

HEALTH INSURANCE (AFTER HIPAA)

TABLE OF CONTENTS

INTRODUCTION AND BASICS	1
BACKGROUND ON HIPAA	1
GENERALITIES OF HIPAA	1
Employer Provided Health Insurance	2
HEALTH INSURANCE BASICS	2
DEFINITIONS.....	2
MEDICAL EXPENSE INSURANCE BASICALLY	3
LONG TERM CARE INSURANCE.....	3
DISABILITY INCOME INSURANCE.....	4
CONSTRUCTION OF HEALTH INSURANCE POLICIES.....	4
INDIVIDUAL vs. GROUP INSURANCE	4
Individual Health Insurance	4
Group Health Insurance	5
Marketing Individual Health Insurance.....	5
THE NEED FOR INDIVIDUAL MEDICAL EXPENSE INSURANCE.....	5
COMPREHENSIVE MEDICAL INSURANCE.....	6
TYPES OF BENEFITS	7
Major Medical Expense Insurance.....	7
Health Maintenance Organizations	7
MISCELLANEOUS INDIVIDUAL INSURANCE PLANS	7
Hospital Confinement Indemnity Plans	7
Critical Illness Insurance.....	8
ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE (AD&D).....	8
Difference by Time	9
Group Supplement or Voluntary	9
Trip AD&D.....	9
Dependents AD&D	9
Medicare supplement Policies.....	9
Specified (Dread) Disease Policies	9
DENTAL INSURANCE.....	10
Classification of Dental Services	10
Policy Deductible, Coinsurance, Benefits.....	11
Policy Details	11
PRESCRIPTION DRUG INSURANCE	11
Exclusions and Limitations	12
VISION CARE INSURANCE	12
TRAVEL ACCIDENT INSURANCE.....	13
ACCIDENT MEDICAL EXPENSE INSURANCE	13
POLICY PROVISIONS	13
SECTION II - UNDERWRITING INDIVIDUAL HEALTH INSURANCE.....	14
Adjusting for Characteristics.....	15
MEDICAL CONDITION & HISTORY OF APPLICANTS.....	15
FINANCIAL CONDITION.....	15

ADDITIONAL UNDERWRITING INFORMATION.....	15
Disability Income Record System (DIRS).....	17
CHAPTER TWO - MEDICARE SUPPLEMENT INSURANCE.....	19
MEDICARE SUPPLEMENT PROVISIONS.....	20
Guaranteed Issue Basis	20
NON-DUPLICATION.....	21
PROVIDERS	21
Hospital.....	21
Accepting Assignment	21
Physician.....	21
Registered Nurse.....	22
Skilled Nursing Facility	22
DEFINITIONS	22
<i>GRACE PERIOD</i>	24
PRE-EXISTING CONDITIONS LIMITATION.....	24
PREMIUMS	24
Misstatement of Age	24
SERVICES COVERED BY MEDICARE PART A.....	24
SERVICES COVERED BY MEDICARE PART B	25
Calendar Year Blood Deductible	26
MENTAL HEALTH SERVICES COVERED BY MEDICARE PART B	26
PREVENTIVE MEDICAL CARE	26
LIMITATIONS.....	27
EXCLUSIONS	27
NON-DUPLICATION OF COVERAGE.....	27
CROSSOVER.....	28
OUT OF COUNTRY CLAIMS.....	28
FRAUDULENT SUBMISSION OF CLAIMS.....	28
REINSTATEMENT	28
ENDORSEMENTS.....	29
OUTPATIENT MENTAL HEALTH SERVICES & AVIATION EXCLUSION ENDORSEMENT	29
ADDITIONAL BENEFITS.....	29
PART B EXCESS.....	30
AT-HOME RECOVERY.....	30
BASIC DRUGS	30
CHAPTER THREE - MSAS, HSAS AND OTHER TAX-FAVORED HEALTH PLANS .	32
MEDICAL SAVINGS ACCOUNTS (MSAs).....	32
Benefits of MSAs.....	32
Qualifications.....	33
Small or Growing Employer	33
Portability.....	33
HDHP.....	33
Other Health Coverage.....	33
Contributions to an Medical Savings Account.....	34
Limits of Contribution	34
Income Limit.....	34
Persons enrolled in Medicare.....	34

Reporting Contributions on Tax Return	34
Excess Contributions	34
Distributions from an Medical Savings Account	35
Insurance Premiums	35
Deemed Distributions	35
Recordkeeping	35
Reporting Distributions on the Tax Return	36
Rollovers	36
Additional Tax	36
Balance in an MSA	36
Death of the MSA Holder	36
Employer Participation.....	36
Comments	37
HEALTH SAVINGS ACCOUNTS (HSAs).....	37
Rollover from an MSA.....	37
Benefits of an HSA	38
Qualifying For an Health Savings Account	38
Health Savings Account High Deductible Health Plan.....	38
Family Plans That do not Meet the High Deductible Rules	39
Other Health Coverages	39
Prescription Drug Plans.....	40
Exceptions.....	40
Contributions to an Health Savings Account	40
Contribution Limit	41
Reduction of Contribution Limit.....	41
Family Coverage with Embedded Deductible.....	41
Enrolling in Medicare	42
Rollovers	42
Reporting Contributions to IRS and Form 8889	42
Excess Contributions.....	42
Distributions from an HSA	43
QUALIFIED MEDICAL EXPENSES	43
Rules for Insurance Premiums	43
Health Coverage Tax Credit.....	43
Deemed Distribution from HSA	44
Recordkeeping	44
Reporting Distribution on Tax Return	44
Balance in an HSA	44
Death of Holder of an HSA.....	44
HSA from the Employers Prospective	44
Comparable Participating Employees	45
Excise Tax.....	45
Employment Taxes	45
MEDICARE ADVANTAGE MSAs	45
FLEXIBLE SPENDING ARRANGEMENTS (FSAs).....	45
Contributions.....	46
Distributions.....	46
Balance in the FSA	46
Employer Participation.....	47
HEALTH REIMBURSEMENT ARRANGEMENTS (HRAs)	47
Benefits of an HRA	47
Qualifying for an HRA.....	47
Contributions.....	47
Distributions.....	47
Qualified Medical Expenses	47
Balance in an HRA	48

CHAPTER FOUR - GROUP HEALTH INSURANCE..... 50

HIPAA GROUP HEALTH INSURANCE REFORMS50

- PORTABILITY50
 - Creditable Coverage.....50
- PREEXISTING MEDICAL CONDITION.....51
 - Preexisting Condition Period51
- PORTABILITY OF GROUP HEALTH PLANS51
 - Continuous Coverage.....51
 - Late Enrollment.....52
 - Waiting Period52
 - Crediting Prior Coverage53
 - Spouse and Children Coverage53
- PORTABILITY WHEN MOVING FROM GROUP TO INDIVIDUAL PLANS53
 - Eligibility for Group to Individual Coverage54
 - Limitations of Group-to-Individual Portability.....54
 - Special Enrollment Periods.....55
 - Individual Losing Coverage.....55
 - Dependent Beneficiaries56
- NON-DISCRIMINATION56
 - PREMIUM AMOUNTS56
 - Guaranteed Issue57
 - Guaranteed Renewability.....57
- FEDERALLY MANDATED BENEFITS.....57
 - Newborns’ and Mothers’ Health Protection Act58
 - Women’s Health and Cancer Rights Act of 199858
 - Excluding Coverage for Specific Risks58
 - Association-Sponsored Group Health Plans59
 - State Requirements59
- COBRA CONTINUATION COVERAGE.....59

GROUP HEALTH INSURANCE MARKETING.....60

- Agents60
- Brokers.....60
- Employee Benefit Consultants61
- Group Representatives61
- THE SALES PROCESS61
 - Prospecting.....61
 - Proposal.....61
 - Presentation.....62
 - Employee Enrollment62
 - Installation of Group62
 - Servicing of the Group.....63
 - Group Sales Attractive to Agents.....63
- GROUP UNDERWRITING.....63
 - Predicting Claims.....63
 - Adverse Selection64
 - Statistical Averages.....65
 - Premium Rates65
 - Competitive Benefits and Premiums.....65
 - Adverse Selection in Small Groups66
- SMALL GROUP REGULATIONS.....66
 - “TURNED DOWN”66
 - Low Participation.....67
 - Fictitious Groups.....67
 - Administration Difficulties67

Persistency	67
PROJECTING CLAIMS EXPERIENCE	67
Age	67
Sex	68
Dependent Coverage	68
Type of Business	68
Income	68
Geographical Area	68
Other Problem Indicators	69
CHAPTER FIVE - DISABILITY INCOME INSURANCE	72
DEFINITION AND OVERVIEW.....	72
Conditionally Renewable	72
THE NEED FOR DISABILITY INCOME INSURANCE	73
DEFINITIONS.....	75
INJURY	75
Accidental Means vs. Results	75
SICKNESS	75
PREEXISTING CONDITION.....	75
DEFINITION OF DISABILITY	76
Partial Disability vs. Residual Disability	76
RESIDUAL DISABILITY INCOME INSURANCE	76
TOTAL DISABILITY.....	76
OWN OCCUPATION	76
Physician Requirement.....	77
PRESUMPTIVE DISABILITY	77
ANY GAINFUL OCCUPATION.....	77
INCOME REPLACEMENT APPROACH	78
POLICY PROVISIONS.....	78
BENEFITS.....	78
ELIMINATION PERIOD.....	78
Voluntary Interruption of Elimination Period	78
THE BENEFIT PERIOD.....	79
Recurrent Disability Provision	79
THE BENEFIT AMOUNT	79
Participation Charts.....	80
BASIC BENEFIT PROVISIONS.....	80
Rehabilitation Benefit	80
Non-Disabling Injury Benefit	81
Transplant Benefit.....	81
Principal Sum Benefit.....	81
OPTIONAL BENEFITS.....	81
RESIDUAL DISABILITY BENEFIT	81
PARTIAL DISABILITY BENEFIT.....	82
SOCIAL INSURANCE SUPPLEMENT (SUBSTITUTE).....	82
INFLATION PROTECTION	83
SUPPLEMENTAL PROVISIONS FOR INCREASED FUTURE BENEFITS	84
Automatic Increase Benefit Provision.....	84
Guaranteed Insurability Option.....	84

TYPES OF GROUP DISABILITY PLANS	85
SHORT TERM DISABILITY	85
MARKETING OF GROUP SHORT-TERM DISABILITY PLANS	85
MARKETING OF GROUP LONG-TERM DISABILITY INCOME PLANS	86
TAXATION OF GROUP DISABILITY INCOME BENEFITS	86
FLEXIBLE BENEFIT PREMIUM PLANS	86
ANNUAL CLAIM COSTS FOR DISABILITY INCOME POLICIES	87
MEASURING MORBIDITY	88
Continuance Tables	88
LOSS RATIO	89
GROSS PREMIUMS	89
Morbidity	90
Expenses	90
Persistency Rate	90
Interest	90
Profits Contingency Assumptions	91
MISCELLANEOUS PREMIUM VARIABLES	91
FINAL DETERMINATION	91
BUSINESS OVERHEAD INSURANCE	91
THE BUSINESS OVERHEAD POLICY	92
Carryover of Monthly Benefits	93
Accumulation Provision	93
Partial Disability	93
TEMPORARY REPLACEMENT	94
BUSINESS CONTINUATION	94
PARTNERSHIP BUY-SELL AGREEMENT	94
CHAPTER SIX - LONG TERM CARE INSURANCE	97
Policy Definitions	97
Long-Term Care Insurance Definition	97
STATUTORY PROVISIONS	97
Qualified Long-Term Care Insurance	99
Tax Deduction Eligible Long-Term Care Premium Limit by Age Group	99
Type of Policy	100
NURSING FACILITY AND RESIDENTIAL CARE FACILITY	100
HOME CARE ONLY	100
Home Health Care	100
Adult Day Care	101
Personal Care	101
Homemaker Services	101
Hospice Services	101
Respite Care	101
Coverage Triggers for Home Care Benefits	101
Medical Necessity Not Allowed As Coverage Trigger	101
Home Care - Minimum Benefit Limits and Duration	101
Prohibited Limitations for Home Care Benefits	102
COMPREHENSIVE LONG-TERM CARE	102
TYPES OF LONG-TERM CARE BENEFITS	102
Reimbursement Policy	102
Indemnity Plan	103
BENEFIT AMOUNTS	103
BENEFIT PERIOD	103

HOME AND COMMUNITY CARE BENEFIT AMOUNTS.....	104
POOLED BENEFITS MANDATED	104
ELIMINATION PERIODS	105
CARE-RELATED ELIMINATION PERIODS.....	105
OPTIONAL BENEFITS	105
Shared-Benefit Rider.....	105
Bed Reservation Benefit.....	105
Restoration of Benefit	105
Home Modification and Therapeutic Devices.....	105
Caregiver Training	106
Limited Pay Options.....	106
Waiver of Premium	106
Non-Forfeiture Benefits	106
Shortened Benefit Period.....	106
REQUIRED BENEFITS.....	106
30-Day Free Look	106
Protection against Unintended Lapse	107
Renewability Provision	107
GRANDFATHERED LTCI POLICIES	107
EXCLUSIONS AND LIMITATIONS	107
PREEXISTING CONDITIONS	107
<i>NO TERMINATION DURING CLAIM.....</i>	<i>107</i>
<i>PRIOR HOSPITAL STAY REQUIREMENT</i>	<i>108</i>
<i>DISCRIMINATION BASED ON INDIVIDUAL'S HEALTH.....</i>	<i>108</i>
USUAL AND CUSTOMARY STANDARD IS PROHIBITED.....	108
<i>OTHER REQUIREMENTS</i>	<i>108</i>
➤ No Preference for Skilled Care.....	108
➤ New Waiting Periods after Conversion or Replacement	108
➤ No New Preexisting Conditions on Replacement Policies	108
➤ Reduction of Benefits Due to Out-of-Pocket Expenditures	108
➤ Value of All Benefits Must Be Disclosed.....	108
➤ No Reduction of Inflation Benefit Increase Due To Payment of Claims.....	108
INFLATION PROTECTION	108
Types of Inflation Protection	108
Automatic Inflation Protection.....	108
Option to Purchase Inflation Protection	108
QUALIFYING FOR BENEFITS.....	109
Chronically ILL Individual	109
Tax Qualified Definitions of ADLs.....	110
Tax Qualified Cognitive Impairment Trigger	110
Substantial Supervision	111
Non-TQ Benefit Triggers	111
Typical Non-Tax Qualified ADL Definitions	111
Non-Tax Qualified Cognitive Impairment	112
GROUP LONG TERM CARE INSURANCE	112
THE MAIN FEATURES OF THE GROUP PLANS	113
ELIGIBILITY FOR GROUP COVERAGE.....	113
GROUP BENEFITS & OTHER PROVISIONS vs. INDIVIDUAL PLANS	113
GROUP LTCI PREMIUMS	114
ASSOCIATION GROUP LTC INSURANCE	114
SELF-EMPLOYED SPECIAL INCENTIVES.....	114

TAXATION TO EMPLOYERS.....	114
TAXATION OF BENEFITS TO EMPLOYEES.....	115
REFERENCES.....	118

HEALTH INSURANCE (AFTER HIPAA)

Note: Throughout this text rather than use the clumsy gender designation as he/she, his/her, himself/her self, etc., the masculine gender is used for the purpose of simplicity. There is no intent to diminish the contributions to the insurance industry by either sex, or imply that either contributes less than the other.

INTRODUCTION AND BASICS

BACKGROUND ON HIPAA

Congress enacted the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as Public Law 104-191, on August 21, 1996, which, along with subsequent changes and changes, provided for changes in the health insurance marketplace and imposed certain federal requirements on health insurance plans offered by public and private employers, including certain tax provisions relating to health insurance. These permitted a limited number of small businesses and self-employed individuals to contribute to tax-advantaged health plans (MSAs, etc.)

As HIPAA regulations become involved in this discussion of Health Insurance, it will be so noted. In addition, there is an entire chapter devoted to MSAs, HSAs and other tax-favored health plans which for the most part, were created or addressed by HIPAA.

GENERALITIES OF HIPAA

The basic stated intent of HIPAA in respect to health insurance provisions was to decrease the possibility that people and small employers will lose their health insurance coverage by making it easier to switch plans or to purchase individual policies on their own if they lose employer furnished health insurance. The Act ensures that people who are moving from one job to another, or from being employed to being unemployed, do not lose their health insurance protection because of a preexisting health condition—hence, the *portability* problem. It also limits the period of time before a health plan covers a preexisting medical condition for participants and beneficiaries in group health plans.

HIPAA guarantees that individuals and employers who choose to purchase coverage are able to find a plan that is guaranteed issued and that individuals who have coverage are able to renew the coverage. It also prohibits discrimination on the basis of health conditions and it requires health plans to offer special enrollment periods.

The Act further raised the tax deduction for health insurance premiums paid by self-employed persons. MSAs were offered on a trial basis (see chapter on MSAs, etc.) and new tax incentives were made available to encourage individuals and employers to purchase Long Term Care Insurance. It also addresses electronic transmission of health insurance and the privacy of personally identifiable medical information.

Other provisions have been added, including plans that cover newborn delivery, to allow for a minimum two-day hospital stay under certain conditions, required plans that offer mental health services to offer them subject to similar limitations as other health benefits, and required

plans that cover mastectomy to also cover reconstructive surgery. Also, the premium deduction for premium costs for the self-employed was changed.

It should be pointed out that HIPAA's provisions attempt to help Americans who are insured and who have a preexisting medical condition and have stayed in a job because of the fear that they would not have coverage because of such condition if they changed jobs. In addition, it attempts to assist individuals who have not been able to purchase insurance because of their health status, either individually or through an employer's group plan.

On the other hand, the tax deduction for health insurance costs for the self-employed may encourage some uninsured, self-employed individuals to purchase health insurance for themselves. Also, HIPAA restrains itself to the availability of insurance and it does not regulate the price of health insurance coverage—which is regulated by the states.

The cost of health insurance in the individual marketplace for individuals who are taking advantage of HIPAA provisions relating to group-to-individual portability is higher than the cost for individuals who could otherwise obtain insurance, according to many critics. Whether this continues for a long period of time remains to be seen, but when viewed as a practical matter, if an employee was covered by group insurance—which had no underwriting requirements—wants to purchase individual insurance—which is, and must be, strictly underwritten—the risk of claims is higher than with those who have been underwritten. Therefore, their premiums should be higher. If, as claimed, the individual could purchase individual insurance at a lower premium otherwise, then the individual certainly has the right and prerogative to do so.

Employer Provided Health Insurance

Contrary to some interpretations, HIPAA does not require employers to offer health insurance for their employees, or pay for such coverage. Further, it does not require that employer-offered plans pay for dependants or spouses, and importantly, it does not require that coverage be offered to part-time, seasonal or temporary employees. However, if an employer does provide or sponsors a group health plan, they must comply with some requirements of the Act.

