charge for the accelerated benefit. The insurer shall make a reasonable effort to assure that the certificateholder is aware of any additional premium or cost of insurance charge if the certificateholder is required to pay a charge.
 - (b) An insurer shall furnish an actuarial demonstration to the state insurance department when filing the product disclosing the method of arriving at its cost for the accelerated benefit.
- (4) Disclosure of Administrative Expense Charge. The insurer shall disclose to the policyowner any administrative expense charge. The insurer shall make a reasonable effort to assure that the certificateholder is aware of any administrative expense charge if the certificateholder is required to pay the charge.
- D. Effect of the Benefit Payment. When a policyowner or certificateholder requests an acceleration, the insurer shall send a statement to the policyowner or certificateholder and irrevocable beneficiary showing any effect that the payment of the accelerated benefit will have on the policy's cash value, accumulation account, death benefit, premium, policy loans and policy liens. The statement shall disclose that receipt of accelerated benefit payments may adversely affect the recipient's eligibility for Medicaid or other government benefits or entitlements. In addition, receipt of an accelerated benefit payment may be taxable and assistance should be sought from a personal tax advisor. When a previous disclosure statement becomes invalid as a result of an acceleration of the death benefit, the insurer shall send a revised disclosure statement to the policyowner or certificateholder and irrevocable beneficiary. When the insurer agrees to accelerate death benefits, the insurer shall issue an amended schedule page to the policyholder or notify the certificateholder under a group policy to reflect any new, reduced in-force face amount of the contract.

Section 7. Effective Date of the Accelerated Benefits

The accelerated benefit provision shall be effective for accidents on the effective date of the policy or rider. The accelerated benefit provision shall be effective for illness no more than thirty (30) days following the effective date of the policy or rider.

Section 8. Waiver of Premiums

The insurer may offer a waiver of premium for the accelerated benefit provision in the absence of a regular waiver of premium provision being in effect. At the time the benefit is claimed, the insurer shall explain any continuing premium requirement to keep the policy in force.

Section 9. Discrimination

An insurer shall not unfairly discriminate among insureds with differing qualifying events covered under the policy or among insureds with similar qualifying events covered under the policy. An insurer shall not apply further conditions on the payment of the accelerated benefits other than those conditions specified in the policy or rider.

Section 10. Actuarial Standards

A. Financing Options

- (1) The insurer may require a premium charge or cost of insurance charge for the accelerated benefit. This charge shall be based on sound actuarial principles. In the case of group insurance, the additional cost may also be reflected in the experience rating.
- (2) The insurer may pay a present value of the face amount. The calculation shall be based on any applicable actuarial discount appropriate to the policy design. The interest rate or interest rate methodology used in the calculation shall be based on sound actuarial principles and disclosed in the contract or actuarial memorandum. The maximum interest rate used shall be no greater than the greater of:
 - (a) The current yield on ninety-day treasury bills; or
 - (b) The current maximum statutory adjustable policy loan interest rate.
- (3) The insurer may accrue an interest charge on the amount of the accelerated benefits. The interest rate or interest rate methodology used in the calculation shall be based on sound actuarial principles and disclosed in the contract or actuarial memorandum. The maximum interest rate used shall be no greater than the greater of:
 - (a) The current yield on ninety-day treasury bills; or
 - (b) The current maximum statutory adjustable policy loan interest rate.

The interest rate accrued on the portion of the lien that is equal in amount to the cash value of the contract at the time of the benefit acceleration shall be no more than the policy loan interest rate stated in the contract.

B. Effect on Cash Value.

- (1) Except as provided in Paragraph (2), when an accelerated benefit is payable, there shall be no more than a pro rata reduction in the cash value based on the percentage of death benefits accelerated to produce the accelerated benefit payment.
- (2) Alternatively, the payment of accelerated benefits, any administrative expense charges, any future premiums and any accrued interest can be considered a lien against the death benefit of the policy or rider and the access to the cash value may be restricted to any excess of the cash value over the sum of any other outstanding loans and the lien. Future access to additional policy loans could also be limited to any excess of the cash value over the sum of the lien and any other outstanding policy loans.