Requirements that must be complied-with include the restriction of preexisting condition limitation periods, prohibiting an employer from discriminating on the basis of health conditions in determining the eligibility of an employee (and spouse or dependents) to participate in a group health plan, prohibits the requirement for an individual to pay higher premiums for coverage because of health status, and mandating documentation of creditable coverage.

Additional discussions of Health Insurance reforms will be discussed in more detail in the Chapter regarding Group Insurance. Also, reforms regarding Long Term Care Insurance will be included in that Chapter.

HEALTH INSURANCE BASICS

DEFINITIONS

First, it may be of benefit to define what it is that is being discussed. "Health Insurance" means different things to different folks. Health insurance policies cover the cost of injuries or sickness, and for the purposes of this text, policies that pay benefits because of physical or mental incapacity. The formal definition of a Health insurance contract is a policy that pays benefits to an insured that becomes ill or injured, *provided that documentation is offered to confirm the illness or injury*. Not commonly known, if anyone cares, is that in many other countries, particu-

larly in Europe, Health Insurance is considered as “non-life insurance,” but in the United States, Health Insurance generally falls within the life insurance branch.

For the purposes of this discussion, Health insurance means any form of insurance whose payment is contingent on the insured incurring additional expenses, or the loss of income, because of either incapacity or loss of good health.

If the individual receives benefits under such a policy because of physical or mental incapacity so that the insured cannot perform the duties of his occupation, such coverage is called ***disability income insurance***.

If the incapacity requires assistance in the insured’s activities of daily living, this is called ***Long Term Care Insurance***.

If it is necessary for the insured to incur hospital, doctor or other health care expenses, then that is called ***medical expense insurance***.

Health Insurance (and life insurance) is typically purchased by an employer for the benefit of their employees in the form of *group* insurance. If the policy is purchased on an individual basis, it may be *industrial* insurance, although this is rarely sold any longer as these types of policies are issued to individuals in small amounts. As with life insurance, Health Insurance policies of with larger amounts of benefits than industrial policies are called *ordinary* Health Insurance. Lastly, policies issued through a lending institutions to cover debtor’s obligations if they become disabled, is *credit health insurance*.

Regardless of the terminology, nearly all private Health Insurance in every market must, by law, be issued by an insurance organization. An insurance organization is simply a mechanism for pooling losses.

MEDICAL EXPENSE INSURANCE BASICALLY

Medical expense insurance, often referred to as simply “health insurance,” provides a wide range of benefits that can cover nearly every hospital and/or medical expense incurred by the insured and covered family members. Medical expense plans can range from basic benefits for specified kinds and types of medical services, or, on the other hand, can provide major medical expenses associated with severe injury or long-term illnesses. The insurance benefits can be paid either to the insured as reimbursement for actual expenses he has incurred, or to the health provider or health institution. With some plans benefits are fixed and are paid regardless of what the actual costs may be or “up-to” some designated amount.

LONG TERM CARE INSURANCE

A Health Insurance product that has increased in popularity—but not as much as anticipated—provides financial protection against the high costs of long-term care expenses by reimbursing such expenses as a result of needing assistance in activities of daily living. With these policies, benefits are “triggered” by the inability of the insured to perform such activities of daily living (referred to as “ADLs”) and the benefits are usually paid as fixed amounts.

As discussed later in the text, The Health Insurance Portability and Accountability Act (hereinafter referred to as “HIPAA”) officially determined that Long Term Care Insurance is considered as “Health Insurance” for tax purposes, and as federal governmental regulations are apt to do, created a new class of policies with designated benefits in order for the insured to take advantage of the tax benefits.

DISABILITY INCOME INSURANCE

Sometimes called *loss of time* or *loss of income insurance*, Disability Income (DI) Insurance provides benefits in the form of periodic payments when the insured loses income because of injury or sickness. Typically, the coverage is related—directly or indirectly—to the occupation and earnings of the insured. Benefits are traditionally paid as fixed amounts while the insured is disabled, however some policies may provide for reimbursement coverage.

CONSTRUCTION OF HEALTH INSURANCE POLICIES

Health Insurance (and Life Insurance) policies are contracts and provisions comply with general contract law. While Life and Health Insurance contracts are similar, Health Insurance contracts are more complex for various reasons: more than one loss can occur while the policy is in force (people only die once, obviously), there is a wider spread of types of losses, and the cause of loss is more subjective with Health Insurance. Therefore, Health Insurance policies require more definitions, and more of a technical nature, than Life Insurance, and they offer more optional coverage's than Life insurance.

One of the most striking differences is that Health Insurance policies must contain many provisions so as to determine how the benefits are determined and maintained. For instance, Health Insurance contracts require that the insurer must be provided with a written notice of any claim within a certain period of time (such as 20 days). The insurer is required to provide their own forms needed to provide proof of loss with 15 days (usually), otherwise the insured can provide their own proof of loss. Proof of loss usually is required within 90 days of the loss, but if the loss is a continuing type of loss, then proof of loss must be provided every 90 days (or so).

The insurer may be required to pay the loss within a designated time period and the insurer usually has the right to require the claimant to be examined (or an autopsy performed) at the expense of the insurer. The Health Insurance policy contains other, well defined provisions as discussed later in more detail, and they are common to all Health Insurance Policies. Other provisions are more specific as to the particular coverage's.

INDIVIDUAL vs. GROUP INSURANCE

Medical expense, Long Term Care Insurance and Disability Income Insurance may be issued either on an individual or group basis. The basic differences lie in the methods of marketing and how the coverage's are issued and administered.

Individual Health Insurance

Individual Health Insurance is simply where coverage is provided to a specific individual under a policy issued to the individual. The "Individual" policy may cover other family members, and frequently does. With the exception of most states and in most mass-marketing methods sponsored by some governmental bodies or plans mandated by law, the insured must provide evidence of insurability, not only for him, but for all covered persons.

Individual policies are maintained by insurers in separate records for each issued policy and all transactions, such as premium collection, benefit payments, etc., are conducted on a direct basis with the insured (unless benefits are paid directly to the provider, in which case the insured is duly notified). The insured policyholder is the owner of the contract.

Group Health Insurance

Group Health insurance is where coverage is provided to a group of individuals under a single master contract issued to the group policyowner which may be an employer, an association, labor union, trust or other organization *not organized for the purpose of obtaining insurance*. For larger groups, coverage can usually be obtained without providing for evidence of insurability, however, many states allow for smaller groups to be issued coverage without such evidence.

Because of the lower marketing costs per individual covered, and lower administrative expense, as a general rule, group health insurance costs less than individual plans with comparable coverage's, particularly for the larger groups. For the smaller groups that are required by law to provide coverage without evidence of insurability, the claims ratio would be much higher with the resulting higher premium than with the larger groups. Also, group coverage's may provide for broader coverage's, or even coverage's not available under individual policies.

This section will concentrate on individual policies and group coverage's will be addressed in a separate section later in this text.

Marketing Individual Health Insurance

As indicated above and described later in more detail, there are certain basic differences between individual and group markets, with the result that marketing individual health insurance can be quite complex as compared to group or mass-marketed health insurance plans. This causes natural difficulties for the consumers as because the obtaining of information in coverage's must be sought for individual plans, as compared to the providing of information by the group policyholder. Individuals must make choices from a plethora of complex products that can be extremely difficult to compare. Even after a particular product is chosen, they must still select from a variety of cost-sharing arrangements (deductible and coinsurance, etc.) and most importantly too many purchasers; the insured must bear the total cost of the coverage.

Contrast this with group insurance offered to employees, starting with the fact that they do not have to face the formidable task of just accessing the insurance marketplace as this is done for them by group insurance (or it just does not apply with governmental insurance). Further, the employer usually offer only one (or no more than a few) health plans, so the job of finding and then comparing plans has been eliminated or at least greatly simplified. Plus, paying for the products is simplified and the cost is considerably lower in most cases for group insurance because of cost sharing with the employer and the ease of payroll deduction.

Most Individual Health Insurance is purchased through agents, except in some cases it is sold directly by insurers that are well recognized—such as Blue Cross/Blue Shield or HMOs who target individuals in their marketing efforts.

Another way to purchase Health Insurance is through business or social organizations, such as trade associations, unions, chambers of commerce, religious organizations, etc. By using the power of pooling risks, these organizations can often negotiate competitively priced products for their members.

THE NEED FOR INDIVIDUAL MEDICAL EXPENSE INSURANCE

The market for Individual Medical Expense Insurance is large and consists of men and women, rich and poor, with various ethnic, religious and educational backgrounds—such as self-employed persons, young people (students generally) no longer covered under the parent's insurance, employees whose employer does not provide group coverage including part-time, tempo-

rary or contract workers, unemployed persons, those ineligible for coverage (such as children, spouses and other dependants) or those whose employer's plan is too costly to coverage of dependants, and those persons who have retired early or are not in the workforce (such as between jobs).

According to the U.S. General Accounting Office, almost 5 percent of the non-elderly US population relies on private Individual Medical Expense Insurance as their only source of such insurance. Large proportions of the population have no Medical Expense Insurance and some of the states have installed programs to encourage access to such coverage's. One approach used in about half of the states allows those "high-risk" applicants to obtain needed medical expense insurance when (usually) they have been rejected for insurance by at least one insurer because of health conditions. The premiums usually are as much as 50% higher than the standard rates for like policies in that jurisdiction available in the individual market. Also, these "pools" are usually restricted to a limited number of individuals, often as little as 5% of those under age 65 with individual insurance; such restrictions due mostly to limited funding, lack of public awareness and high premiums, not to mention higher than anticipated claims.

Individual Health Insurance may be used as supplements to other coverage's, such as those who are covered under government health insurance programs that do not cover all health care expenses or usually have delays in obtaining government-provided care. This is, of course, the situation with Medicare Supplement policies.

And there are those who have inadequate coverage from other sources, such as paying less than current hospital charges or inadequate amounts for surgery. Therefore, the use of supplemental health policies, such as a hospital indemnity policy can be important. Some people that can afford to cover some of their own medical expenses or have insufficient coverage may purchase "catastrophe" coverage with a deductible of several thousand dollars.

COMPREHENSIVE MEDICAL INSURANCE

Perhaps the most popular and common type of medical insurance is the Comprehensive Medical Insurance plans that cover a wide variety of medical care charges, have few internal limits and a high maximum benefit. These plans are most often offered by life insurance companies, Blue Cross/Blue Shield insurers and Health Maintenance Organizations (HMOs). The life insurance companies offering health insurance have offered Comprehensive plans for many years.

Blue Cross/Blue Shield organizations and insurers are major insurers in many states and they offer relatively comprehensive plans. In some states the "Blues" offer the same type of policy as other insurers, but in many states the Blues negotiate and pay hospital and other health care providers directly—usually at a lower rate than would be paid in a reimbursement plans. In these states, the traditional life insurers use indemnity-type reimbursement plans. (This also applies to Blue Cross/Blue Shield group plans also.)

In respect to HMOs, they offer health care and its financing through a single organization, with individual coverage much akin to their group programs (with obvious exception of administration and pricing). HMOs will be discussed in detail later, but suffice it to say that HMOs have grown in importance as attempts are made to hold down the rapidly escalating medical care costs. HMO individual plans are similar to group plans that they offer except for the difference in administration and pricing.

TYPES OF BENEFITS

As indicated by its name, Comprehensive medical insurance covers a wide range of health care benefits such as hospital services (both inpatient and outpatient), physician and diagnostic services, various types of physical therapy, and often, prescription drugs (which are usually more liberal in group insurance plans).

There are various cost-sharing arrangements in individual plans, with deductibles of \$250 to \$2,500 (or more for “catastrophe” plans) and with limits on the total amount that the insured would pay during a specified period of time (usually one year) which can be anywhere from \$1,200 to over \$6,000 during this period.

Major Medical Expense Insurance

The most popular type of health expense insurance is Major Medical Expense Insurance, which is offered by most life insurers and Blue Cross/Blue Shield organizations. Under these types of plans, the medical expense reimbursement applies to both the deductible and coinsurance. For instance: a plan that pays for 80% of all combined covered expenses during a calendar year after a \$500 deductible, and with a lifetime maximum benefit of \$1 million.

As with most other Health Insurance plans there are a variety of plan variances, such as providing for “first-dollar” coverage. Some plans allow certain expenses (such as hospital expenses) to be reimbursed without a deductible and with no coinsurance on the initial hospital expenses (usually with a maximum of \$2-5,000). Surgeon’s fees may also be subject to the no-deductible, no-coinsurance provision. Various other and similar plans are discussed later in this text.

Health Maintenance Organizations

HMOs offer individual policies that provide basically the same or equal to the coverage’s provided under major medical plans; however, the HMOs usually offer coverage’s not usually offered under the major medical policies. Preventative care services are a hallmark of the HMO with coverage for periodic examinations, immunizations and health education. Also, they are more apt to provide significant prescription drug coverage than other medical expense plans.

Deductibles are generally much more liberal with HMOs, typically ranging from \$10 or \$15 for physician office visits and \$100 to \$500 for hospital admission. However, their out-of-pocket maximums are similar to major medical plans.

MISCELLANEOUS INDIVIDUAL INSURANCE PLANS

In addition to the policies discussed, insurers offer several other types of individual policies. These can be broken down into (1) hospital confinement and hospital indemnity policies; (2) Medicare supplement insurance; and (3) specified disease policies (or dread disease policies).

Hospital Confinement Indemnity Plans

These plans pay a fixed sum for each day of hospitalization. Simple plan, not very expensive, and often is purchased by those who just cannot afford any other type of health insurance and are not eligible for Medicaid or other government program. The benefits are sold as monthly amounts between \$1,000 and \$6—\$7,000 for *continuous* confinement for periods of up to one year or more. The monthly amount, when designated in this manner, is actually an aggregate of potential daily payments (30-day months) so that a \$1,500 monthly payment would pay \$50 for

each day that the insured was in the hospital. Some policies pay a daily amount stated, such as \$100 a day and can go up to \$400 a day.

Benefits are paid from the first day of hospital confinement and pays for either sickness or injury. The maximum benefit period is usually 3, 6, or 12 months.

The purpose of this coverage is to provide money for the insured to pay for out-of-pocket expenses required by other coverage's (deductibles, coinsurance, etc.), medical expenses not covered by other policies (such as additional medical opinions, prescription drugs, rehabilitation services, home health care, etc.) and incidental expenses during illness, such as child care, transportation, housekeeping, loss of income due to illness, etc.

Critical Illness Insurance

Similar to Hospital Indemnity insurance, this coverage is not based on actual expenses, but is paid in addition to and regardless of other benefits the insured may receive. It is intended to provide money for the insured to help pay for medical and related out-of-pocket expenses not paid by other coverage.

Critical Illness Insurance pays a lump sum if the insured suffers from one of the specified serious illnesses or injuries, such as heart attack, angioplasty, heart bypass, organ transplant, stroke, kidney failure, paralysis, cancer, Alzheimer's, multiple sclerosis, and the loss of limb, sight, hearing or speech.

The amount of the benefit varies according to the illness and the seriousness of the illness or injury. Different plans have different benefits, with maximums ranging from \$10,000 to as high as \$2 million. The lump sum payment is usually paid following a waiting period of 30 days after the confirmed diagnosis of a covered illness or accident.

Policies are available to persons age 18 through 64 and terminate after the lump sum payment has been made or the person reaches age 65. These policies are either individually issued, part of group coverage, or riders to existing life insurance policies.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE (AD&D)

Accidental death and dismemberment insurance pays benefits when the insured dies, loses the sight of one or both eyes, or loses a hand or a foot directly as the result of an accidental bodily injury. It is usually offered on a group basis, but may also be sold as an individual policy.

This policy establishes the maximum benefit, known as the **principal sum**. Typically, benefits are paid for loss of life (full principal to designated beneficiary), the severance of hand or foot at or above the waist or ankle, or irrecoverable loss of sight of one eye (one-half the principal sum); and for loss of more than one loss of hand, foot or eye from the same accident, the full principal sum is paid. The benefit for any one accident never exceeds the principal sum, even if there are more than two losses.

There are several limitations and exclusions. Losses that result directly or indirectly, wholly or partly from any of the following, are excluded:

- disease or bodily or mental infirmity or their medical or surgical treatment;
- ptomaine or bacterial infection, except infections occurring through an accident cut or wound;
- suicide or an intentionally self-inflicted injury;
- war, or act of war; drug use, except if taken as prescribed by a physician

Difference by Time

AD&D policies are either nonoccupational or 24-hour coverage. Nonoccupational policies do not cover accidents resulting from the insured's employment; 24-hour coverage cover accidents occurring at any time, on or off the job.

Group Supplement or Voluntary

AD&D may be sold either as a supplement to an employer's group life insurance (usually not optional) or sold on a voluntary basis. Voluntary AD&D is also sold on a group basis, but each employee or group member may or may not receive (and pay for) the coverage.

Note: The principal sum of group life supplement AD&D is usually the same as the benefits of the group life insurance. While group life insurance may continue after the retirement of the insured, usually AD&D coverage does not continue.

Trip AD&D

Some employers want to furnish supplementary accident insurance protection for employees who travel on company business, and the employer usually pays for the coverage. This coverage usually is one of three types:

- Comprehensive (all-risk) plans which provide 24 hours coverage for the entire trip, from the time the employee leaves home or business, until he returns.
- Common-carrier plans cover only accidents involving common carriers, defined as public conveyances licensed and used for transportation of passengers.
- All conveyance plans cover accidents involving any sort of conveyance, including person or company-owned vehicles.

Dependents AD&D

There are also AD&D plans for employees who may cover their dependents. It is always 24-hour coverage, regardless of what coverage is provided for employees. Eligible dependents include the employee's spouse and unmarried children, up to a specific age.

Medicare supplement Policies

Medicare is discussed in more detail later, but for purposes of definition of types of plans, Medicare contains certain deductible (such as \$100 annual deductible) and coinsurance requirements (Part B has a 20% deductible of "reasonable charges"). Medicare was introduced in 1965, probably because the insurance industry was unable to provide meaningful and affordable health insurance to its senior citizens (and to those eligible for Social Security Disability payments, after a 24-month waiting period in most cases). The insurance industry provided a mish-mash of supplemental plans, sometimes with the result that a senior citizen could find himself with several "supplemental" policies. In 1991, the National Association of Insurance Commissioners (NAIC) implemented the law that introduced 10 standard plans. These plans were accepted by all of the states and companies are not allowed to sell any unapproved Medicare supplement policies (also called "Medigap" policies).

Specified (Dread) Disease Policies

These types of policies pay a variety of benefits up to rather-substantial maximums solely and exclusively for the treatment of the disease(s) named in the policy. This type of policy

started with the “Polio” policy during the time in history when there was a near-epidemic of polio patients and most of the medical care expenses were not covered under the typical health insurance policy. After a cure to Polio was discovered, the insurers that had been offering these plans switched to other dread disease coverage’s, primarily cancer coverage.

Benefits are paid as scheduled amounts of indemnity as the result of a specified and designated event (such as diagnosis of cancer, hospital care as a result of cancer, etc.) or for specific treatment (such as chemotherapy, etc.). These policies provide coverage only for certain diseases; therefore they should be used only for supplementing other health insurance.

This has proven to be an interesting product as when it was introduced, it was generally ignored by life and health insurers. However, when clever marketing produced significant premium income for a very few insurers offering the product, some of the major life insurers took notice. They attempted to “squell” the sale of this product (primarily at the request of their General Agents who were losing agents to these companies) by the “Coordination of Benefits” clause, which would have made these policies unattractive to anyone with health insurance as both policies could not pay if the specified disease were contracted by the insured. Whereupon the President of the major writer of the dread disease policy met with the Presidents of two of the largest life insurance companies and threatened a lawsuit with a jury in his state of domicile—with the predictable result that the Duplication of Coverage provisions does not apply to these policies.

This product is often marketed on a group basis and is sometimes bundled with a short-term disability insurance product. Another interesting item is that an American insurer has marketed these policies with considerable success in Japan, using primarily women agents.

DENTAL INSURANCE

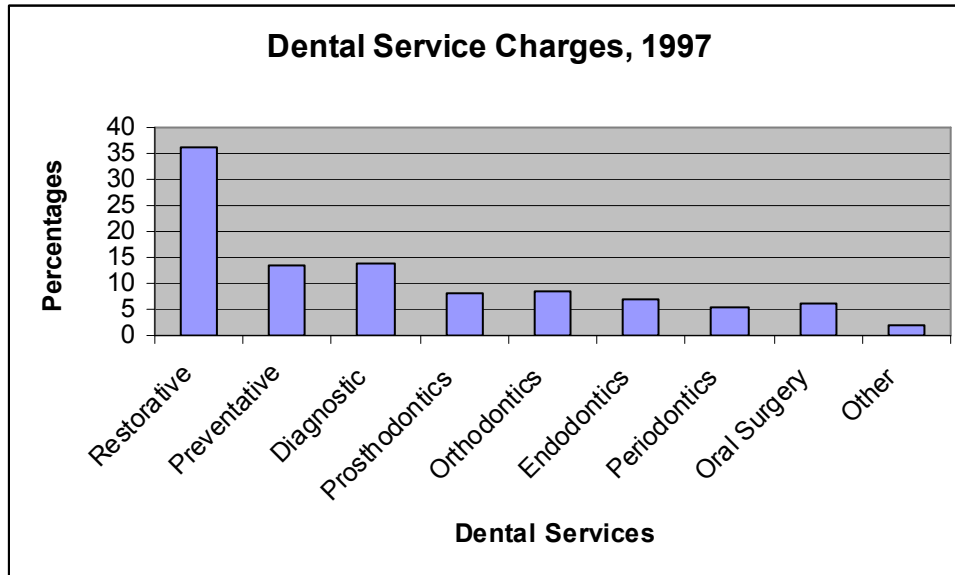
Dental insurance policies are reimbursement type plans covering the expense of dental services and supplies, usually excluded from medical expense plans.

Plans differ between integrated and nonintegrated plans: An integrated plan may be integrated into a medical expense policy, or a separate policy (nonintegrated or stand-alone).

They also can be scheduled or non-scheduled reimbursement plans. The plan may reimburse for dental services based on a schedule or based on the “usual and customary” charges for dental services. The dental schedule specifies amounts for certain services and reimburses up to that amount. The amounts may vary with geography to reflect the level of charges in that particular area of the country. Usually integrated plans reimburse on a nonscheduled basis, while nonintegrated plans may reimburse on either basis.

Classification of Dental Services

Dental services are classified as diagnostic, preventative, restorative, prosthodontics, oral surgery, periodontics, endodontics or orthodontics. Most dental claims relate to restorative charges; fillings, cleaning, etc. The distribution of charges from one of the larger writers of Dental Insurance is as follows:



Policy Deductible, Coinsurance, Benefits

Deductibles: Most plans have deductibles (like most medical expense plans) and generally it must be satisfied by each individual during each calendar year. In integrated plans there is a single deductible for both dental and medical expenses. To encourage preventative care, the deductible is usually not applied to preventative and diagnostic services.

Coinsurance: Generally, Dental plans also have coinsurance and the percentage may differ by services performed or class of service, ranging from 20% to 50% as a general rule. Coinsurance is usually higher for major procedures (as opposed to “basic” services).

Maximum Benefit: Some of the nonintegrated dental plans have a calendar year or policy year maximum on benefits. Some have a lifetime maximum for orthodontic benefits, and some have a lifetime maximum for periodontal care.

Policy Details

The frequency of some services may be limited such as not allowing more than two dental cleanings and one fluoride treatment in a 12-month period. There usually is a restriction on bridgework and dentures, such as they may not be replaced for a period of (usually) 5 years except under certain specified situations.

Cosmetic and experimental services are excluded.

Replacement of missing teeth that were missing prior to the effective date of the plan may be excluded entirely, or sometimes covered at a reduced reimbursement rate.

Orthodontic services are usually either not covered or available as an (expensive) option as these services are expensive and can increase the premiums significantly.

PRESCRIPTION DRUG INSURANCE

Prescription Coverage for Medicare beneficiaries and certain others has been approved and will go into effect in the latter months of 2005 and early 2006. Basically, there will be a monthly premium which will usually be deducted from an individual’s Social Security benefits each

month. There will be a deductible depending upon the plan and whether the drug is generic or preferred brand. For drug costs between \$2,251 and \$5,100, the person must pay all of the drug costs, and over \$5,100, the person will pay only 5%. Anyway, that is generally what it will accomplish, but there are already supplemental policies available weeks before the plan is offered.

For “regular” Prescription Drug insurance, the plans cover drugs and medicines prescribed by a physician, and usually are offered through an employer on a group basis. These plans usually use a co-payment feature, which is a flat amount that the insured pays each time a certain kind of service is provided—much like coinsurance but the amount is a flat dollar amount. These co-payments range from \$5 to \$15 usually and can be as high as \$50 with some plans. Usually there are lower co-payments for generic drugs.

There are two types of drug plans:

Reimbursement plans are where the insured pays a pharmacist for prescribed drugs, the pharmacist completes a claim form, and the insured submits the form to the insurer and the insurer reimburses the insured. These are based upon usual and customary charges.

Service Plans are where the insured obtains prescription drugs from the pharmacies who participate in the plan. Therefore, the insured does not pay the pharmacist or pays only a co-payment. The insurer reimburses the pharmacist.

Service plans need large networks of participating pharmacies and involve large numbers of small claims. About the only way that this can be profitable is for a third-party to administer the business that can manage the business and negotiate discounts with the pharmacies.

Service plans include mail-order prescription drug programs who basically serve those who use maintenance medication and order 60 to 90 day supplies.

Exclusions and Limitations

As a general rule, any drugs that are dispensed while the insured is confined to in a hospital or extended care facility are usually covered by regular health insurance, so they are excluded. Prescription drugs are usually limited to a specific number-of-days supply, such as 30-days for a drug obtained from a regular pharmacy and 90-day supply from mail order pharmacies.

Also excluded are medical devices, such as syringes, hypodermic needles, bandages, compresses, etc. Sexual dysfunction drugs are usually excluded, as are beauty aids, cosmetics, dietary supplements, immunization agents, sera, and blood or blood plasma. Contraceptive drugs and devices are usually excluded, but may be covered with some plans at additional premium.

VISION CARE INSURANCE

Vision care is usually offered as part of group coverage and usually provides reimbursement for such as eye examinations; single vision, bifocal and trifocal lenses; contact lenses; other aids for subnormal vision; and frames with some limitations. Services covered require the authorization of an ophthalmologist or optometrist.

These are reimbursement plans that reimburse for all expenses up to a stated maximum per person per year based on usual and customary charges, or based upon a schedule.

Coverage is usually limited to one examination and one pair of lenses in any 12 month period and frames every 2 years (which are limited to a certain amount that covers the “average” frames. Luxury frames incur added cost to the insured. Sunglasses, tinted lenses and safety glasses are usually excluded, as is duplication of glasses due to breakage or loss.

Medical or surgical treatment is usually excluded as it would be covered by medical expense plans.

TRAVEL ACCIDENT INSURANCE

Travel accident insurance provides benefits in case of accidental death or dismemberment while the insured is a passenger on a common carrier—usually an airplane. Protection is for a single trip, usually on a round-trip basis. These policies may be sold by machines located in airports and terminals. They may also be sold at travel agencies where they can be purchased as an option or prepackaged into the traveler's tour plan. Some credit card companies provide travel accident as an additional benefit.

This coverage is classified differently than AD&D because of the method in which it is marketed. These sales methods make it very limited as to type of coverage and the low cost.

ACCIDENT MEDICAL EXPENSE INSURANCE

Accident medical expense insurance reimburses for care needed because of an accidental injury. Benefits are not paid for any disease. Benefits include treatment by a physician, hospital care, nursing care and X-ray and laboratory work. This is usually sold as a supplement to regular medical expense insurance.

Usually the coverage applies only if the expenses occur within a specified time from the date of the accident. Benefits are subject to an overall maximum benefit for any one accident. The plan may have a small deductible, or not.

POLICY PROVISIONS

There are many provisions that are common to all health insurance policies and are discussed later in this text. Benefits and cost-sharing provisions of medical expense insurance policies were mentioned earlier. However, the contract provisions dealing with future premium levels and renewability of the policy are of specific interest.

Most individual medical expense insurance policies provide that the insured can continue coverage under the policy if the premiums are paid in full and on time, up to a specific age—usually age 65. Premiums in the future are not guaranteed but are subject to change from year to year by the insurer with the approval of the appropriate regulatory body. Most importantly, the premiums on an individual policy cannot be revised or the policy cannot be non-renewed based on the claims experience of any particular individual. Premiums can be increased only on a class basis.

Even with the guaranteed right to continue a policy and the rate increase restrictions, there have been concern about certain insurer practices, such as the *closed block durational rating*. With this system, an insurer can offer guaranteed renewable policies at very low rate to attract new insureds and increase their market share. Then the insurer, at some later time, closes this block of business by no longer accepting new applicants, and then increases rates on that block. Coincidentally (?) they start marketing a new policy with low rates.

This is not as convoluted as it may seem. Simply, a closed block of health insurance business creates premium increases at a more rapid rate as healthy insureds lapse their policies and buy new ones—many times from the same insurer and/or agent—creating *adverse selection*. Those who are not all-that-healthy remain in the closed block with its increasing growth of poor-

er risks and increasing rates, or they lapse their policies and risk not being able to purchase similar or acceptable coverage at affordable prices.

Actually, this does not occur as often as it once did, as regulators in most states will not allow this practice. They recognize that the effect of this procedure is to change a block of guaranteed renewable policies into policies whose premiums escalate with advancing age. Many states have prohibited this practice through guaranteed-issue requirements and restrictions on raising premium rates.

SECTION II - UNDERWRITING INDIVIDUAL HEALTH INSURANCE

There are similarities between group and individual health insurance underwriting, but there are important differences. A good example is that individual underwriters often decline applications, which group underwriters rarely do. Individual underwriters are concerned with the health, occupation and financial status of the individual prospect. Obviously, therefore, the individual and group underwriters use different sources of information to make their decisions.

Group or individual, the underwriter's function is to make sure that the proper premium is received for the risk assumed. In either case, the projection of claims is the heart of the underwriting process.

As discussed later, group underwriters can look at the group's previous experience, or of similar groups. Individual underwriters look at the past experience of many individuals as to how often they have become ill or injured over a certain period of time, and then use this information to determine how often on the average, the prospect will become ill and/or injured.

While this sounds simple, actually it is quite involved and complex. An individual underwriter can make claims projections (assumptions) more accurately by using the averages of persons with the same general characteristics—age, sex, marital status, occupation, income, etc.—as the person being underwritten.

An area unique to individual underwriting is that underwriters examine each applicant to determine whether they are more likely to make claims. This is reasonable as if a person is an asthmatic it is very likely that they will continue to have asthma attacks, if a person has had a myocardial infarction, they will in all likelihood have another heart attack, etc.

The group approach is that of accepting large numbers of applications on the basis that there will be a balance between those who use the benefits often, and those who do not. The reason is *adverse selection* against the insurer. In a preexisting group, the underwriter may assume that future claims experience will mirror past experience where there is a mix of healthy and unhealthy persons. This will not work for individual insurance as many people seek health insurance because they have a particular health problem or are likely to become ill in the near future—selection, therefore against the company, is appropriately called adverse selection. Individual underwriters try to identify such persons and then either decline coverage, provide modified coverage (such as excluding certain conditions from benefits) or adjust the premiums accordingly.

Insurers have more latitude in accepting or declining a risk in individual policies than in group health insurance plans, but there are still some restrictions. Under HIPAA, individual health insurance coverage must be made available without preexisting condition limitation to certain individuals who have lost group coverage. Some state laws require guaranteed availability of individual insurance or limit the rate differentials to different applicants.

Adjusting for Characteristics

Adjusting for general characteristics are similar in group and individual health insurance (this is discussed in more detail in later discussion of group underwriting) but occupation and income are more important in individual policies, particularly for disability income and AD&D policies.

Generally, higher-paid individuals and those in professions have fewer disability claims and shorter disability claim periods than the average. Conversely, those who have jobs requiring heavy manual labor or where there are accidental hazards have, on the average, higher numbers of disability and longer period of disability coverage. Because of this, underwriters use *Occupational Manuals* where occupations are classified as to risk, and these manuals are heavily used to determine premiums and types and amount of coverage offered.

Occupation is really not a major factor in underwriting individual major medical expense insurance and premiums do not vary by occupation. Having said that, the fact is that insurers look very closely at those who are in extremely hazardous occupations, and if they do issue insurance to these applicants, they usually exclude occupational injuries—rodeo riders, deep-sea divers, and stock car racing come to mind.

MEDICAL CONDITION & HISTORY OF APPLICANTS

The two most important factors in underwriting individual health insurance are the present physical condition of the applicant and his medical history. From this information the underwriter hopes to be able to determine if the present health condition and his health history differ significantly from the average for persons of his age, sex, etc., and what will his present medical condition have on future claims, taking into consideration his past medical history. What they are looking for primarily is whether the applicant has a medical condition that will lead to future claims and if so, what additional illness or injury would he suffer and would it prolong a disability from an unrelated cause?

Details of the applicant's past medical history is necessary in respect to the possibility of a recurrence or complication as some conditions can have problems or complications that can arise much later.

FINANCIAL CONDITION

In most cases, the applicant's financial status is not under consideration, except in underwriting of disability income insurance. In disability income applications, the underwriter must set benefits at a level so that the disability income of the individual is not considerably less than his present income, but at the same time the disability income should never be higher than the present income.

For disability income, the underwriter must consider income, both earned and unearned (such as from investments) and also the owned assets of the applicant. If a person has considerable assets, it could be possible to shift the assets into a situation creating substantial investment income if he becomes disabled. Then, when it is combined with income from the disability income policy, it would make it unattractive to return to work.

ADDITIONAL UNDERWRITING INFORMATION

After reviewing the application and agent's statements, the underwriter may find it necessary to obtain additional information so as to either provide the requested coverage, modify the benefits, or decline the application—or as happens often, more information is needed before making a

decision. Additional information generally consists of a medical or paramedical examination, an attending physician's statement (APS), inspection report from an independent inspection company, income or other financial documentation, and information available from industry databases. It is necessary for an applicant to sign a release so that the insurer can have access to his medical records.

Understandably, medical records and more frequent use of examinations are used to underwrite older applicants.

If a medical examination is requested, it is generally because of age or some other reason, and the underwriter needs the information that provides such important items as height and weight, pulse, blood pressure and other medical findings. Insurers have limits as to height and weight, beyond which the application cannot be considered—such information is furnished to the agents who should make the decision whether to submit an application if the applicant does not meet the height and weight standards.

Another valuable feature of medical records is that an individual will discuss his health with his physician much more readily than they will with an insurance agent. However, even if it appears that medical records are "clean" and the applicant's health history is excellent, it still is possible for a person to be totally uninsurable, such as an individual who has had a coronary infarction or history of heart attacks but who has not revealed this to his present doctor, therefore the record is clean but the individual is a heart-attack-waiting-to-happen.

Sometimes a paramedical examination may be required, which is conducted by a medical technician under the supervision of a physician. These are popular as they are more economical, easier for the applicant, and they free physicians from the time-consuming task of insurance physicals.

APSs are invaluable at times as they are usually the source of disclosures of serious medical conditions or questionable history, and is considered as the most complete and accurate source of information on medical history. Usually there is a charge for an APS by the physician to offset the cost of duplicating records, such charge is usually paid by the insurer, but in some cases, the applicant may have to pay this fee—usually when an applicant is asking for reconsideration of an application.

Laboratory tests are necessary, of course, but the interpretations of lab results are usually included in the APS. If additional lab work is required, usually it is in the form of blood work to resolve or explain an abnormality.

Inspection reports are investigations conducted by inspection companies who investigate the individual's occupation, financial status, health history and personal information within the privacy laws and guidelines.

The Medical Information Bureau has always been referred to as the "MIB," and in recent years it has changed its name to "MIB, Inc. It is an association of more than 700 companies writing life and health insurance in the US and Canada. It manages an information exchange used by insurers in their underwriting process. Member companies may request information on the MIB records—which are records of medical conditions and non-medical impairments (driving records, for instance). Any member of the MIB is required to file all impairments on an individual developed by the member company during their underwriting process. The MIB does not employ investigators or obtain copies of records, but reports the impairment information using a code number. They do not report the underwriting action or the type of amount of insurance applied for.



Contrary to common beliefs, an insurer may not act on information provided by the MIB only. Before any underwriting decision can be made using MIB furnished information, the information furnished by the MIB must be **confirmed** through other sources. An underwriting decision based entirely on MIB-furnished information is prohibited.

Disability Income Record System (DIRS)

The MIB also maintains the Disability Income Record System, a similar system used for disability income insurance. When a member company receives an application for disability income with a monthly benefit of \$300 or more, with benefit period of one year or more, this is reported to the DIRS and the information is stored for a minimum of 5 years. Other member companies can access this information for the purpose of making sure that the applicant is not over-insuring by obtaining coverage from more than one company.

STUDY QUESTIONS

1. The principal purpose of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) was
 - A. to make insurance more affordable.
 - B. to provide health insurance to all working Americans.
 - C. to increase agent's compensation.
 - D. to decrease the possibility that people will lose their health insurance by making it easier to switch plans or buy individual coverage on their own.