- C. Effect of Any Outstanding Policy Loans on Accelerated Death Benefit Payment. When payment of an accelerated benefit results in a pro rata reduction in the cash value, the payment may not be applied toward repaying an amount greater than a pro rata portion of any outstanding policy loans.

Section 11. Actuarial Disclosure and Reserves

- A. Actuarial Memorandum. A qualified actuary should describe the accelerated benefits, the risks, the expected costs and the calculation of statutory reserves in an actuarial memorandum accompanying each state filing. The insurer shall maintain in its files descriptions of the bases and procedures used to calculate benefits payable under these provisions. These descriptions shall be made available for examination by the commissioner upon request.
- B. Reserves
 - (1) When benefits are provided through the acceleration of benefits under group or individual life policies or riders to such policies, policy reserves shall be determined in accordance with the Standard Valuation Law. All valuation assumptions used in constructing the reserves shall be determined as appropriate for statutory valuation purposes by a Member in good standing of the American Academy of Actuaries. Mortality tables and interest currently recognized for life insurance reserves by the National Association of Insurance Commissioners (NAIC) may be used as well as appropriate assumptions for the other provisions incorporated in the policy form. The actuary shall follow both actuarial standards and certification for good and sufficient reserves. Reserves in the aggregate should be sufficient to cover:
 - (a) Policies upon which no claim has yet arisen; and
 - (b) Policies upon which an accelerated claim has arisen.
 - (2) For policies and certificates that provide actuarially equivalent benefits, no additional reserves need to be established.
 - (3) Policy liens and policy loans, including accrued interest, represent assets of the company for statutory reporting purposes. For a policy on which the policy lien exceeds the policy's statutory reserve liability, the excess shall be held as a non-admitted asset.

Section 12. Filing Requirement [Optional]

The filing [and prior approval] of forms containing an accelerated benefit is required.

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

1990 Proc. 16, 27, 442, 444-446 (adopted as a guideline).

1991 Proc. 19, 17, 539-540, 542-543, 544-548 (amended and reprinted as a regulation).

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This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state’s activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column or Related State Activity column based on the definitions listed below. The NAIC’s interpretation may or may not be shared by the individual states or by interested readers.

This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.

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KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

RELATED STATE ACTIVITY: Examples of Related State Activity include but are not limited to: older versions of the NAIC model, statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column **only** (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner**.

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Alabama	ALA. ADMIN. CODE r. 113 (1997).	
Alaska	NO CURRENT ACTIVITY	
American Samoa	NO CURRENT ACTIVITY	
Arizona		ARIZ. REV. STAT. ANN. § 20-1136 (1990).
Arkansas	ARK. CODE R. § 60 (1994).	
California		CAL. INS. CODE §§ 10295 to 10295.19 (2013/2014).
Colorado		COLO. REV. STAT. § 10-7-113 (1989/1990).
Connecticut	CONN. GEN. STAT. § 38a-457 (1990/2011); CONN. AGENCIES REGS. §§ 38a-457 to 38a-457 (1992/2013).	
Delaware	NO CURRENT ACTIVITY	
District of Columbia	BULLETIN dated 4/13/95 adopts model standards by reference.	
Florida	NO CURRENT ACTIVITY	

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NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Georgia	NO CURRENT ACTIVITY	
Guam	NO CURRENT ACTIVITY	
Hawaii	NO CURRENT ACTIVITY	
Idaho	NO CURRENT ACTIVITY	
Illinois		215 ILL. COMP. STAT. 5/4 (1937/1989); ILL. ADMIN. CODE tit. 50, §§ 1407.20 to 1407.60 (1990/2000).
Indiana	760 IND. ADMIN. CODE 48 (1993/1995).	
Iowa	NO CURRENT ACTIVITY	
Kansas	KAN. ADMIN. REGS. § 40-2-20 (1991/2015).	KAN. STAT. ANN. § 40-401 (1927/2013).
Kentucky	NO CURRENT ACTIVITY	
Louisiana	LA. ADMIN. CODE tit. 37, §§ XIII.1501 to XIII.1523 (Regulation 44) (1992).	
Maine		ME. REV. STAT. ANN. tit. 24-A, § 2555 (1989/1999).
Maryland	NO CURRENT ACTIVITY	
Massachusetts		211 MASS. CODE REGS. §§ 55.01 to 55.07 (1991/2005).
Michigan	MICH. COMP. LAWS § 500.603 (2003).	
Minnesota		MINN. STAT. § 61A.072 (1989/2003).
Mississippi	MISS. CODE ANN. §§ 83-7-101 to 83-7-119 (1991).	
Missouri	NO CURRENT ACTIVITY	