2. Disability Income insurance is often called
 - A. loss of time insurance.
 - B. job security insurance.
 - C. casualty insurance.
 - D. worker's compensation insurance.

3. Group insurance must
 - A. always be an employer-employee contract.
 - B. be considerably cheaper than individual insurance.
 - C. insure employers, association, labor union, trust or other organization not organized for the purpose of obtaining insurance.
 - D. be sold only by salaried representatives.

4. The most common and popular type of medical insurance is
 - A. Long Term Care Insurance.
 - B. Disability Income Insurance.
 - C. Comprehensive Medical Insurance.
 - D. Hospital indemnification.

5. Accidental Death and Dismemberment insurance is
 - A. too expensive for most people to consider.
 - B. the same as Dread Disease policies.
 - C. either occupational or 24-hour coverage.
 - D. issued only by mutual companies.

6. When AD&D insurance is part of an employees benefit package, dependents
 - A. are never covered.
 - B. are always covered with 24-hour coverage, regardless of the employee's coverage.
 - C. coverage is prohibitive in cost.
 - D. are covered at 50% of the employees coverage.

7. Dread Disease benefits
 - A. are paid as scheduled amounts of indemnity as the result of a specified event or treatment.
 - B. are only sold as part of a group life plan.
 - C. are illegal in many states.
 - D. are always reimbursement plans.

8. Of the various dental services available in a dental plan, the one that is most used is
 - A. oral surgery.
 - B. restorative.
 - C. periodontics.
 - D. orthodontics.

9. The underwriter's primary function is
 - A. to seek reinsurers to accept part of the risk.
 - B. to make sure that the proper premium is received for the risk assumed.
 - C. to pay claims.
 - D. decline as many applications as possible and still keeps the agents happy.

10. The "MIB" is
 - A. an independent company that reports criminal violations of applicants to the FBI.
 - B. an association of life and health insurers in the US & Canada that manages an information exchange used in the underwriting process by member companies.
 - C. medical information in physicians records that can be used for underwriting purposes.
 - D. a laboratory that serves life and health insurers in interpreting EKGs and EEGs.

ANSWERS TO STUDY QUESTIONS

1D 2A 3C 4C 5C 6B 7A 8B 9B 10B



CHAPTER TWO - MEDICARE SUPPLEMENT INSURANCE

While many of the provisions of a Medicare Supplement policy mirrors many Health Insurance policy provisions, particularly those of Major Medical plans, there are several points of difference, primarily because their purpose is different. Whereas Most Health Insurance policies are designed to provide primary coverage, the Medicare Supplement policies are designed as supplemental (secondary) policies.

In 1992, federal regulations and guidelines were passed whereby all Medicare Supplement policies were to furnish certain specified benefits. They were to be designated as plans “A” through “J” with “A” being the most basic plan, and “J” being the policy with the most coverage’s. Plans “C” through “F” are the most popular, as they provide the best coverage’s at the most reasonable cost. Shortly thereafter, Insurers were allowed to offer “Select” plans, covering the same risks as the Plans A-J, but with limitations as to Providers (similar to PPO’s). The policyholder must use one of the approved Providers to receive the supplemental benefits. Medicare will still pay their share of the medical claims) except for an emergency, when any Provider may be used. The Select policy is quite popular because it is sold at a much lower cost because of contracts between insurance carriers and Providers.

Benefits	“Core” A	B	C	D	E	F	G	H	I	J
CORE benefits										
Part A hospital (Days 61–90)	X	X	X	X	X	X	X	X	X	X
Lifetime reserve (Days 91–150)	X	X	X	X	X	X	X	X	X	X
365 Lifetime hospital (Days at 100%)	X	X	X	X	X	X	X	X	X	X
Part A and Part B blood	X	X	X	X	X	X	X	X	X	X
Part B coinsurance–20%	X	X	X	X	X	X	X	X	X	X
Additional benefits										
Skilled nursing facility (Days 21–100)			X	X	X	X	X	X	X	X
Part A deductible		X	X	X	X	X	X	X	X	X
Part B deductible			X			X				X
Part B excess charges						100%	80%		100%	100%
Foreign travel			X	X	X	X	X	X	X	X
At-home recovery				X			X		X	X
Preventive medical care					X					X
Prescription drugs								Basic	Basic	Extended

The Balanced Budget Act of 1997 made changes in the Medicare program by making more choices available to Medicare Beneficiaries as to benefits and how they will receive these benefits. The intent of the Medicare program is to reduce costs of Medicare and at the same time, increase the choices of health insurance options.

This attempt to try to maintain the Medicare Hospital Insurance Trust Fund until year 2010 (at least) allows Medicare Beneficiaries to actively participate in their own health care by offering certain benefits with the flexibility of paying for part of their medical care. There is continual reduction of benefits and amounts paid to health providers but Medicare seems to have a life of its own and continues to grow.

Any of the plans must closely follow Federal guidelines, which include:

1. Medical Services must be available at all times, 24 hours a day, 7 days a week.
2. Certain Grievance and Appeal procedures must be documented and established.
3. All plans must not restrict a Provider's advice to a patient about medical care or treatment.
4. Renal (kidney) Dialysis must be made available to all Medicare beneficiaries while he/she is temporarily outside of the health plan's service area.
5. They must provide at least the same benefits as Medicare's Fee-For-Service plans (with the exception of Hospice care), and may provide additional benefits.
6. The requirement of patient confidentiality, particularly patient's medical records.
7. There are certain restrictions regarding the furnishing of medical services when using a compensation arrangement with doctors.

In addition to Medicare, Medicare Supplement Insurance Plans and Medicare HMO's, the following plans are made available:

- Provider Sponsored Organizations (PSO's) - These are physician groups and hospitals that contract directly with Medicare to enroll Medicare Beneficiaries for a fixed and contracted payment. Medicare benefits are furnished independently of any Insurance Company.
- Preferred Provider Organizations (PPO's) - These are groups of doctors and hospitals that have contracted with insurance companies to provide medical services and care for their insured's at a pre-determined and contracted price. The Providers may provide medical services to others who are not members of the PPO, but the PPO insured will receive lower charges. The PPO members may choose their Providers from lists of contracting Providers. They may use Providers who are not part of the PPO organization in most cases, but if they do so, they will pay higher out-of-pocket expenses in most cases.
- Fee-For-Service Plans - Medicare Beneficiaries will be able to enroll in private plans that allow them to choose their own Providers. Medicare makes payments to these plans. Very similar to the original Medicare program, physicians will be unable to charge more than 15% above the amount that was contracted.
- Medicare Medical Savings Accounts (MSAs) (See discussion of MSAs and other tax-related plans)—though highly touted, as of this date there have been no plans available to Medicare recipients.
- Religious Fraternal Benefit Society Plans: These will be offered by some religious fraternal society, but only on its members, and they must meet the IRS and Medicare requirements to qualify.

MEDICARE SUPPLEMENT PROVISIONS

Guaranteed Issue Basis

Many Medicare Supplement policies, particularly if they are replacing other Medicare supplement plans, are issued on a guaranteed issue basis, and the application does not ask health

questions. Therefore a material misrepresentation would not pertain to health conditions in these situations, but could reflect misrepresentation of date of birth, citizenship, Medicare coverage, or knowingly having duplicate coverage that was not revealed to the agent.

NON-DUPLICATION

Federal and State regulations are very strict in regards to marketing duplication of coverage to Medicare beneficiaries. Any agent that sells a Medicare beneficiary a second supplemental policy will lose their insurance license and are liable for other damages. This provision provides that any benefits due the Medicare Beneficiary under Medicare will not be duplicated by the policy.

PROVIDERS

Hospital

The definition of a "Hospital" is an institution licensed as a Hospital and operated pursuant to law; and which is primarily and continuously engaged in providing or operating, either on its premises or in facilities available to the Hospital on a prearranged basis and under the supervision of a staff of physicians, and has medical, diagnostic and major surgery facilities for the medical care and treatment of sick or injured persons on an Inpatient basis for which a charge is made; and provides 24 hour nursing service by or under the supervision of Registered Nurses (R.N.'s).

The term "Hospital" DOES NOT include: convalescent homes, convalescent, rest, or nursing facilities; or facilities primarily affording custodial, educational or rehabilitative care, whether or not licensed as "Hospitals" or facilities for the aged, drug addicts or alcoholics.

References to Participating Hospitals is peculiar to Medicare Select policies (very popular plans) In most cases, with Select programs, only certain Hospitals are participating, however the policyholder may use any physician or health Provider covered under Medicare. On Select programs, Participating hospitals have entered into agreements with the insurer to participate in their network program. A list is always furnished for participating hospitals and other health providers if applicable.

Accepting Assignment

"Accepting Assignment" means that the Provider (which can be a Hospital, Doctors, or other Medical professionals) will accept the amount that Medicare pays for health services, as payment in full for their services. By law, a Provider who does not accept assignment, may treat a Medicare Beneficiary and charge a maximum of 15% more than the Medicare Allowance. This percentage may be changed by future legislation.

A Federal law states that if a referring physician accepts Assignment [i.e. accepts the Medicare payment as payment in full for their medical services] then the specialist must also accept the Medicare payment. Therefore, although not stated in policy provisions, in practice if the original doctor accepted Assignment, then so must the specialist.

Physician

Physicians include a wide variety of health providers and include Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) legally qualified to practice medicine and perform surgery; Doctor of Dental Surgery (D.D.S. or D.M.D.); Doctor of Surgical Chiropody (D.S.C.); Doctor of Po-

diatric Medicine (D.P.M.); Doctor of Chiropractic (D.C.); Optometrist (O.D.); Psychologist (Ph.D.). One should always review the policy provisions as certain types of doctors may be added in the future. For instance, those practicing the ancient art of acupuncture are not considered as health providers but there is increased pressure to accept them in the future.

Registered Nurse

A Registered Nurse (R.N.) is a person duly licensed by the state to engage in the practice of nursing.

Skilled Nursing Facility

Skilled Nursing Facility (referred to herein as "Facility") means a licensed Facility which:

- is operated pursuant to law;
- is approved for payment of Medicare benefits or is qualified to receive such approval, if so requested;
- is primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a duly licensed Physician;
- provides continuous twenty-four (24) hours a day nursing service by or under the supervision of a Registered Nurse (R.N.); and
- maintains a daily medical record of each patient

This definition does not include:

- any home, place or part thereof used primarily for rest, custodial, educational, convalescent, or rehabilitative care;
- a home or place for the aged or for the care of drug addicts or alcoholics; or
- a home or place primarily used for the care and treatment of mental diseases or disorders

DEFINITIONS

Certain definitions are well-known and understood however there are some definitions in the policies that should be better understood to avoid erroneous assumptions.

Accident means accidental bodily injuries sustained by the Contract Holder which are the direct cause, independent of disease, bodily infirmity or other cause, of the loss which occurs while the Contract is in force. Injuries shall not include injuries to the extent benefits are paid under any worker's compensation, employers' liability or similar law, State Automobile Reparations Reform Act (motor vehicle no-fault plan or similar law) unless prohibited by law.

A Benefit Period is an interval of time during which the insured is confined in a Hospital or Facility as an Inpatient. The Confinement may be continuous or intermittent. A Benefit Period begins the day the insured entered a Hospital or Facility and ends when he has not been a patient in a Hospital or Facility for sixty (60) consecutive days.

Confinement means the number of days spent as a registered Inpatient following each admission to a Hospital or Facility. If seven or more days have not elapsed between the date of discharge from a Hospital or Facility and the date of the next admission, the days will be counted as one Confinement. This occurs whether or not benefits were provided during the Confinement. One Confinement may consist of several admissions.

An **Inpatient** means a patient who is admitted to a Hospital or Facility as a bed patient and is charged for room and board for Medically Necessary care or treatment upon the orders of a Physician working within the scope of his license.

A **Medical Emergency/Accident** means the sudden, unexpected onset of a condition of such a severe nature that immediate care must be given to prevent death or serious impairment of his health or bodily function. Some examples of Medical Emergencies include, but are not limited to the following: unusual or excessive bleeding; serious burns; poisoning; unconsciousness; and convulsions.

Medically Necessary means that in the opinion of Medicare and/or the Insurance Company, a specific medical, health care, or Hospital service is required for the identification, treatment, or management of a medical symptom or condition. A service, care, or supply is Medically Necessary if, in the opinion of the Insurance Company and/or Medicare (see also Medicare Eligible Expenses), it is: (1) consistent with the symptom, diagnosis, and treatment of the Contract Holder's condition; and (2) in accordance with standards of good medical practice; and (3) approved by the appropriate medical body or board for the condition in question; and (4) is not primarily for the convenience of the Contract Holder, a Physician, or other Provider; and (5) is the most appropriate, efficient, and economical medical supply, service, or level of care which can be safely provided.

Medicare means the two programs of health insurance provided under Title XVIII of the Social Security Act. The two programs are sometimes referred to as Health Insurance for the Aged and Disabled Act. Medicare also includes any later amendments to this initial law.

The first program, called Medicare Part A, provides basic protection against the cost of Inpatient and outpatient Hospital care, as well as other institutional care. Medicare Part A is financed through the Social Security tax.

The second of these programs, Medicare Part B, is a voluntary program which covers the cost of Physicians' services and certain other services which are not covered under Medicare Part A. It is funded through monthly premiums from participating Medicare beneficiaries and contributions from the federal government.

Medicare Eligible Expenses are expenses of the kind covered by Medicare to the extent recognized as reasonable and necessary by Medicare. The Contract may provide reimbursement which is based upon a percentage or fixed amount of Medicare's determination of what charge is reasonable or permitted for this service. The Medicare Supplement's reimbursement, in those circumstances, is based upon Medicare's determination. This determination by Medicare of the reasonable or permitted charge is the Eligible Expense.

When Medicare does not provide coverage for a service, this Contract may provide reimbursement. In those circumstances, the reimbursement is based upon a percentage of or fixed amount that is what Medicare would have paid if the service were covered. The insurer reserves the right to make the determination of what is an Eligible Expense when Medicare does not provide coverage.

Sickness means any illness or disease of the Contract Holder. This will exclude Sickness or disease to the extent benefits are paid under any worker's compensation, occupational disease, employer's liability or similar law.

The **United States** refers to all 50 states, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and America Samoa and includes the territorial waters adjoining the land areas of the United States.

GRACE PERIOD

The grace period for a Medicare Supplement policy is 31 days.

PRE-EXISTING CONDITIONS LIMITATION

The Pre-existing condition provision is usually waived if the insured is transferring from one Medicare Supplement policy to another Medicare Supplement policy. The question may arise when a Medicare Beneficiary is covered under a Medicare HMO, and then decides to return to a traditional Medicare Supplement plan. In most situations, either by regulation or company practice, they will now allow this with a waiver of pre-existing conditions. This particular exclusion also excludes those who are confined to a hospital or SNF on the effective date of the policy.

Under the Medicare provisions of the Balanced Budget Act of 1997, if a Medicare Beneficiary has had a Medicare Supplement policy for at least 6 months, and decides to change policies, there will be no pre-existing condition period as a general rule. However, if the Beneficiary transfers to a plan that provides coverage that was not provided under the original plan, there may be a Pre-Existing Condition applied. Under the regulations, a Pre-Existing Condition is defined as health problems that required a doctor's visit within the six months before the effective date of the policy.

The typical preexisting condition clause states that any stay which occurs, or medical expenses the insured incurred, during the first 3 months following the Effective Date of Insurance will not be covered, under the Medicare Supplement - Pre-existing Condition provision. If the insured is confined as an Inpatient in a Hospital or Skilled Nursing Facility on the day before the Effective Date of Insurance, then the Effective Date of Coverage for that Condition will not begin until that Confinement ends, or six months have passed, whichever comes first.

PREMIUMS

The policies provide that "from time to time, Premium adjustments for this Contract may be necessary" and in actual practice, they increase each year. One reason that they increase, it should be noted, is that the benefits increase each year also as they are indexed for inflation. The insurer must notify the insured at least 45 days in advance in writing of any increase.

Misstatement of Age

If any age, sex, or geographical area information for any Contract Holder has been misstated on the application, all amounts payable will be what the Premium would have been at the time purchased according to the correct age, sex or geographical area.

SERVICES COVERED BY MEDICARE PART A

When the insured is confined as an inpatient in a hospital and the confinement is medically necessary and approved by Medicare, and caused by injury or sickness, and starts while the contract is in force, the following benefits will be paid:

First 60 Days per Benefit Period - Inpatient Medicare Part A Deductible Benefits are provided if the hospital is a Participating Hospital except in case of medical emergency when any hospital can be used.

61st Day through 90th Day per Benefit Period - Daily Coinsurance Amount

Benefits are paid which is equal to one-fourth (1/4) of the Inpatient Medicare Part A Deductible per day from the 61st through the 90th day of care during each Benefit period when

confined to a Participating Hospital, except in case of medical emergency when any hospital can be used.

Lifetime Reserve Days-91st Day through 150th Day Daily Coinsurance Amount

The policy provides benefits for the daily coinsurance amount which is equal to one-half (1/2) of the Inpatient Medicare Part A Deductible per day for the 91st through the 150th day of care when the insured is confined to a Participating Hospital (unless it is a medical emergency).

Beyond The Lifetime Reserve Days-151st Day and Thereafter

The policy provides benefits beyond the insured's lifetime reserve days if he is confined to a Participating Hospital (except for medical emergency) of 100% of Medicare's eligible expenses up to a lifetime maximum benefit of an additional 365 days.

Calendar Year Blood Deductible

The policy pays for the first three (3) pints of blood or blood derivatives each Calendar Year, provided the blood is not replaced or already paid-for under Medicare Part B.

Facility Services

To receive Facility benefits, the insured must first be a Medicare patient in a Hospital for at least three consecutive days and then enter the Facility within 30 days after he gets out of the Hospital.

Medicare Part A will pay, in full, charges for semi-private room and other covered services for the first 20 days of care in the Facility.

Coinsurance 21st - 100th day for Facility Services. After 20 days, the insured is responsible for the coinsurance amount each day for the next 80 days. This coinsurance amount which is equal to one-eighth (1/8) of the Medicare Part A deductible per day is not paid by Medicare Part A. The policy provides benefits to pay the daily coinsurance amount (equal to one-eighth of the Medicare Part A deductible) each day for the 80 days.

Payment will not exceed the amount for which the insured is actually billed and for which he has liability to pay. After the insured has exhausted the insured's 100 days of coverage during any one Benefit Period, Medicare will pay nothing for Facility benefits and the policy does **not** provide benefits to pay after the 100th day of care in a Facility.

SERVICES COVERED BY MEDICARE PART B

Medicare Part B covers, in part, the cost of Physicians' services, outpatient Hospital care, and many services and supplies not covered by Medicare Part A.