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NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Montana	NO CURRENT ACTIVITY	
Nebraska	NO CURRENT ACTIVITY	
Nevada	NO CURRENT ACTIVITY	
New Hampshire	NO CURRENT ACTIVITY	
New Jersey		N.J. ADMIN. CODE §§ 11:4-30.1 to 11:4-30.13 (1995/2003).
New Mexico	NO CURRENT ACTIVITY	
New York		N.Y. INS. LAW § 3230 (1991/2014); § 3201 (1991/2014) (authority to adopt regulation); N.Y. COMP. CODES R. & REGS. tit. 11, §§ 41.1 to 41.8 (Regulation 143) (1992/2006).
North Carolina	11 N.C. ADMIN. CODE 12.1201 to 12.1212 (1992).	
North Dakota	NO CURRENT ACTIVITY	
Northern Marianas	NO CURRENT ACTIVITY	
Ohio	OHIO REV. CODE ANN. §§ 3915.21 to 3915.24 (1991) (portions of model, authority to adopt regulation); OHIO ADMIN. CODE 3901:6-06 (1997/2013).	
Oklahoma	OKLA. ADMIN. CODE §§ 365:10-5-100 to 365:10-5-110 (1992/2007).	OKLA. STAT. tit. 36, § 702 (1957/1989).
Oregon	OR. REV. STAT. § 743.154 (1991/1993) (portions of model); OR. ADMIN. R. 836-051-0300 to 836-051-0380 (portions of model) (1992/1996).	
Pennsylvania		31 PA. CODE §§ 90f.1 to 90f.16; §§ 90g.1 to 90g.16; §§ 90h.1 to 90h.11 (1991) (statement of policy).

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NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Puerto Rico	NO CURRENT ACTIVITY	
Rhode Island	NO CURRENT ACTIVITY	
South Carolina	NO CURRENT ACTIVITY	
South Dakota	NO CURRENT ACTIVITY	
Tennessee	NO CURRENT ACTIVITY	
Texas		28 TEX. ADMIN. CODE §§ 3.4301 to 3.4317 (1989/2008).
Utah	NO CURRENT ACTIVITY	
Vermont	NO CURRENT ACTIVITY	
Virgin Islands	NO CURRENT ACTIVITY	
Virginia	14 VA. ADMIN. CODE 5-70-10 to 5-70-150 (1992/2002).	
Washington	WASH. ADMIN. CODE 284-23-600 to 284-23-730 (1994/1998).	WASH. ADMIN. CODE 284-23-800 to 284-23-806 (2009).
West Virginia	NO CURRENT ACTIVITY	
Wisconsin	NO CURRENT ACTIVITY	
Wyoming	NO CURRENT ACTIVITY	

ACCELERATED BENEFITS MODEL REGULATION

Proceeding Citations

Cited to the Proceedings of the NAIC

Section 1. Purpose

The Life Insurance (A) Committee first discussed the issue of accelerated benefits early in 1989. These riders are usually attached to whole life insurance contracts and pay a certain percentage of the death benefit if the policyholder contracts a certain health condition such as a heart attack, bypass surgery, or life-threatening cancer. Some of the committee members viewed these options as very constructive from a public policy perspective, because they put money into the hands of the policyholders at a time when additional funds were necessary. **1989 Proc. II 422.**

Many states had taken action in the form of life insurance legislation. Issues which needed to be addressed by the NAIC included rates, actuarial projections and reserving practices. **1989 Proc. II 415.**

It was the intent of the drafting committee that individual states use the guideline in reviewing and approving policy filings. **1990 Proc. IA 449.**

The purpose section was amended to explain that the provisions of the guideline would provide only a minimum level of disclosure. The committee decided the guideline would not apply to policies or riders subject to the NAIC Long-Term Care Insurance Model Act. **1990 Proc. IA 447.**

While drafting the guideline, the committee also considered companies providing benefits by purchasing life insurance contracts from persons who were terminally ill and paying a proportionate amount of the face value to the policyowner. It was suggested that there be further inquiry as to the legitimacy of these companies before additional companies became operational throughout the United States. **1990 Proc. IA 448.**

The Life Insurance Committee worked with the Long-Term Care Insurance Task Force to identify areas where there was an overlap in the regulation of long-term care insurance and accelerated benefits. The accelerated benefits products are to be considered life insurance and should be maintained as such. **1990 Proc. II 564.**

When amendments to the guideline were first considered, the draft took the form of a statute. Advisory committee members suggested that 44 or 45 states had the authority to approve various forms of accelerated benefit products, so a regulation would be more appropriate. The working group concurred in the recommendation. **1991 Proc. IA 578.**

Section 2. Definitions

A. The definition of accelerated benefits was amended by the drafters to allow either policies with a specified disease provision or imminence of death provision. The committee decided that accelerated benefits would not apply to annuity or endowment contracts. The insured would have the option of accepting the benefit in a lump sum or in periodic payments for a fixed period of time. Qualifying events were redefined as specified diseases and/or imminence of death. **1990 Proc. IA 447.**

When amendments were adopted in 1990, the working group rewrote this section to clarify that accelerated benefits covered under this model are those which were payable upon the occurrence of a single qualifying event which results in the payment of a fixed benefit amount. The working group expressed its intention that this additional language was to assist in differentiating between life insurance and health insurance. **1991 Proc. IA 596-597.**

B. When originally drafted, the timeframe for a reduced life span was 12 months. After listening to comments on the exposure draft, the definition of qualifying event was amended to mean a medical condition resulting in a drastically limited life span, or a medical condition which required extraordinary medical intervention without which the insured would die, or a specified disease. **1990 Proc. IA 443.**

While drafting amendments to the model in 1990, the working group added language to clarify that the time frame associated with a drastically limited life span is that timeframe which is specified in the contract. **1991 Proc. IA 597.**

Section 2A (cont.)

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The advisory committee recommended and the working group accepted a new paragraph to add confinement in an eligible institution as a qualifying event. The term “eligible institution” was not defined by the advisory committee since it could be broader than just a nursing home and they wanted to leave the guideline as flexible as possible. The working group added language stating that an eligible institution was as defined in the contract. **1991 Proc. IA 597.**

Extensive discussions were held on whether or not to include cancer in the list of medical conditions under the definition of qualifying event. The committee chose not to include it because, while cancer is a catastrophic illness, the consensus of the committee was that the range of severity of the illness was too great. There was as much risk in including it and having an insured denied who thinks he has access to the benefits. The guideline did provide for each state to accept or reject a specific medical condition. It was suggested that “life-threatening cancer” be one of the medical conditions. That suggestion was rejected because of the opinion that doctors would be reluctant to make statements in writing that something is a life-threatening disease or may result in imminent death. **1990 Proc. IA 440-441.**

When drafting amendments in 1990, the working group decided to add Acquired Immune Deficiency Syndrome as another of the specific medical conditions which would drastically limit life spans. This was because AIDS was the original trigger for development of the accelerated benefit concept. **1991 Proc. IA 580.**

The purpose of the language “but are not limited to” is to give state regulators an idea of the types of severe medical conditions which would trigger an accelerated benefit payment. **1991 Proc. IA 563.**

The advisory committee suggested, and the working group agreed, that a Paragraph (5) be added to the subsection to give state insurance departments flexibility in approving other medical conditions as qualifying triggers. **1991 Proc. IA 587.**