The following costs are **not paid by Medicare Part B:**

The deductible is the amount you are responsible for before you can receive Medicare Part B benefits. This deductible applies once each Calendar Year. There is no deductible on Forms C, F and J.

The 20% coinsurance: Medicare does not pay the 20% coinsurance amount. Medicare Part B has a schedule of allowances for all covered services. After the Medicare Part B deductible is paid, Medicare Part B pays 80% of its Eligible Expense for the covered services you receive. The Medicare Supplement will cover the 20%.

Calendar Year Blood Deductible

Medicare does not cover the first three (3) pints of blood or blood derivatives that the insured receives during a Calendar Year. Medicare supplement policies cover this “deductible.”

MENTAL HEALTH SERVICES COVERED BY MEDICARE PART B

Medicare Part B covers, in part after a 50% coinsurance, the cost of covered outpatient mental health services received from professionals such as Physicians, clinical psychologists, clinical social workers and other non-physician practitioners. After the Medicare Part B deductible is paid, Medicare Part B pays 50% of its Eligible Expense for the covered outpatient mental health services. The Medicare Supplement provides benefits to pay the 50% coinsurance amount after the insured satisfy the Medicare Part B deductible.

PREVENTIVE MEDICAL CARE

This provision is peculiar only to Plans E and J)

The policy provides benefits to pay 100% of charges not covered by Medicare up to the Medicare approved amount for each service as if Medicare were to cover the service as identified in American Medical Association current procedural terminology (AMA CPT) codes to a maximum of \$120 annually for the following preventive health services:

- an annual clinical preventive medical history and physical examination that may include tests and services listed in the following provision and patient education to address preventive health care measures;
- any one or a combination of the following preventive screening tests or preventive services, the frequency of which is considered a Medically Necessary: 1) fecal occult blood test and/or 2) digital rectal examination;
- Mammogram; - dipstick urinalysis for hematuria, bacteriuria and proteinuria; - pure tone (air only) hearing screening test, administered or ordered by a Physician; - serum cholesterol screening (every five [5] years); - thyroid function test; - diabetes screening.
- Influenza vaccine administered at any appropriate time during the year and Tetanus and Diphtheria booster (every ten [10] years).
- any other tests or preventive measures determined appropriate by the attending Physician

This benefit shall not include payment for any procedure covered by Medicare.

In addition to the above standard Preventative Benefits, the following benefits must be offered:

- **Annual Mammograms:** All Medicare-eligible women over the age of 40 will be allowed to have an annual mammogram, and the Part B deductible will not apply
- **Annual PAP Smears and Pelvic Examinations.** For certain “High-Risk” women, annual PAP smears and pelvic examinations will be allowed. For those women who are not “High Risk”, they will be covered every 3rd year.
- **Colon Cancer Screenings.** Colon Cancer Screenings will be allowed for all beneficiaries over age 50. How often these will be allowed has not as yet been determined.
- **Diabetes Self-Management Training Services:** Diabetes outpatient self-management training services including blood glucose monitors and testing strips for all diabetics will be provided.

- **Bone Mass Measurement:** For high-risk beneficiaries, Bone Mass Measurement will be expanded.

LIMITATIONS

The Contract does not provide benefits to pay for the following services or supplies:

- Services or supplies not covered or approved by Medicare, and considered eligible as a Medicare Eligible Expense, except as provided for under the “Out of Country Claims” and “Preventive Medical Care” provisions.
- Services or supplies in excess of what Medicare determines or would have determined is a covered service and a Medicare Eligible Expense.
- Services or supplies which would duplicate what Medicare has paid or would have paid had a claim for services been submitted to Medicare.
- No payment will be made for services provided by a Non- Participating Hospital unless specified in this Contract.
- Sometimes the insured might receive services for which there is no charge or for which he has no legal liability to pay. The policy does not provide benefits to pay for these services.

EXCLUSIONS

In addition to the above, payments for services or supplies related to the following are also excluded from this Contract:

- Mental or nervous disorders, alcoholism and drug addiction in excess of what Medicare allows.
- Illness, treatment or medical conditions arising out of War or act of war (whether declared or undeclared); participation in a felony, riot or insurrection, engaging in an illegal occupation, service in the armed forces or auxiliary units thereto; suicide or attempted suicide, whether sane or insane, or intentionally self-inflicted injury; aviation; being intoxicated or under the influence of any narcotic unless taken on the advice of a physician.
- Cosmetic surgery, except that "cosmetic surgery" does not exclude benefits for reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, or to restore normal bodily function.
- Hearing aids and eyeglasses and examinations for their prescription or fitting.
- Rest cures, custodial care, transportation and routine physical examinations.
- Care received outside of the United States that is not Medically Necessary and of an emergency nature.

The Medicare Supplement policy does not contain limitations or exclusions on coverage that are more restrictive than those of Medicare.

NON-DUPLICATION OF COVERAGE

Basically, if the policyholder is eligible for other health benefits duplicated by the Medicare Supplement policy, the policy will not pay even if the insured did not apply for or receive the other benefits. This includes workers’ compensation benefits, auto insurance policies, or any other health insurance program.

CROSSOVER

The following Automatic Crossover service is not offered by all insurance companies but is often offered and is a source of confusion with many Medicare Supplement insureds.

The Medicare Supplement policy may provide a service that is called Automatic Crossover. The Automatic Crossover is a process by which Medicare automatically transfers the Explanation of Medicare Benefits (EOMB) (also called “the gray form”)—which is sent to the Medicare beneficiary when a claim has been submitted to Medicare and is sent as “information only”—those who are new to Medicare are often confused as they believe the EOMB to be a “bill” for the medical services—to the Medicare Supplement insurer for payment of covered benefits under the Medicare Supplement policy.

“Crossover” works, as follows: When the insured applied for coverage under the policy, he signed an authorization for the ongoing release of any and all information, including but not limited to, Explanation of Medicare Benefits and Part B billing and enrollment forms, regarding any and all of the Medicare claims, to the Medicare Supplement Insurance Company.

If the Medicare claim is processed by the Medicare Supplement Insurance Company, an explanation of what Medicare allowed will automatically be transferred to the insurer’s supplemental coverage claim processing unit. This will be a Notice and Proof of Loss. The insurer will determine from these documents whether the insured has coinsurance due and the insurer will then pay the amounts for which they are obligated.

OUT OF COUNTRY CLAIMS

(Foreign Travel Emergency benefits are not available for Plans A and B).

Medicare does not pay for services received outside the United States. However, the Medicare Supplement provides that after the insured has satisfied a \$250 Calendar Year deductible, the policy will pay 80% of Medicare Eligible Expenses, up to a lifetime maximum of \$50,000 for Medical Emergency/Accident services received outside of the United States under the following conditions:

- While out of the United States, the insured is confined in a Hospital or receive Medically Necessary care which is needed immediately;
- the care begins within sixty (60) days of the insured being outside of the United States; and
- the care would have been covered by Medicare if provided in the United States

FRAUDULENT SUBMISSION OF CLAIMS

Because of the open enrollment and abbreviated applications used, there is arguably more misrepresentation in claims handling than in applications. However, problems with fraud seem to be as much with the Providers as the policyholder.

If, in the opinion of Medicare Supplement insurer, any Contract Holder commits fraud, or misrepresents or omits material information in requesting the receipt of benefits, that Contract Holder's coverage may be cancelled or rescinded at any time by the Insurance Company. This remedy is available in addition to any other remedies which may be available to the insurer.

REINSTATEMENT

Reinstatement of a Medicare Supplement policy differs from the reinstatement of a Major Medical policy in that there is no waiting period for sickness or injuries sustained after the date

of reinstatement, unless the reinstatement does not require an application for reinstatement. In actual practice, insurance companies are quite liberal in reinstating an expired policy, frequently taking the age of the insured into consideration when the insured states that a momentary loss of memory was the reason the premium was not submitted on time. The following is typical of the majority of Medicare Supplement policies.

“If the renewal Premium is not paid before the Grace Period ends, the Contract will lapse. Later acceptance of the Premium by the insurance company or by an agent authorized to accept payment without requiring an application for reinstatement, will reinstate the Contract. When the insurance company or its agent requires an application, and if the application is approved, the Contract will be reinstated as of the approval date. Lacking such approval, the Contract will be reinstated on the first billing date after the date of receipt of the Premium unless the insurer has previously written and advised the insured of its disapproval. The reinstated Contract will cover only losses that result from an injury sustained after the date of reinstatement or Sickness that starts after such date. In all other respects, the rights of the insured and the insurer’s rights remain the same. Any premiums that the insurer accepts for reinstatement will be applied to a period for which Premiums have not been paid. No Premiums will be applied to any period for more than 60 days before the reinstatement date.”

ENDORSEMENTS

Endorsements are frequently used with Medicare Supplement policies for the same purpose as with Major Medical policies. The following is a recent Endorsement dictated by regulation:

OUTPATIENT MENTAL HEALTH SERVICES & AVIATION EXCLUSION ENDORSEMENT

“The exclusions provision under "Illness, treatment or medical conditions arising out of: War or act of war . . . physician", is modified by deleting the word "aviation", and now reads as follows:”

"Illness, treatment or medical conditions arising out of War or act of war (whether declared or undeclared); participation in a felony, riot or insurrection, engaging in an illegal occupation, service in the armed forces or auxiliary units thereto; suicide or attempted suicide, whether sane or insane, or intentionally self-inflicted injury; coverage for air related accidents which occur outside of the United States; being intoxicated or under the influence of any narcotic unless taken on the advice of a Physician."

“This Endorsement shall not extend, vary, alter, replace, or waive any of the provisions, benefits, exclusions, limitations, or conditions contained in the Contract, other than as specifically stated in this Endorsement. In the event of any inconsistencies between the provisions contained in this Endorsement and the provisions contained in your Contract, the provisions contained in this Endorsement shall control to the extent necessary to effectuate the intent of Your Insurance Company as expressed herein.”

ADDITIONAL BENEFITS

There are other modifications that will appear in the policies, depending upon the type of policy chosen, such as the following:

PART B EXCESS

Health Providers either accept “assignment”, i.e. will accept the Medicare payment as payment in full for their services, or they will not accept assignment. Presently, Providers that do not accept assignment may charge 15% above what Medicare allows for the medical service. This is known as Part B Excess. Plan G covers 80% of the excess, Plans F, I and J covers 100% of this excess.

AT-HOME RECOVERY

This benefit offers up to \$1500 for at-home recovery after a person has been hospitalized, and supplements home health care. It is available Plans D, G, I and J.

BASIC DRUGS

These provisions pay a portion of prescription drugs with an annual limit of \$1,250 for Plans H and I, and \$3,000 for Plan J. The new Medicare Prescription Drug Plan (Medicare Part D) may have a decided negative effect on these prescription drug provisions available on plans H, I and J – which are not particularly attractive because of the high premiums.

STUDY QUESTIONS

1. Medicare Supplement Insurance plans are limited to
 - A. 10 plans.
 - B. 8 plans.
 - C. unlimited, if approved by Medicare.
 - D. marketing by direct mail, television or radio.
2. Today (2005) all of the Medicare Supplement plans must include
 - A. coverage for experimental drugs.
 - B. prescription drugs
 - C. renal (kidney) dialysis coverage.
 - D. nursing home coverage for custodial care.
3. Medicare Supplement policies are
 - A. issued on a guaranteed issue basis.
 - B. subject to severe underwriting if the applicant is over age 75.
 - C. entirely paid for by taxes.
 - D. restricted to no more than 3 such policies per insured.
4. “Accepting Assignment” means
 - A. the insured must accept the Medicare supplement policy recommended by Medicare.
 - B. the cash value of a Medicare supplement policy can be borrowed against.
 - C. the provider will accept the Medicare amount for payment in full for health services.
 - D. an agent may reduce the premium by a maximum of 25% if it appears the applicant can not otherwise afford the policy.

5. A “Skilled Nursing Facility” according to Medicare, would include
 - A. 24-hour nursing service by or under supervision of a Registered Nurse.
 - B. a convalescent center.
 - C. a drug rehabilitation center.
 - D. a retirement home with an RN on duty 24 hours a day.

6. A Medicare program that provides basic protection against the cost of inpatient and outpatient hospital care is
 - A. Medicare Part A.
 - B. Medicare Part B.
 - C. Medicare Part C.
 - D. Medicare Part D.

7. Medicare eligible expenses are expenses of the kind covered by Medicare to the extent
 - A. that no other insurer or health provider would cover the expenses.
 - B. that treatment is for a life-threatening disease or condition.
 - C. that the insured is mentally incompetent to determine proper treatment.
 - D. recognized as reasonable and necessary by Medicare.

8. Medicare premiums
 - A. remain level and constant by law.
 - B. must increase in proportion to the increase in the Stock Market.
 - C. will increase as they are adjusted for inflation.
 - D. are limited to an annual increase of 2.47% per year.

9. Then the Medicare supplement policy provides a service whereby Medicare automatically transfers the Explanation of Medicare Benefits to the Medicare supplement insurers, is
 - A. transferability.
 - B. direct routing.
 - C. EOMB transfer.
 - D. cross over.

10. Medicare supplement policies differ from a Major Medical plans inasmuch as
 - A. there is no waiting period for sickness or injuries sustained after the date of reinstatement.
 - B. Medicare supplement policies are underwritten.
 - C. Major Medical policies are issued by the Social Security Administration.
 - D. the insured pays no premium for Medicare supplement policies.

ANSWERS TO STUDY QUESTIONS

1A 2C 3A 4C 5A 6A 7D 8C 9D 10A



CHAPTER THREE - MSAs, HSAs AND OTHER TAX-FAVORED HEALTH PLANS

NOTE: In this Chapter, the person who is the holder of the plan or covered by the plan described, is referred to variously as the “holder,” “individual,” “person,” and when applicable, “employee.” Again, the masculine format is used only for simplicity purposes.

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 authorized the establishment of new health savings accounts, effective January 1, 2004. This Chapter describes in detail these plans, particularly since there has been such emphasis on these plans by the Administration and the Congress. These plans have deliberately been made attractive for tax purposes; therefore, this discussion will concentrate on the tax advantages of the various health plans. In respect as to the insurance vehicle, in most of these plans a high-deductible health plan (HDHP) is used. Other than the high deductible, the plans are basically comprehensive major medical plans. Some insurers make some variations, but usually these are minor and are simply for marketing purposes.

Even though the Medical Savings Account (MSAs) have not succeeded in popularity as much as desired or projected, these other plans have been added in an attempt to make the concept of an individual paying for the majority of his medical expenses out-of-pocket—instead of having an insurer pay nearly all of the cost—as attractive to the consumer as possible.

MEDICAL SAVINGS ACCOUNTS (MSAs)

Congress enacted, in 1996, a law that allowed individuals and small employers to fund medical expenses by creating up to 750,000 *Medical Savings Accounts* (MSAs), which are defined as savings accounts whose funds are used exclusively to pay for an individual’s or family’s medical expenses. Tax-deductible contributions can be made to the account and the interest on the account is tax deferred. Any withdrawals for the purpose of paying for medical expenses are not taxable as income.

MSAs works in the following manner: High-deductible medical expense insurance is purchased, along with the medical savings account, with high deductibles ranging from \$1,700 to \$2,600 for unmarried individuals, and \$3,450 to \$5,150 for families and with out-of-pocket maximums of \$3,450 for individuals and \$6,300 for families (no minimum lifetime benefit is required). Note: These amounts are indexed for inflation and these figures are for year 2004. The reasoning is that relatively small medical expenses will be covered by the MSA, with large expenses covered by the insurance.

Contributions to the MSA have an annual maximum of an amount that equals 65% of the deductible for individuals, and 75% for families—no established minimum.

Benefits of MSAs

The MSA holder can claim a tax deduction for contributions made by the holder, even if deductions are not itemized on Form 1040. The interest or other earnings of the assets in the Archer MSA are tax free. Distributions are tax-free if the holder pays qualified medical expenses. (See Discussion of Qualified Medical Expenses under following discussion of HSAs.) The contributions stay in the Archer MSA from year to year until used by the MSA holder.

Qualifications

In order for a person to qualify for a Medical Savings Account, they must be either:

- An employee or the spouse of an employee of a small employer that maintains an individual or family High Deductible Health Plan (HDHP) for the employee or his spouse, or
- A self-employed person or the spouse of a self-employed person, who maintains an individual or family HDHP.

Also, the individual must not have any other health or Medicare coverage except what is permitted under “*Other Health Coverage*” as defined later, plus the person not can be claimed as a deduction on another person’s tax return, even if the person does not claim the exemption.

Small or Growing Employer

A small employer is considered an employer who had an average of 50 or fewer employees during either of the last two calendar years. This definition is modified for new and growing employers.

A small employer may begin HDHPs and Archer MSAs for his or her employees and then grow beyond 50 employees. The employer is considered as meeting the requirement for small employers if he had 50 or fewer employees when the MSA started, made a contribution that was excludable or deductible as an MSA for the last year he had 50 or fewer employees, and had an average of 200 or fewer employees each year after 1996.

Portability

If the holder changes employers, the Medical Savings Account goes with him but he cannot make any additional contributions unless he is otherwise eligible.

HDHP

The person must have an HDHP that has a higher annual deductible than typical health plans and a maximum limit on the annual out-of-pocket medical expenses that he must pay for covered expenses as described previously.

There are some family plans that have deductibles for both the family as a whole and for individual member members and if the individual meets the deductible for one family member, they do not have to meet a higher annual deductible amount for the family. If either the deductible for the family or the deductible for an individual family member is below the minimum annual deductible for family coverage, the plan would NOT qualify as an HDHP.

Other Health Coverage

The Medical Savings Account holder generally cannot have any other health coverage except the HDHP, but he (they) may have additional insurance that provides other benefits only for the following:

- Liabilities from Workers’ Compensation laws, torts, or ownership or use of property.
- A specific disease or illness.
- A fixed amount per day (or other period) of hospitalization (in-hospital indemnity).

They may also have coverage, insurance or otherwise, for accidents, disability, dental care, vision care and long-term care.

Contributions to an Medical Savings Account

Contributions to a Medical Savings Account must be made in cash—no stock or property. If the individual is an employee, the employer may make contributions to the MSA and the holder does not pay tax on these contributions. If the employer does not make contributions to the MSA, or if the person is self-employed, he can make his own contributions to the MSA. Both the individual and employer cannot make contributions to the MSA in the same year and it is not necessary for the individual to make contributions to the MSA each year.

If the spouse is covered by the individual's MSA and an excludable amount is contributed by the spouse's employer to an MSA belonging to that spouse, the individual cannot make contributions to his own MSA that year.

Limits of Contribution

There are two limits on the amount that the individual or his employer can contribute to his Medical Savings Account, the annual deductible limit and an income limit.