The original model contained a statement that the necessity for a second medical opinion was to be left to the state insurance departments. This was added to give latitude to the states, but was deleted from the regulation before adoption. The drafters felt this should be a company decision rather than an insurance department decision. **1991 Proc. IA 587-588.**

Section 3. Type of Product

Initially the drafting committee thought it should leave it up to the state insurance departments to decide whether accelerated benefits were a life insurance or health insurance product. **1990 Proc. IA 447.**

Industry representatives commenting on the draft suggested that the exposure draft fostered confusion by allowing individual state insurance departments to determine whether a product was life or health insurance. Benefit payments are certain, unlike health insurance; the only unknown is the timing of that payment. The committee voted to change the language to state that the product was life insurance. **1990 Proc. IA 441-442.**

The regulation must clearly state whether the accelerated benefit product is a life or health product. The advisory committee expressed support for the draft amendments which accommodated that philosophy. Some of the members of the working group reported a desire to regulate or at least review rates and suggested adding a sentence to allow prior approval, as was done with health insurance products. Advisory committee members suggested that an implication these could be health products could raise tax questions and might subject life companies to health insurance regulations. The working group decided instead to add a new optional section requiring filing of forms and the additional option of requiring prior approval. **1991 Proc. IA 578.**

The working group amending the model agreed with the recommendation to insert language to clarify that accelerated benefits riders and policies are considered primarily mortality risks rather than morbidity risks. It was suggested that the type of regulation in each state should not effect the determination of whether these products are life or health products; this should be determined by the product characteristics alone. **1991 Proc. IA 597.**

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Section 4. Assignee/Beneficiary

A provision was added to the draft to require the assignee's signature acknowledging concurrence for payout in the event of a policy assignment. **1990 Proc. IA 447.**

Industry representatives suggested deleting this section, expressing concern that lawsuits could result if the company was forced to insert itself into the relationship between an irrevocable beneficiary and the policyowner. One company representative reported that his company would not permit an accelerated benefit if there was an irrevocable beneficiary. The working group decided to retain the section, feeling this alerts the companies to a potential problem when irrevocable beneficiaries are designated by the policyowner. **1991 Proc. IA 578-579.**

The advisory committee suggested clearly exempting an insurer from requiring the signed acknowledgment from an assignee as the result of an outstanding policy loan. The working group concurred in the recommendation and added clarifying language. **1991 Proc. IA 542.**

Section 5. Criteria for Payment

A. The initial consensus of the drafters was to limit the payout to 50 percent of the face amount of the policy. In the final discussion before adoption, the committee considered raising the amount to 75 percent, but then removed the limitation completely, believing that any limitation was inappropriate and the NAIC should encourage as much flexibility as possible. They were also concerned about entrepreneurial firms providing a greater payout than any limitation in the guideline. **1990 Proc. IA 440, 443.**

When modifications to the model were considered, some states continued to support a mandatory ceiling on the amount of the death benefit that could be accelerated. The working group decided not to take this action for several reasons: (1) as much flexibility as possible should be available in the marketplace, (2) the need for the accelerated benefit may override the need for the life benefit later on, (3) the beneficiary does not have a right to the proceeds of the policy until the death of the insured, and (4) individual companies may restrict the benefit as they choose in the marketplace. **1990 Proc. II 567.**

Insurers should be allowed the flexibility to structure new emerging products to the varying needs of consumers. Consumers should be able to choose between a contract that offers only a lump-sum payment, only a periodic payment, or a combination of the two as it suits their needs; limiting policy designs benefits no one. One industry spokesperson suggested that requiring the payment of a fixed amount for an indefinite period of time is not an appropriate payment option for the acceleration of death benefits under this guideline. **1990 Proc. IA 441.**

At one drafting session there was considerable discussion regarding the merits of reducing the cost to the consumer and the company by allowing policy designs with the periodic payment option only. The working group expressed concern with the idea of allowing companies to write periodic payment option policies only. They decided to explore further the issue of how the option of a lump sum or a periodic benefit option should be priced. **1990 Proc. II 567.**