The annual deductible limit allows the individual or his employer to contribute up to 75% of the annual deductible of the HDHP (65% if it is a self-only plan) to the MSA. The individual must have had the MSA for an entire year to contribute the full amount. If he does not qualify to contribute the full amount for the year, IRS Form 8853 provides instructions as how to determine the annual deductible.

Simply put, if the individual has an HDHP for his family for an entire year, the annual deductible is \$4,000 (for 2004). He can contribute up to \$3,000 for the year (75% of the MSA for the year). If, for instance, the HDHP had been in force for 6 months (July thru December), he can contribute up to \$1,500 for the year (\$4,000 x 75% for 6 months [half of the year]).

If the individual and his spouse each have a family plan, he would be treated as having family coverage with the lower annual deductible of the two health plans. The contribution limit is split equally, unless there is agreement on a different division.

Income Limit

An individual cannot contribute more than they earn for the year from the employer through whom he has the HDHP. If the individual is self-employed, he cannot contribute more than his net self-employment income—defined as income from self-employment less expenses (including the ½ of self-employment tax deduction).

Persons enrolled in Medicare

A person cannot contribute to an MSA effective with the first month enrolled in Medicare. However, he may be eligible for a Medicare Advantage MSA, discussed later.

Reporting Contributions on Tax Return

All contributions to an MSA must be reported on Form 8853 which is filed with the IRS Form 1040. All contributions by the individual and/or his employer made for the taxable year must be reported.

The individual should receive *Form 5498-SA, HSA, Archer MSA, or Medicare Choice MSA Information* from the trustee that shows the amount contributed by the individual and/or employer during the year.

Excess Contributions

If the contributions to the MSA is larger than the limits as discussed, such excess contributions are not deductible and any excess contributions made by the employer are included in the

gross income of the individual. If the excess contribution is not included in Box 1 on Form W-2, it must be reported as “Other Income” on the individual’s tax return and the individual may have to pay a 6% excise tax on excess contributions.

Some or all of the excess contributions maybe withdrawn and no excise tax is payable on the amount withdrawn if the excess contribution is withdrawn by the due date, including extensions, on the individual’s tax return, and the individual withdraws any income earned on the withdrawn contributions and includes the earnings in “Other Income” on the tax return on the year the contributions were withdrawn.

Distributions from an Medical Savings Account

The usual procedure is for the individual to pay medical expenses during the year without being reimbursed by the High Deductible Health Plan until the annual deduction has been reached. When medical expenses are paid during the year that is not reimbursed by the High Deductible Health Plan, the trustee should send the individual a distribution from the Medical Savings Account.

The individual can receive tax-free distributions from the Medical Savings Account to pay for qualified medical expenses. If distributions are received for other reasons, the amount may be subject to income tax and may be subject also to an excise tax.

If the individual no longer is qualified to make contributions, he may still receive tax-free distributions to pay or reimburse his qualified medical expenses.

Note: Qualified Medical Expenses are described in detail in the section following the discussion of the HSA plan.

The individual cannot deduct qualified medical expenses as an itemized deduction on Schedule A of Form 1040 that are equal to the tax-free distribution from the MSA.

Insurance Premiums

As a general rule, insurance premiums may not be treated as qualified medical expenses for an MSA. However, the individual can treat premiums for Long-Term Care Insurance (amount subject to HIPAA regulations), health care coverage while receiving unemployment benefits, or health care continuation coverage required under any federal law as qualified medical expenses for MSAs. Also, the individual cannot claim this credit for premiums that he paid with a tax-free distribution from the MSA.

Deemed Distributions

A transaction that is prohibited by section 4975 with respect to any MSA during the year makes the account a deemed taxable distribution as it ceases to be an MSA. Therefore, the fair market value of all assets in the account must be shown on Form 8853.

If the individual used any portion of the MSA as security for a loan at any time during the year, the MSA ceases and the fair market value of the assets used as security for the loan must be shown on Form 1040, line 21.

Recordkeeping

The individual must keep records to show later that the distributions were used exclusively to pay or reimburse qualified medical expenses, the qualified medical expenses had not been previously paid or reimbursed from another source, and the medical expenses had not been taken as an itemized deduction in any year.

These records are not to be sent with the tax return but kept with tax records.

Reporting Distributions on the Tax Return

If the distribution is used for qualified medical expenses, taxes do not have to be paid on the distribution but it must be reported on Form 8853.

If the distribution is not used for qualified medical expenses, tax must be paid on the distribution and the amount reported on Form 8853.

If an amount, *other than a rollover*, is contributed to the MSA by the individual or employer, he must also report and pay tax on a distribution received from the MSA that year that is used to pay medical expenses of another person who is not covered by the HDHP, or is also covered by another health plan that is not an HDHP, at the time the expenses are incurred (Form 8853).

Rollovers

As a general rule, any distribution from an MSA that is rolled over into another MSA or an HSA is not taxable if the rollover is completed within 60 days. Only one rollover a year is permitted.

Additional Tax

There is a **15%** additional tax on the part of the distributions not used for qualified medical expenses. Tax is calculated using Form 8853 and filed with Form 1040.

Note: There is no additional tax on distributions made after the date the individual becomes disabled, reaches age 65, or dies.

Balance in an MSA

An MSA is usually exempt from tax. The individual is permitted to take a distribution from the MSA at any time, however only those amounts used exclusively to pay for qualified medical expenses are tax free. Amounts that remain at the end of the year are generally carried over to the next year. Earnings on amounts in an MSA are not included in the individual's income while the earnings are held in the MSA.

Death of the MSA Holder

A holder of an MSA should always choose a beneficiary because the disposition of the MSA upon the death of the holder depends upon who is the designated beneficiary.

If the spouse is the designated beneficiary, the MSA will be treated as belonging to the spouse after death of the holder.

If the spouse is not the designated beneficiary, then the accounts stops being an MSA and the fair market value of the MSA becomes taxable to the beneficiary in the year in which the holder died.

If the estate is the beneficiary, the value is included in the final income tax return of the holder

The amount taxable to a beneficiary other than the estate is reduced by any qualified medical expenses for the decedent that are paid by the beneficiary within 1 year after the date of death.

Employer Participation

Please note the discussion of the HSA in the following section in respect to the requirement affecting employers that want to make the plan available to their employees, as the MSA requirements are identical in this respect.

Comments

Supporters of the MSA plan to fund individual and small group health care believe that it can lead to greater individual accountability as individuals will be more vigilant in seeking medical care if they have to pay for it by money from their MSA. When individuals have medical plans that are paid by third parties (insurers, for example) there is little incentive to control the expenditures and the danger of *over-utilization* arises.

In addition to the tax savings and the control of expenses feature, another important advantage is that MSAs will often allow individuals who previously had no health insurance to obtain it on more favorable terms, with greater freedom of choice in health care providers and in health care financing. Individuals who may not be eligible for a major medical plan may be acceptable in many cases if they “share-the-risk” with the insurer through a high deductible that eliminates many of the smaller claim, thereby favorably affecting both the loss ratio and the expenses of the policy.

There are detractors, principally those who maintain that MSAs may discourage insureds from seeking medical care because of their reluctance to spend their own money. This concern applies more readily to preventative care. These same persons also argue that adverse selection will occur inasmuch as the wealthy and healthy will take advantage of the option, which means that other insuring arrangements will have less healthy groups which, in turn, create higher costs for those who are not wealthy.

HEALTH SAVINGS ACCOUNTS (HSAs)

“The Medicare Prescription Drug, Improvement and Modernization Act of 2003” authorized the establishment of new health savings accounts, effective January 1, 2004. These accounts are similar to Medical Savings Accounts inasmuch as they allow eligible individuals to save for, and pay, health care expenses on a tax-free basis.

A Health Savings Account may receive contributions from an eligible individual or any other person, including an employer or a family member, on behalf of an eligible individual. Contributions, other than the contributions of the employer, are deductible on the eligible individual’s return whether or not the individual itemizes deductions. Employer contributions are not included in income. Distributions from a Health Savings Account that are used to pay qualified medical expenses are not taxed.

Technically, a Health Savings Account is a tax-exempt trust or custodial account that is set up with a qualified Health Savings Account trustee to pay or reimburse certain medical expenses that is incurred by the individual or qualified family member.

It is not necessary to seek permission or authorization from the IRS to establish an HSA but the individual must work with a trustee, which can be a bank, insurance company or anyone that is approved by them to be a trustee of IRAs or MSAs. The HSA can be established through a trustee that is different from the health plan provider.

Rollover from an MSA

If the individual has an Archer MSA, generally they can roll it over into an HSA tax free.

Benefits of an HSA

- The individual can claim a tax deduction for contributions that he, or someone other than the individual's employer, makes to the HSA even if the deductions are not itemized on the IRS Form 1040.
- Contributions to an HSA made by the employer—including contributions made through a cafeteria plan—may be excluded from the person's gross income.
- Contributions remain in the account from year to year until used.
- Interest or other earnings on the assets in the account are tax free.
- Distributions may be tax free if the individual pays qualified medical expenses.
- An HSA is "portable" so it stays with the individual even if he changes employers or leaves the work force.

Qualifying For an Health Savings Account

(This is where Health Insurance enters the picture, similar to the Medical Savings Account). To be eligible and qualify for the Health Savings Account, he must have a high deductible health plan (High Deductible Health Plan), on the first day of the month. He must have no other health coverage except what is permitted, not enrolled in Medicare, and not be claimed as a dependant on someone else's tax return. (Note: If another taxpayer is entitled to claim an exemption for the individual, the individual cannot claim a deduction for an HSA contribution—even if the other person does not actually claim the deduction.)

Each spouse who is eligible and who wants a Health Savings Account must open a separate Health Savings Account – no "joint" Health Savings Account.

Health Savings Account High Deductible Health Plan

A High Deductible Health Plan has a higher deductible than the typical health plans, and a maximum limit on the sum of the annual deductible and out-of-pocket medical expenses that must be paid for covered expenses. Out-of-pocket expenses include copayments and other amounts, but do not include premiums.

An HDHP may provide for preventative care benefits without a deductible, or with a deductible below the minimum annual deductible. Preventive care includes (but it not limited to:

- Periodic health evaluation, including tests and diagnostic procedures that are ordered in connection with routine examination, such as annual physicals.
- Routine prenatal and well-child care.
- Child and adult immunizations.
- Tobacco cessation programs.
- Obesity weight-loss programs
- Screening services, including screening for the following:
 - ✓ Cancer
 - ✓ Heart and vascular diseases
 - ✓ Infectious diseases.
 - ✓ Mental health conditions
 - ✓ Substance abuse
 - ✓ Metabolic, nutritional, and endocrine conditions

- ✓ Musculoskeletal disorders
- ✓ Obstetric and gynecological conditions
- ✓ Pediatric conditions
- ✓ Vision and hearing disorders.

Minimum annual deductible and maximum annual deductible and other out-of-pocket expenses for HDHPs for 2004.

Type of Coverage	Minimum Annual Deductible	Maximum Annual Deductible and other out-of-Pocket Expenses
Self-only	\$1,000	\$5,000
Family	\$2,000	\$10,000

(These limits do not apply to deductibles and expenses for out-of-pocket network services if the plan uses a network of providers. Instead, only deductibles and out-of-pocket expenses for services within the network should be used to figure whether the limit applies.)

Note, also, that these amounts pertain only to HDHPs for HSAs and other such plans. MSAs have different minimum deductibles and expenses, as discussed earlier.

“Self-only” HDHP coverage is an HDHP covering only an eligible individual. Family HDHP coverage is an HDHP covering an eligible and at least one other individual, whether or not that individual is an eligible individual.

Note: Some states may require a health plan to provide certain benefits without a deductible or a deductible that is less than the minimum annual deductible, in which case the plan may not be an HDHP. However, for years 2004 and 2005, plans that would otherwise qualify will be treated as HDHP if those benefits were required by state law in effect on Jan. 1, 2004.

Family Plans That do not Meet the High Deductible Rules

There are family plans available that have deductibles for both the family (as a whole) and for individual family members. Under these types of plans, if the individual meets the individual deductible for one family member, the individual does not have to meet the higher annual deductibles for the family. If either the deductible for the family as a whole or the deductible for an individual family member is below the minimum annual deductible for family coverage, then the plan does not qualify as an HDHP.

For example, Jones has a family health insurance plan in force in 2004. The annual deductible for the family plan is \$3,500. This plan also has an individual deductible of \$1,500 for each family member. The plan does not qualify as an HDHP because the deductible for an individual family member is below the minimum annual deductible (\$2,000) for family coverage.

Other Health Coverages

The individual (and spouse if family coverage) usually cannot have any other health coverage that is not an HDHP. However, they may have additional insurance that provides benefits only for the following items:

- Liabilities incurred under Workers Compensation laws, tort liabilities, or liabilities related to ownership or use of property.
- A specific disease or illness.

- A fixed amount per day (or other period) or hospitalization (such as in-hospital indemnification plan).

However, the individual may have coverages, whether by insurance or otherwise, for accidents, disability, dental care, vision care, and long-term care. Plans in which substantially all of the coverage is through these items are not considered as HDHPs. As an example, if the plan is a dread disease policy, it is not considered as an HDHP for the purposes of establishing an HSA.

Prescription Drug Plans

A prescription drug plan, either as part of an HDHP or as a separate policy or rider, will allow the individual to qualify as an eligible individual *if the plan does not provide benefits until the minimum annual deductible of the HDHP has been met*. If the individual can receive benefits before that deductible is met, then the eligibility is not present. However, if the individual can receive benefits during 2004 or 2005 under a separate drug plan or rider before the deductible of the HDHP has been met, the individual can still qualify. This is a “grandfather” type of situation and was included as the legislators did not want an individual to go without prescription drug coverage not covered by the HDHP during the first 2 years of this program.

As a general rule, an employee covered by an HDHP and a Health FSA or HRA that pays or reimburses qualified medical expenses generally cannot make contributions to an HSA, Health FSA or HRA (discussed later).

Exceptions

An employee may make contributions to an HSA while covered under an HDHP, and one or more of the following plans:

A limited purpose health FSA or HRA may pay or reimburse the items listed under “*Other health coverage*” except for long-term care. These arrangements/plans can pay or reimburse for preventive care expenses as they can be paid without having to satisfy the deductible.

A suspended HRA—before the HRA coverage starts, the individual may elect to suspend the HRA. The HRA does not pay or reimburse (at any time) for the medical expenses incurred during the suspension period except preventative care and items listed under “*Other health coverage*.” At the end of the suspension period, the individual is no longer eligible to make contributions to an HSA.

A post-deductible health FSA or HRA—these arrangements do not pay or reimburse any medical expenses incurred before the minimum annual deductible has been met. The deductible for these arrangements do not have to mirror the HDHP deductible, but the benefits may not be provided before the minimum annual deductible HDHP deductible is met.

Retirement HRA—pays or reimburses only those medical expenses incurred after retirement. After retirement an individual is no longer eligible to make contributions to an HSA.

Contributions to an Health Savings Account

Any eligible individual can contribute to a Health Savings Account. If it is an employee’s Health Savings Account, the employee and/or the employee’s employer can contribute to the Health Savings Account in the same year. If the HSA is established by a self-employed or un-employed individual, the individual can contribute. Family members or any other person may also make contributions on behalf of an eligible person. However, all contributions must be made in cash—stock or property cannot be used as contributions.

Contribution Limit

The contribution amount that the individual or any other person can contribute to an HSA depends entirely upon the type of HDHP coverage and the age of the individual. (There were exceptions for those who established the plan in 2004, but it does not extend further). The individual must be an eligible individual and have the same coverage all year to contribute the full amount. If the individual does not qualify to contribute the full amount for the year, then the contribution limit is determined by using IRS Form 8889 instruction.

These instructions are relatively simple, as, for instance, if the person has an HDHP for the entire months of July through December and the annual deductible is \$4,000 (and the person is under age 55), and \$4,000 is contributed each month, then the total of these amounts (\$24,000) is divided by 12 (months in the year) to determine the contribution limit—\$2,000.

Incidentally, if the individual is age 55 or older, the contribution limit is increased by \$500. Therefore, as an example, if the individual has a self-only coverage, he can contribute up to the amount of the annual health plan deductible, plus \$500, but not more than \$3,100. In the example in the preceding paragraph, if the person reached age 55 on September of that year, \$4,500 would be shown on worksheet for Form 8889, (July through December), \$4,500 times 6 = \$27,000, divided by 12 would show contribution limit of \$2,250 for the year. (These calculations are for year 2004, for 2005 the additional contribution amount is \$600 — \$2,300 contribution limit.)

If there are multiple HSAs, the total contributions cannot be more than the limits as discussed above.

Reduction of Contribution Limit

The contributions to the HSA must be reduced by the amount of any contribution made to an Archer MSA—including employer contributions—for the year. (Note exceptions for married persons below.)

The amount that can be contributed to the individual's HSA is the amount made by the employer that is excludable from the individual's income.

For married couples, if either spouse has family coverage, then both spouses are treated as having family coverage. If each spouse has family coverage under a separate plan, both are considered as having family coverage under the plan with the lower annual deductible. Therefore, the individual must reduce the limit on contributions before considering any additional contributions, by the amount contributed to both spouse's Archer MSAs. After that reduction, the contribution limit is split equally between the spouses unless they agree on a different division.

If both spouses are age 55 or older and not enrolled in Medicare, each spouse's contribution limit is increased by the additional contribution. If both spouses meet the age requirement, the total contributions under family coverage cannot be more than \$6,150.

Family Coverage with Embedded Deductible

An HDHP with family coverage may have deductibles for both the family as a whole (umbrella deduction) and for individual family members (embedded deductible). The limit of contribution under this situation is the *least* of:

1. the maximum annual contribution limit for family coverage (\$5,150 for 2004),
2. the umbrella deductible, or

3. the embedded deductible multiplied by the number of family members that are covered by the plan

The following example may clarify this provision:

In 2004, Jones had an HDHP with family coverage for him, his wife, and two dependant children. The HDHP will pay benefits for any family members whose covered expenses are more than \$2,000 (the embedded deductible) and will pay benefits for all family members when the family's covered expenses exceed \$5,000 (the umbrella deductible). The maximum annual contribution limit is \$5,000—the least of \$5,150, \$5,000 or \$8,000 ($\$2,000 \times 4$). [If the plan only covered a married couple, then the maximum annual contribution limit is \$4,000—least of \$5,150, \$5,000 or \$4,000 ($\$2,000 \times 2$)]

A plan will not qualify as an HDHP if either the umbrella deductible or the embedded deductible is less than the minimum annual deductible (\$2,000) for family coverage. If there is no umbrella deductible, the deductible for each family member multiplied by the number of family members cannot exceed the maximum annual deductible and other out-of-pocket expenses (\$10,000) for family coverage.

Enrolling in Medicare

A person who enrolls in Medicare cannot contribute to an HSA, beginning with the first month the person enrolls.

Rollovers

Amounts from Archer MSAs and other HSAs can be rolled over into an HSA without being limited by annual contribution limits, and they do not need to be in cash. However, the amount must be rolled over within 60 days after the date of receipt, only one rollover contribution to an HSA is allowed during any one year period, and rollovers from an IRA, an HRA or a health FSA into an HSA, are not allowed.

Reporting Contributions to IRS and Form 8889

Employer contributions to an HSA are not included in the individual 1040 tax return. Contributions made and contributions made by any other person (other than employer) can be claimed as an adjustment to income.

All contributions to HSAs are reported on Form 8889, *Health Savings Accounts (HSAs)*, and filed with the Form 1040. The individual should receives *Form 5498-SA, HSA, Archer MSA, or Medicare Choice MSA* from the trustee showing the amount contributed during the year. Employer's contributions will also be shown in Box 12 of the employee's Form W-2, with Code W shown. HSA deduction is reported on Form 1040 line 28.

Excess Contributions

Contributions to an HSA that is greater than the limits are considered as “excess contributions” and are not deductible. If the employer makes excess contributions, they are not reported in gross income. If the excess contribution is not included in Box 1 on Form W-2, then the excess must be reported as “Other Income” on the tax return, and as a general rule, the individual must pay a 6% excise tax on excess contributions.

In order to avoid the excise tax, all or some of the excess contributions may be withdrawn if the excess is withdrawn by the due date (including extensions) of the tax return for the year the contributions were made, or the income earned on the withdrawn contributions are withdrawn and included in “Other Income” on the tax return for the year that the contributions and earnings are withdrawn.

Distributions from an HSA

Any medical expenses occurring during the year are paid by the individual until such time that the expenses exceed the annual deductible for the HDHP. When medical expenses are paid that are not reimbursed by the HDHP, the trustee of the HSA can (and should) provide a distribution from the HSA.

Any distributions from the HSA used to pay or be reimbursed for qualified medical expenses incurred after establishment of the HSA, are considered as tax-free distributions. If distributions are received for any other reason, the amount withdrawn will be subject to income tax and may be subject to an additional 10% tax. It is not necessary to make distributions from the HSA every year.

If an HSA has been established by April 15, 2005, distributions are tax-free for qualified medical expenses incurred on or after the first day of the first month that the individual became eligible.

Note: If an individual is no longer eligible, they can still receive tax-free distributions to pay or reimburse for qualified medical expenses.

QUALIFIED MEDICAL EXPENSES

Are defined as those expenses that would generally qualify for the medical and dental expenses, as explained in *IRS Publication 502, Medical and Dental Expenses*.

Basically, Qualified Medical Expenses are the costs of diagnosis, cure, mitigation, treatment and prevention of disease, and the costs for treatment affecting any part or functions of the body. They include the costs of equipment, supplies and diagnostic devices needed for these purposes. They also include dental expenses.

Medical care expenses must be primarily to alleviate or prevent a physical or mental defect or illness. They do not include expenses that are merely beneficial to general health, such as vitamins or a vacation.

Medical expenses include premiums paid for insurance that covers the expense of medical care and the amounts that are paid for transportation to get medical care. Medical expenses also include amounts paid for qualified long-term care service and limited amount paid for any qualified Long-Term Care Insurance.

Note: One cannot deduct qualified medical expenses as an itemized deduction on Schedule A (Form 1040) that are equal to the tax-free distribution from the HSA.

Rules for Insurance Premiums

While as a general rule insurance premiums are not considered as qualified medical expenses for HSAs, but premiums for Long-Term Care Insurance, health care coverage while receiving unemployment benefits, or health care continuation coverage required under any federal law are considered as qualified medical expenses for HSAs. If the person is age 65 or older, he can treat insurance premiums (except for premiums for a Medicare Supplement policy) as qualified medical expenses for HSAs.

Premiums for Long-Term Care coverage that can be treated as qualified expenses are subject to the limits as established under HIPAA, which are based on age and are annually adjusted.

Health Coverage Tax Credit

One cannot claim credit for premiums paid with a tax-free distribution from the HSA.

Deemed Distribution from HSA

The following are considered as taxable distributions from HSAs:

- The individual engaged in any transaction prohibited by regulation with respect to any HSA. If this occurs, the account ceases to be an HSA and the fair market value of all assets in the account as of the first of the year must be reported on tax from 8889 (line 12a).
- The individual used any portion of any of their HSA as security for a loan at any time during the year, if so used, the fair market value of the assets used as security must be included as income for Form 1040 (line 21).

Recordkeeping

Every person who has an HSA must keep records, according to regulations, that shows that the distributions were used exclusively to pay or reimburse qualified medical expenses, the qualified medical expenses had not been previously paid or reimbursed from another source, and the medical expenses has not been taken as an itemized deduction in any year. It is not necessary to send these records with the tax return, but should be kept with the tax records.

Reporting Distribution on Tax Return

Without going into detail on how distributions are reported to the IRS, basically distributions are reported on Form 8889.



Distributions that are not used for qualified medical expenses are subject to an additional 10% tax.

There is no additional tax on distributions made after the date the individual is disabled, reach age 65, or die.

Balance in an HSA

As a general rule, an HSA is generally exempt from tax. The individual may take a distribution from his HSA at any time; however only those amounts used exclusively to pay for qualified medical expenses are tax-free. Amounts that remain at the end of the year are generally carried over to the next year. Earnings in an HSA are not included in the individual's income for tax purposes while held in the HSA.

Death of Holder of an HSA

A holder of an HSA should always choose a beneficiary as the disposition of the HSA upon the death of the holder depends upon who is the designated beneficiary.

If the spouse is the designated beneficiary, the HSA will be treated as belonging to the spouse after death of the holder.

If the spouse is not the designated beneficiary, then the accounts stops being an HSA and the fair market value of the HSA becomes taxable to the beneficiary in the year in which the holder died.

If the estate is the beneficiary, the value is included in the final income tax return of the holder.

HSA from the Employers Prospective

If the employer wants to make HSAs available to their employees, the employees must have an HDHP, and the employer cannot provide any additional coverage other than those exceptions listed as “*Other Health coverage.*”

The employer can make contributions to the employees HSAs and these contributions are listed on the “Employee Benefit Programs” for the year in which the contributions are made.

If contributions are made, the employer must make comparable contributions to all comparable participating employees HSAs. Contributions are comparable if they are either of the same amount, or the percentage of the annual deductible limit under the HDHP covering the employees.

Comparable Participating Employees

The “comparable participating employees” are those who are covered by the employer’s HDHP and are eligible to establish an HSA, have the same category of coverage (family or self), and have the same category of employment (part- or full-time). **Note however, that comparability rules do not apply to contributions made through a cafeteria plan.**

Excise Tax

If the employer makes contribution to the employees that were not comparable, the employer must pay an excise tax of **35%** of the amount contributed.

Employment Taxes

Amounts contributed to the employees’ HSAs are usually not subject to employment taxes, but the amount must be shown in Box 12 of the employee’s Form W-2.

MEDICARE ADVANTAGE MSAs

A Medicare Advantage MSA is an MSA designated by Medicare to be used solely to pay the qualified medical expense of the account holder. The holder must be enrolled in Medicare and have a high deductible health plan meeting Medicare Guidelines.

This plan follows the MSA and the HSA plans in respect to operation and tax exemptions of earnings. Unfortunately, as of this date, no HDHP had been approved by Medicare so there has not been any Medicare Advantage plans established.

FLEXIBLE SPENDING ARRANGEMENTS (FSAs)

A health flexible spending arrangement (FSA) allows employees to be reimbursed for medical expenses, and is usually funded through voluntary salary reduction agreements with the employer. No employment or Federal Income Taxes are deducted from the contribution. The employer may also contribute. For other information on the relationship between a health FSA and an HSA, see “*Other employee health plans*” under “*Qualifying for an HSA*” earlier,

The benefits of an FSA include

- Contributions made by the employer can be excluded from the gross income of the employee.
- No employment or federal income taxes are deducted from the contributions.
- Withdrawals may be tax free if qualified medical expenses are paid.
- The employee may withdraw funds from the account to pay qualified medical expenses even if they have not yet placed the funds in the account.

Health Flexible Savings Accounts are employer-established benefit plans, usually offered in conjunction with other employer-provided benefits as part of a cafeteria plan. Employers have complete flexibility to offer various combinations of benefits in the plan. An employee does not have to be covered under any other health care plan to participate.

Self-employed persons are not eligible for a Flexible Savings Account. There are certain limitations that may apply if the individual is a highly compensated participant or a key employee.

Contributions

The FSA holder contributes to his FSA by electing an amount to be voluntarily withheld from his pay by his employer—often called a salary reduction agreement. The employer may also contribute to the FSA if so specified in the plan.

The holder does not pay federal income tax or employment taxes on the salary they contribute or the amounts his employer contributes to the FSA. If the employer contributes towards a long-term care plan, then those contributions must be included in the income.

At the beginning of each plan year, the holder must designate how much he wants to contribute. Then his employer will deduct amounts periodically (usually each payday) in accordance with his annual election. The election can be changed or revoked only if there is a change in employment or family status and so specified in the plan.

There is no limit as to the amount of money that the holder or employer can contribute to the accounts, but the plan must prescribe either a maximum dollar amount or maximum percentage of compensation that can be contributed to the health FSA.

Any contributed amounts that are not spent by the end of the plan year, are forfeited. Therefore, it is important to base the holder's contribution on an estimate of the qualifying expenses he will have during the year.

Distributions

Distributions from a health FSA must be paid only to reimburse the holder for qualified medical expenses incurred during the coverage period. He must be able to receive the maximum amount of reimbursement—the amount that was elected to be contributed for the year—at any time during the coverage period, regardless of the amount that was actually contributed. The maximum amount that he can receive tax free is the amount that he elects to contribute to the health FSA for the year.

The individual must provide the health FSA with a written statement from an independent third party stating that the medical expense has been incurred and the amount of the expenses. Also, he must provide a written statement that the expense has not been paid or reimbursed under any other health plan coverage. The FSA cannot make advance reimbursements of future projected expenses.

(Qualified medical expenses are those explained previously from IRS Publication 502, Medical and Dental Expenses.)

Basically, he cannot receive distributions from his FSA for any amount paid for health insurance premiums, amounts paid for long-term care coverage or expenses, or amounts that are covered under another health plan.

He cannot deduct qualified medical expenses as an itemized deduction on Schedule A, Form 1040, that are equal to the distribution received from the FSA.

Balance in the FSA

Flexible spending accounts are described as “use-it-or-lose-it” type of arrangements, and any amount in the account at the end of the year cannot be carried over to the next year and the employer is not allowed to refund any part of the balance to the individual.

Employer Participation

Employers must comply with certain requirements that apply to cafeteria plans in order for the health FSA to maintain the tax-qualified status, such as restrictions for plans that cover highly compensated employees and key employees.

HEALTH REIMBURSEMENT ARRANGEMENTS (HRAs)

A Health Reimbursement Arrangement must be funded only by an employer. The contribution cannot be paid through a voluntary salary reduction agreement on the part of an employee. Employees are reimbursed tax-free for qualified medical expenses up to a maximum dollar amount for the coverage period. A Health Reimbursement Arrangement may be offered with other health plans, including Flexible Savings Accounts.

Benefits of an HRA

The employee benefits from the fact that the contributions made by his employer can be excluded from his gross income. Reimbursements may be tax free if he pays qualified medical expenses. And, any unused amounts in the Health Reimbursement Arrangement can be carried forward for reimbursements in later years.

Qualifying for an HRA

HRAs are employer-established benefit plans and they may be offered in conjunction with other employer-provided health benefits. The employer has complete flexibility to offer various combinations of benefits in designing the plan. The employee does not have to be covered under any other health care plan in order to participate.

Self-employed persons are not eligible for an HRA. Certain limitations may apply if the individual is a highly compensated participant.

Contributions

HRAs are funded solely through employer contributions and may not be funded through employee salary deferrals under a cafeteria plan. These contributions are not included in the employee's income. The employee does not pay federal income taxes or employment taxes on amounts the employer contributes to the HRA.

There is no limit on the amount of money that the employer can contribute to the accounts, and also, the maximum reimbursement amount credited under the HRA in the future may be increased or decreased by amounts that are not previously used.

Distributions

HRA distributions must be paid to reimburse the employee for qualified medical expenses incurred; such expenses must have been incurred on or after the date of enrollment in the HRA. If any distribution is, or can be, made for other than the reimbursement of qualified medical expenses, any such distribution (including reimbursement of qualified medical expenses) made in the current tax year is included in gross income.

Reimbursements can be made to current and former employees, spouses and dependants of these employees, or spouses and dependents of deceased persons.

Qualified Medical Expenses

Qualified medical expenses are discussed earlier in this text. In addition, qualified medical expenses from an HRA include amounts paid for health insurance premiums, amounts paid for long-term care coverage, and amounts that are not covered under another health plan.

Qualified medical expenses cannot be deducted as an itemized deduction on Schedule A (Form 1040) that are equal to the distribution from the HRA.

Balance in an HRA

Amounts that remain at the end of the year generally can be carried over to the next year. The employer is not permitted to refund any part of the balance to the employee and these amounts may not be used for anything but reimbursements for qualified medical expenses.

Note: For further and more detailed information on these plans, go to IRS Publication 969, available through the IRS or on the internet at <http://www.irs.gov/publications/p969/ar02.html>

STUDY QUESTIONS

1. Contributions to an MSA has an annual maximum of
 - A. 65% of the deductible for individuals, 75% for families.
 - B. 100% if the deductible for individuals, no maximum for families.
 - C. \$500 for individuals, \$1,000 for families.
 - D. no more than 25% of the gross adjusted income reported on Form 1040.

2. The interest or other earnings of the assets in an MSA are
 - A. tax deferred.
 - B. taxed as ordinary income.
 - C. considered as deferred compensation.
 - D. tax free.

3. If the holder of an MSA changes employers
 - A. he just continues to make additional contributions in any event.
 - B. he loses the tax protection of the MSA.
 - C. the MSA is cashed in and the growth is considered as earned income.
 - D. the MSA goes with him but he cannot make additional contributions unless he is otherwise eligible.

4. An MSA holder, and spouse if it is family coverage, generally cannot
 - A. have a high deductible health plan.
 - B. be covered under a Worker's Compensation plan.
 - C. have a specific disease policy.
 - D. also have an in-hospital indemnification policy.

- 5 Contributions to an MSA must be
 - A. made by the employer only.
 - B. in cash only.
 - C. in cash, real estate or stocks traded on the American Stock Exchange.
 - D. made only through an employers flexible benefit Section 125 plan.

6. Insurance premiums may not be treated as qualified medical expenses for an MSA
 - A. except premiums for Long Term Care Insurance subject to HIPAA regulations.
 - B. except life and other health insurance premiums.

- C. but he can claim this credit for premiums paid out of a tax-free distribution from the MSA.
 - D. until the premiums paid for the calendar year exceed \$2,500.
7. A tax-exempt trust or custodial account that is set up with a qualified trustee to pay or reimburse certain medical expenses incurred by the individual or qualified family member, is
- A. an MSA.
 - B. a 401(k).
 - C. an HSA.
 - D. an HRA.
8. An HSA HDHP
- A. has a higher deductible than the typical health plans and a maximum limit on the annual deductible and out-of-pocket medical expenses that must be paid.
 - B. does not allow for preventative care benefits unless the high deductible is paid.
 - C. does not allow for a deductible below the minimum annual deductible for cancer screen
 - D. has a much lower deductible than an HDHP used with an MSA.
9. A prescription drug plan as part of an HDHP or as a separate policy or rider
- A. will not allow the individual to qualify as an eligible individual under any circumstances.
 - B. is immaterial for plan purposes.
 - C. will allow the individual to qualify as an eligible individual if the plan does not provide benefits until the minimum annual deductible of the HDHP is met.
 - D. will be allowed as part of an HDHP except the total premium must be paid by the employer.
10. "Qualified Medical Expenses" according to the IRS, include
- A. vitamins if prescribed by a Naturopath.
 - B. a certain amount of time at a health spa.
 - C. treatment and prevention of diseases.
 - D. Yoga.

ANSWERS TO STUDY QUESTIONS

1A 2A 3D 4A 5B 6A 7C 8A 9C 10C



CHAPTER FOUR - GROUP HEALTH INSURANCE

The majority of the changes in Health Insurance as a result of HIPAA are in the Group Health Insurance area. “Group” is not a “product,” but is an arrangement where coverage is provided for groups of individuals under a single master contract issued to a group policyowner. The policyowner may be an employer, an association, a labor union, a trust, or any other legitimate entity not organized solely for the purpose of obtaining insurance. Members of larger groups, generally, may obtain coverage without providing evidence of insurability. Because of reduced marketing and administrative expenses, group health usually costs less than individual plans with comparable coverage and in addition, the plans often provide benefits not available under individual plans—such as maternity benefits.

HIPAA GROUP HEALTH INSURANCE REFORMS

The two principal areas of insurance reform addressed by the HIPAA are group health insurance and Long Term Care Insurance. The stated principal of the Act was the portability problem of an employee moving from one group plan to another situation where there either is no insurance or the employee does not qualify for the health plan at the new employer because of health reasons, or the employee is unable to get individual insurance after the COBRA period with his former employer.

PORTABILITY

Under HIPAA’s “portability” protection, once a person obtained *creditable health plan* coverage, he can use evidence of that coverage to reduce or eliminate any preexisting medical condition exclusion period that might otherwise be imposed when the person moved from one job to another. This applies whether the person moves from one health plan to another, from a group plan to an individual plan, or from an individual plan to a group plan. Portability is simply being able to maintain coverage and being given *credit* for having been insured when changing health plans. It does not, of course, mean that a person can take his insurance policy with him from one job to another.

Creditable Coverage

Creditable coverage applies when an individual is given credit for previous insurance when applying for a new health insurance plan. Creditable coverage is coverage under any of the following:

1. Group health plan;
2. Health insurance coverage including individual health insurance;
3. Medicare or Medicaid;
4. Military health care;
5. Medical care program of the Indian Health Service or a tribal organization;
6. A state health benefits program;
7. The Federal Employee Health Benefits Program;
8. A public health plan (defined in the regulations); or
9. A health benefit plan as part of the Peace Corps Act.

PREEXISTING MEDICAL CONDITION

Under HIPAA, a preexisting medical condition is a physical or mental condition for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period ending on the enrollment date. The enrollment date is the date of employment of the individual in the plan, or, if earlier, the first day of the waiting period for such enrollment. Pregnancy is not considered a preexisting medical condition.