The original model contained an option for an annuity payout. The revised language did not contain that sentence, and instead included language expressly prohibiting an annuity contingent on the life of the insured. It was decided that a lump sum payment should be the primary payment option, but that policies could offer other payment alternatives. The policyowner or certificateholder has the option to choose the form of payment. **1991 Proc. IA 597.**

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Section 6. Disclosures

A. A title description of the coverage must be used and must contain the terminology “accelerated benefits.” **1990 Proc. IA 448.**

B. Clear disclosure of the tax consequences of accepting an accelerated benefit payment was required at both the time of application and at the time the accelerated benefit payment request was submitted. Disclosure statements were also required to be prominently displayed on the first page of the policy or rider and any other related documents. **1990 Proc. IA 448.**

Originally the language in the disclosure section required disclosure of the tax consequences at the time the “claim” was submitted. The drafting committee expressed concern about the use of the term “claim” in connection with an accelerated benefit and changed the language to “accelerated death benefit payment request.” **1990 Proc. IA 447.**

Comments received by the committee suggested that the required disclosure regarding tax consequences should not be in the contract but in other supplementary materials. The committee voted to retain the requirement for disclosure of the potential tax consequences on the first page of the policy or rider. **1990 Proc. IA 442-443.**

Originally the model required “clear disclosure” of the potential tax implications. Industry representatives suggested removal of the requirement entirely, but the working group decided to retain the requirement, but substituted the words “a disclosure statement” for “clear disclosure.” **1990 Proc. II 567.**

The draft adopted continued to include the requirement that the first page of any accelerated benefit policy or rider contain a disclosure statement on the tax consequences. Insurance company representatives urged removal of the requirement in the belief that the benefits are not taxable and Congress would soon clarify the issue. The working group voted to retain it; Congress had not yet taken any action, so removal of the requirement for disclosure was premature. **1991 Proc. IA 579.**

The minutes of the December 1990 NAIC meeting contained a memorandum regarding the tax treatment of accelerated death benefits. It summarized current tax law and opined that tax treatment of accelerated benefits is not clear, whether they are considered life or health or nursing home policies. **1991 Proc. IA 591-592.**

C. A solicitation section was added to the guideline and required that applicants be given a numerical illustration demonstrating the effect of the benefit being paid on the policy’s cash value, death benefit, premiums, policy loans and liens. A written disclosure including a brief description of the accelerated benefits, and definitions of the conditions or occurrences triggering payment of the benefit must also be given to the applicant. This written disclosure must be signed by the applicant, the policyowner and the writing agent. **1990 Proc. IA 448.**

Comments received before adoption suggested that disclosing the effect of payment of an accelerated benefit was needlessly burdensome and impractical. There was no allowance for delivery by direct marketers who could not provide the required numerical illustrations or written disclosures at the time of application. The committee voted to add language to address the problem of direct mail solicitation companies, allowing that disclosure to be made upon acceptance of the application. **1990 IA 442-443.**

The advisory committee suggested deleting all of Subsection C(1), especially objecting to the requirement for a illustration numerically demonstrating the effect of payment of a benefit on the cash value, death benefit, premium, policy loans and policy liens. They suggested this hypothetical example had no real meaning for the person receiving the benefit. The information would be more meaningful and accurate at the time acceleration is requested. The working group members expressed concern that the purchaser be able to see what he is buying, especially if there is an extra charge. The version finally adopted required a written disclosure explaining the effects of payment, without specifically requiring a numeric illustration. **1991 Proc. IA 598.**

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Section 6C (cont.)

Working group members discussed the draft provision which required direct response marketers to make an additional mailing if they had to wait for receipt of an acknowledgment of the disclosure form before they could issue the policy. Even though disclosure at the point of solicitation might be most effective for the consumer, the requirements were burdensome for the direct mailer. The working group voted to require disclosure at the time the policy was issued, tying this requirement to the 30-day free look. **1991 Proc. IA 579.**

The section was originally drafted with a 30-day free look requirement. It was suggested that the standard be whatever the current free look requirement is in each state. The working group deleted that language requiring a 30-day free look and added a drafting note recommending that states consider providing a 30-day free look period for this product. **1991 Proc. IA 542.**

Section 6C(3)(a) was clarified to require disclosure when the insurer used financing options other than those described in Section 10A(2) and (3). The working group was concerned that there might be companies which would claim there was no extra premium charge or cost of insurance charge for the accelerated benefit. The purpose of this additional language was to try to avoid companies claiming that there is no charge where the charge was built into the premiums. **1991 Proc. IA 563.**

Section 6C(3)(a) requires disclosure to the policyowner of any premium or cost of insurance charge for the accelerated benefit. The group considered giving certificateholders in a group policy this information. The working group was concerned that the only time that a disclosure would be made to a certificateholder was for those policies which had a separate charge for this benefit. The group directed that the minutes reflect that their intent was not to require a breakout of the amount if there was not a separate charge to the certificateholder. **1991 Proc. IA 543.**

The new language inserted in the 1990 amendments originally require a “written explanation” to the state insurance department if the benefit was offered without additional charge. That was changed to require an “actuarial demonstration.” This language gives regulators the authority to require that a separate charge be identified for this benefit. The working group strongly supported identification of a specific dollar amount allocated to this benefit. **1991 Proc. IA 580.**

Paragraph (3)(b) was clarified to show that the actuarial demonstration furnished to the department disclose the actuarial calculations only for the accelerated benefit provision of the policy. **1991 Proc. IA 542.**

D. The committee discussed various aspects of marketing the accelerated benefits product and decided that a statement needed to be included on the face of the policy or rider to make clear that cash values, loan values and death benefits would be reduced if the policyholder receives an accelerated benefit. **1990 Proc. IA 448.**

Section 6D (cont.)

A new section was added by the working group to provide information on Medicaid eligibility. The suggested wording indicated that a rider on the policy might require the funds to be received and spent prior to eligibility for Medicaid or other governmental assistance programs. **1990 Proc. II 568.**

One draft of the regulation contained a statement that purchase of an accelerated benefit policy or rider could affect eligibility for Medicaid. This was changed after receipt of letters from the Department of Health and Human Services expressing the opinion that eligibility to receive an accelerated benefit would not affect government benefits under Medicaid or supplemental security income. The governmental agencies involved would not require policyholders to apply for and spend down the accelerated benefit before becoming eligible for aid. After receiving this information, the model provision was modified. **1991 Proc. IA 590-591.**

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Section 6D (cont.)

The statement to the policyholder, certificateholder and irrevocable beneficiary should include information to alert them to the possible tax consequences of receipt of the accelerated benefit payment. **1991 Proc. IA 564.**

The working group changed Subsection D to require the insurer to send a statement to the policyowner or certificateholder and irrevocable beneficiary when an acceleration is requested. A revised disclosure could be in the form of either a new or amended schedule page. **1991 Proc. IA 598.**

Section 7. Effective Date of the Accelerated Benefits

When the model was originally drafted, the benefit was effective on the effective date of the policy or rider. When revisions were being considered, the advisory committee requested that the effective date be no more than 60 days following the effective date of the policy or rider. They suggested there is a potential for fraud with accelerated benefits and this language gave insurers a window of opportunity to investigate. Without the waiting period there would be more incentive to commit fraud. The working group amended the model by differentiating between waiting periods for accidents and illness. **1991 Proc. IA 599.**

Section 8. Waiver of Premiums

An amendment which was proposed just before adoption of the guideline allowed companies the option of waiving the premium. This language was specific to the accelerated benefit rider. **1990 Proc. IA 439.**

Section 9. Discrimination

Just before adoption of the guideline, the drafters added the phrase “or among insureds with similar medical conditions” at the end of the first sentence and “other than those conditions specified in the policy or rider” at the end of the second sentence for clarification. **1990 Proc. IA 439.**

As originally drafted the section referred to “medical conditions” instead of “qualifying events.” Qualifying event is already a defined term and would be more restrictive than the original language. The group voted to replace “similar medical conditions” with “similar qualifying events.” **1990 Proc. IA 439-440.**

“Covered under the policy” was added to further define qualifying events after a suggestion that the language seemed to indicate that every life threatening condition must be covered. **1991 Proc. IA 579.**

Section 10. Actuarial Standards

A. When initially drafted, it appeared there were two distinct ways in which consumers could pay for the accelerated benefit. They may either make an additional premium payment or agree to take a discounted present value of the face amount. Commenters suggested that the exposure draft failed to take into account the two ways to pay for the benefit. The committee added an introductory paragraph to allow for two ways to pay for accelerated benefits. A footnote was also added to charge industry with development of an actuarial standard. **1990 Proc. IA 442-443.**

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Section 10A (cont.)

It was suggested that language be included to further clarify the effect of an accelerated benefit payment on the death benefit, cash value, future premiums and loan balance. After considerable discussion, the drafting committee decided to add the suggested language to Paragraph (3). When the lien approach is used, the proceeds of any accelerated death benefit payments would initially be applied toward paying off the portion of any outstanding loan balances which would cause the sum of the accelerated death benefit and policy loan to exceed the cash surrender value. Future policy loans should be limited to the difference between the cash surrender value and the sum of the lien payments made and the outstanding policy loans. Additional clarification was added to prevent the accidental death benefit in the policy or rider from being affected by the payment of an accelerated death benefit. **1990 Proc. IA 448.**

Just before adoption of the model, additional language was added. The charge made for the accelerated benefit provision may be added to the mortality charge, and this language made provision for those instances in which the charge is the cost of insurance and not a premium payment. **1990 Proc. IA 440.**

The title of the section was changed from “Premiums” to “Actuarial Standards” after the actuarial group had time to consider the issues referred to it and to develop standards. The original section was deleted in its entirety and replaced with a new section detailing three financing options and their effect on cash value. **1991 Proc. IA 583-584.**

After considerable discussion of the appropriate language, the working group decided to set maximum interest rates based on 90 day treasury bills or the current maximum policy loan interest rate. The advisory committee recommendation for an 18 percent rate was not accepted. **1991 Proc. IA 579.**

The draft of this section originally contained the language that charges should be “based on sound actuarial principles and shall not be excessive.” Actuaries expressed concern that this language was too subjective and might result in rate regulation for which the departments have no statutory authority to develop standards. They noted that the phrase “sound actuarial principles” in and of itself insures that premiums will not be excessive based on the standards of the American Academy of Actuaries. That term has been around for approximately 20 years, has been used in law and encompasses both the adequacy and equity concerns. **1991 Proc. IA 542.**

A sentence was added to Paragraph (1) to clarify that the additional cost may also be reflected in the experience rating. When an experience rating refund is made to group policyholders, the accelerated benefit cost is deducted from that refund, thereby financing it through the experience rating refund. After discussion about whether this guideline is restrictive as to funding options and whether the experience rating financing option is acceptable, the working group concurred in the addition of this language. **1991 Proc. IA 543.**

Section 11. Actuarial Disclosure and Reserves

Adequate reserving for accelerated benefit payments was also discussed by the drafting committee, and it was decided to refer the question to the Life and Health Actuarial Task Force to determine the proper reserve. **1990 Proc. IA 448.**

This section was added late in the drafting of the original model. The section required that, at the time of filing of the policy form, the valuation method and assumptions should be filed with the insurance department. **1990 Proc. IA 443.**

A new section on reserves was added after recommendations from the actuarial group. **1991 Proc. IA 579.**

A. The word “member” in the middle of Paragraph (1) was capitalized in one of the final drafting sessions. This recommendation was technical, but important, since the capitalized term applies to “accredited” members of the Society of Actuaries. **1991 Proc. IA 543.**

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Section 12. Filing Requirement

This optional section was added to reduce concerns in some states where it was desired to have more authority to examine rates and forms. The language had originally been considered as a part of Section 3. **1991 Proc. IA 578.**

Chronological Summary of Actions

December 1989: Model adopted as a guideline.

December 1990: Model amended to regulation format and substantially revised.