A preexisting medical condition limit or exclusion may not be imposed on covered benefits for newborns that are covered under creditable coverage, within 30 days of birth.

A preexisting medical condition limit or exclusion may not be imposed on covered benefits for newly adopted children, or children newly placed for adoption if the child becomes covered under creditable coverage within 30 day of the adoption or placement.

Preexisting Condition Period

During this 6-month period, a plan may exclude or restrict coverage of a participant's or beneficiary's preexisting medical. Under the Act a group health plan is prohibited from imposing more than a 12-month preexisting condition limitation period—18 months for late enrollees—on an eligible participant or beneficiary. (Note: Under HIPAA those individuals who have individual coverage also have portability protection, but the conditions and requirement are more complex.)

PORTABILITY OF GROUP HEALTH PLANS

HIPAA requires that group health plans offered to an employment-based group—including both employers and employee organizations—that are covered by the Act to meet certain portability requirements.

When a person with prior creditable coverage, first enrolls in a group health plan, the plan cannot impose a limitation period on a preexisting condition that is longer than 12 months (or 18 months for late enrollees). The length of the allowed preexisting condition limitation is based upon any creditable coverage that the person may have. The plan cannot apply any preexisting condition waiting period on pregnancy, a covered newborn, or any covered child under age 18 who is adopted (whether or not the adoption has been finalized). The employer is allowed to require individuals to work for a period of time (waiting period, not *preexisting condition period*) before they may participate in the health plan.

All employers who sponsor group health plans are required to provide enrollees with a certificate that states the amount of creditable coverage accumulated and whether or not the enrollee was subject to a waiting period under the employer's plan. This certificate can be used to demonstrate creditable coverage when moving to another group or to an individual health insurance plan.

The Act does not require an employer to continue offering coverage to enrollees who have left their jobs, except under COBRA continuation provisions.

Continuous Coverage

In order to benefit from HIPAA, it is important for individuals to maintain health insurance coverage without experiencing significant lapses in coverage. The portability protection only applies to people with "continuous coverage," defined as coverage with no lapses of 63 or more days, so individuals should not allow their insurance coverage to lapse for more than 62 days.

If a person moves from one group plan to another group plan, or from individual to group coverage, the new plan must reduce any preexisting condition limitation period for 1 month for every month that the individual had creditable coverage under a previous plan, provided they enroll when they are first eligible and with no break in coverage over 62 days. As an example, if an individual had creditable coverage for 6 months they could have 6 months of a preexisting condition limitation period. If they had 11 months of creditable coverage, they could face one month preexisting coverage limitation coverage. The good news is that once a 12 month limitation is met, no new limitation may ever be imposed provided that continuous coverage is maintained and there is no break in coverage lasting longer than 62 days. This would apply even if there is a change in jobs or in health plans.



If there is a period of 63 consecutive days during which individuals have no creditable coverage, they may be subject to as much as a 12-month preexisting condition exclusion period—or 18 months to late enrollees.

Persons may be eligible for a waiver of preexisting condition limitations by presenting certifications that document prior creditable coverage. Health insurers and other health plans must provide the individual with written certifications of the period of creditable coverage under the plan, coverage (if applicable) under COBRA provisions, and any waiting or affiliation period imposed. The certification must be provided at any of three times:

1. When the person is no longer covered under the plan or otherwise becomes covered under a COBRA continuation provision;
2. After the termination of the COBRA coverage; or
3. Upon a request which is made not later than 24 months after coverage ends.

Late Enrollment

“Late enrollment” occurs when an individual enrolls in a group health plan *other than* the first period in which the person is eligible to enroll, or a special enrollment period. They should be aware that a later enrollee could make the person wait for as long as 18 months before a preexisting condition is covered.

Waiting Period

The waiting period is the time that an employee must wait before he is eligible to enroll in a health plan. A typical waiting period is 6 months before health insurance benefits are available and the Act does not prescribe the waiting period—it is up to the insurer and the employer. However, the Act does require that the waiting period be applied uniformly without regard as to the health status of potential plan participants or beneficiaries. Waiting period days are not taken into account in determining the length of a break in coverage.

The waiting period is different than the preexisting condition exclusion limitation period which allows the plans to exclude coverage for certain health conditions for periods up to 12 or 18 months.



The waiting period that an employee or his family member must endure to become covered under a health plan, must run concurrently with any preexisting condition limitation period.

As an example, if an employer hires a person with no creditable coverage and requires such person to wait for 5 months before becoming eligible for the group health plan, then the preexisting condition limitation period imposed on the coverage of that individual could not exceed 7 months from the date of actual enrollment of the plan. If the individual had 7 or more months of creditable coverage, then no preexisting condition limitation period could be imposed on the coverage under the new plan.

Crediting Prior Coverage

When a person change plans, sometimes the new benefit package may cover some benefits that the most recent prior plan did not cover. The Act allows the new plan or issuer some discretion in applying prior creditable coverage to those new benefits. Plans and issuers may choose between two alternatives when crediting coverage:

1. They can choose to include all periods of coverage from qualified sources and ignore specific benefits, or
2. They can examine prior coverage on a benefit-specific basis and are allowed to exclude any categories or classes of benefits not covered under the most recent plan, from creditable coverage.

Under a later (interim) rule, the categories of benefits that may be treated separately are

- Mental health;
- Substance abuse treatment;
- Prescription drugs;
- Dental care; or
- Vision care.

Example: If a prior plan did not cover prescription drugs and the new plan includes prescription drug coverage, the new plan may exclude prescription drug coverage for up to 12 months under this (2d) method—and, if this method is chosen, plans or issuers must disclose its use at the time of enrollment or sale of the plan, and apply it uniformly. i.e., an insurer must not allow other employees to obtain prescription drug coverage under the same circumstances, for a shorter period of time.

Spouse and Children Coverage

An employer is not required to offer coverage to an individual's spouse or family. If the employer does offer family coverage, the same protection applies to a spouse and dependents, and, for instance, coverage may not be denied because a family member is sick, and preexisting condition restrictions are limited.

PORTABILITY WHEN MOVING FROM GROUP TO INDIVIDUAL PLANS

HIPAA “guarantees” the availability of a plan and it prohibits preexisting condition exclusions for certain eligible individuals who are moving from group insurance to individual insur-

ance. States are given the right to either accept or enforce HIPAA individual guarantees, (called the “federal fallback”) or they may establish an acceptable alternative state mechanism. For those using the federal fallback approach, HIPAA requires that all insurers who operate in the individual health insurance field to offer coverages to *all eligible individuals* and prohibits the insurers from placing any limitations of coverage on any preexisting medical condition.

The issuers (usually insurers) can comply in three ways:

1. Offer eligible individuals access to coverage to every individual insurance policy that they sell in the state; or
2. Offer eligible individuals access to coverage to their two most-popular insurance policies (popularity based upon premium volume); or
3. Offer eligible individuals access to a lower-level and higher-level coverage. These two policies must include benefits that are (substantially) similar to other coverage offered by the issuer in the state, and must include risk adjustment, risk spreading or financial subsidization,

Issuers do have the right to refuse coverage for those individuals seeking portability from the group market if financial or provider capacity would be impaired. For example, an HMO can show that it is filled to capacity, health providers cannot accept new patients because of the number of patients they already have, health care within the area in which the individual resides and works cannot be provided at reasonable cost, etc., all could be advanced as a reasons not to cover a person, but the exception would have to be applied uniformly without regard to the health condition of the applicants—for instance they could not accept an individual from the same geographical area and who would be using health care providers that had been represented as being overwhelmed by the number of patients.

Eligibility for Group to Individual Coverage

For an individual formerly insured under a group plan to be eligible for individual coverage the individual must have

- Creditable health insurance coverage for 18 months or longer, at least the last day of which was under a group health plan;
- Most recent coverage under a traditional employer group, governmental, or church plan;
- Exhausted any COBRA or other continuation coverage;
- Not eligibility for coverage under any employment-based plan, Medicare or Medicaid; and
- No breaks in coverage of 63 or more days.

Persons who purchase insurance coverage on their own, and who do not meet these eligibility requirements, are not protected by HIPAA’s portability and guaranteed availability options. However, they may be protected under state laws.

Limitations of Group-to-Individual Portability

The portability provisions of group-to-individual coverage applies only to individuals whose most recent coverage was provided through traditional employer-based group arrangements, governmental plans or church-sponsored plans. HIPAA defined group plans as those plans that meet the ERISA definition which is limited to those sponsored through employer-employee relationship or an employment-based association. Governmental plans are defined in ERISA as plans established or maintained for its employees by the federal, state or political subdivision.

This means that persons whose most recent coverage was sponsored by the military (CHAMPUS and TRICARE), many college sponsored student plans, the Peace Corps, the Veteran's Administration, the Indian Health Service, Medicare, Medicaid and SCHIP are NOT eligible for the federal group-to-individual portability and guaranteed availability protections. Again, however, states may offer these individuals such protections.

States may provide an acceptable state mechanism for coverage of eligible individuals, must allow a choice of health insurance coverage to all eligible individuals, not impose any preexisting condition restrictions, and include at least one policy form of coverage that is comparable to either comprehensive health insurance coverage offered in the individual market in the state, or a standard option of coverage available under the group or individual health insurance laws in the state.

In addition, a state may implement certain National Association of Insurance Commissioners (NAIC) Model Acts; a qualified high-risk pool that meets certain specified requirements, other risk-spreading or risk-adjustment approach or financial subsidies for participating insurers or eligible individuals, or any other mechanism under which eligible individuals are provided a choice of all individual health insurance coverage otherwise available.

Some states have provided for health insurance coverage pools, mandatory group conversion policies, guaranteed issue of one or more plans or individual health insurance coverage, open enrollment by one or more health insurance issuers, or a combination of such mechanisms.

Basically, 10 states (AZ, DE, HI, MD, MO, NV, NC, RI, TN, and WV) have adopted the federal fall-back position; another 24 states adopted an alternative mechanism of a high-risk insurance pool. The remaining 16 states have various alternative mechanisms, including two that use Blue Cross/Blue Shield as the guaranteed issue carriers. Florida has guaranteed issue to HIPAA persons, and health plans must offer a choice of conversion plans, one of which must be the state approved" standard policy" offered in the small group market. Some states change the preexisting coverage limit time, adjustments in premium for various risks, retaining pregnancy as a preexisting condition, separate open enrollment period for HIPAA-eligibles, etc.

Special Enrollment Periods

The Act provides for two special enrollment period to make sure that people who lose group health insurance coverage can have an easier time of obtaining coverage when available. The two special enrollment periods are for individuals losing coverage and dependent beneficiaries.

Individual Losing Coverage

Any group health plan or issuer, who offers coverage in connection with a group health plan, must allow an eligible employee (but not enrolled) to become covered under the health plan under the following conditions:

- ✓ The employee or dependent had coverage under a group health plan at the time coverage was previously offered to the employee or dependent, which can include coverage by a spouse's health plan and he had therefore declined coverage under his own employer's plan.
- ✓ The employee must have stated (in writing) when they declined enrollment that the reason for declining the enrollment was that he was covered under another health plan. This condition applies only if the plan sponsor or issuer requires such a written statement.

- ✓ The employee's or dependent's previous coverage was under COBRA continuation provision that had become exhausted or was under some other coverage that had been terminated as a result of loss of eligibility for the coverage for a variety of reasons, including divorce, death, termination of employment, reduction in number of hours of employment, or because the employer discontinued contributing to such coverage.
- ✓ To use the special enrollment period, the employee would have to request enrollment no later than 30 days after the date in which his prior coverage was terminated, or in the case of COBRA, exhausted.

Dependent Beneficiaries

The other special enrollment period applies to those who became dependents because of marriage, birth, adoption or placement of adoption. This provision would apply if the group health plan makes dependent coverage available and the new dependent's spouse or parent is a participant, or eligible and the waiting period has been satisfied, to participate in the plan. The new dependent must be allowed to enroll as a beneficiary under the plan provided that enrollment has been sought within 30 days of the "qualifying event" (marriage, adoption, etc.)

Employees or their spouses who are eligible but who have not previously enrolled in the plan may enroll during this special enrollment period and coverage would be effective on the date of the birth, adoption, or placement for adoption. For marriage situations, coverage is effective on the first day of the month beginning after the date the request for enrollment is received.

NON-DISCRIMINATION

Under HIPAA, a group health plan (and an issuer) cannot offer group health coverage with rules for eligibility for any individual to enroll in the plan, based on health status of the person. These are considered as discrimination factors, and include health, medical and mental illnesses, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, and disability. A rather interesting point is that evidence of insurability includes conditions arising out of domestic violence. Also, a group health plan may not fail to re-enroll a participant or beneficiary on the basis of these health status factors. Further, plans may not charge different premiums for enrollees within a group plan based upon these health related factors.

An employer cannot require rules of eligibility to enroll when such rules discriminate based on one or more health-status related factors.

Individuals that engage in "high-risk" recreational activities cannot be denied enrollment or charged different rates than those that do not engage in such activities. However, HIPAA only addresses enrollment policies and premiums, and does not address benefits under the plans. Therefore, there is no federal requirement to cover treatments for injuries associated with high risk activities even if the treatments are covered under the plan. As an example, a plan may exclude coverage for a broken leg or arm, etc., if such occurs as a result of a high risk activity. Further, under a group health plan, while an employer is not required to offer coverage to a spouse or children, if they do offer family coverage, then the same non-discrimination provisions apply to the wife and children,

PREMIUM AMOUNTS

HIPAA does not restrict the premium amounts that an employer or insurer can charge and it expressly permits an employer or group health insurer to offer premium discounts or rebates or

to modify applicable copayments or deductibles for participation in health promotion and disease prevention programs. Having said that, HIPAA *does* prohibit a health plan from charging a higher premium than the premium charged for another similarly situated individual enrolled in the plan on the basis of a health-related factor, particularly a preexisting condition.

Guaranteed Issue

Insurers, Health Maintenance Organizations, and other issuers of health insurance that market in the *small group market* must accept any small employer that applies for coverage, regardless of the health status or claims history of the employer's group. "Small employer" is defined by the Act as one with two to 50 employees, however many states have reforms where groups of 2 to 25, 35 or 50 persons are considered as small groups, with a few states provide for guaranteed issue for groups of *one*.

On the first day of the plan year, the plan has fewer than 2 employees (when two is the minimum) who are current employees, then the plan would not be considered as "guaranteed issue." "Guaranteed issue" means that the issuer must accept every eligible individual in the employers' group who is eligible for participation in the plan and applies for it on a timely basis. The interim rules consider the guaranteed issue requirement as applying to all products actively marketed by an insurer in the small group market.

There are exceptions noted in the Act for network plans that might otherwise exceed capacity limits or in the event that the employer's employees do not live, work, or reside in the network plan's area.

Employer groups who have more than 50 employees are not protected by this requirement (unless required under state law); primarily because traditionally issues of health insurance did not, as a rule, examine the health status of employees in large groups during the underwriting phase. HIPAA does require the Secretary of Health and Human Services and the General Accounting Office to report every three years, starting in December 2002, on access to health insurance in the large group market.

Guaranteed Renewability

If the group requests renewal from the group health issuer, the issuer must renew the group regardless of the health conditions of the participants or the amount of use of the services. An issuer has the right to discontinue coverage for non-payment of premium, fraud, or similar reasons not related to health conditions, such as violation of participation or contribution rules.

FEDERALLY MANDATED BENEFITS

In the original Act, HIPAA did not require an employer or issuer of group health insurance to offer specific benefits, however on two occasions since HIPAA was passed, Congress added mandated specific benefits, but only for plans that cover certain coverages. (Discussion of State vs. Federal regulation of insurance is beyond the scope of this text, however does the mandating of two benefits remind one of the adages of the camel getting its nose under the tent?)

Health plans may limit the treatment of mental illnesses by covering fewer hospital days and outpatient office visits, and they can increase cost sharing for mental health care by raising deductibles and copayments. At least 23 (at last count) states have since passed laws that require health plans to impose the same treatment limitations and financial requirements on their mental coverage, as they do on medical and surgical coverage. Other states have enacted laws that re-

quire health plans to provide some specified mental health benefits, but not fully the same as for medical and surgical coverage. Self-insured employers are exempt from state regulation under ERISA and are, therefore, immune from these state laws.

Congress in 1996, passed the Mental Health Parity Act (MHPA) which amends ERISA and the Public Health Service Act by establishing new federal standards for mental health coverage offered by employer-sponsored plans, and shortly thereafter, the IRS established identical provisions. The MHPA is rather limited and does not require insurers to provide full-parity coverage.

For group plans that elect to mental health benefits, MHPA requires parity only for annual and lifetime dollar limits of coverage, but the plans are allowed to have more restrictive treatment limitations and cost-sharing requirements on their mental health coverage. Employers with 50 or fewer employees are exempt from the law. Also, employers that can show an increase in claims costs of at least 1% as a result of MHPA can claim an exemption.

In 2003, Congress attempted to pass legislation that would amend and expand MHPA by requiring plans that choose to offer mental health benefits to provide full-parity coverage, however, lawmakers only reauthorized MHPA through Dec. 31, 2002. There have been attempts by the Bush administration (S.543) that would provide for full parity, but it has been opposed by employers and health insurance organizations because of concerns that it would drive up health costs.

Newborns' and Mothers' Health Protection Act

The Newborns' and Mothers' Health Protection Act was also passed which prohibits group health plans and issuers offering group coverage from restricting the hospital length of stay for childbirth for either the mother or newborn child to less than 48 hours for normal deliveries and to less than 96 hours for caesarian deliveries.

Women's Health and Cancer Rights Act of 1998

This Act was enacted in 1998 and requires group plans and health insurance issuers providing coverage in connection with a group plan that provides medical and surgical benefits related to mastectomy to cover breast reconstruction procedures. It contains a requirement requiring beneficiaries to be notified of available coverage for prostheses and treatment of physical complications of reconstructive procedures.

Excluding Coverage for Specific Risks

Interestingly, Federal law does not prohibit employers from excluding treatment of specific illnesses or conditions from their health benefit plan. However, there are a number of things that restrict an employer from excluding specific illnesses from coverage. Most states have laws that require that specific benefits or coverages must be included in insured plans. Also, employers that purchase insurance products have little or no discretion in choosing or excluding specific types of services or procedures. The reason for this is that many insurance companies and HMOA have certain standard plans available that do not vary much from one employer to another. Self-funded plans are under the umbrella of ERISA that prevents state laws from applying and benefits are crafted by each individual employer plan. Therefore only the few requirements of HIPAA and subsequent amendments require specific coverage on these self-funded plans.

Association-Sponsored Group Health Plans

Association plans must also comply with the requirements of HIPAA that relate to group health coverage. As an example, a sponsor of an association plan cannot drop a group from coverage because of the use or overuse of medical services by its members. The preexisting condition limitations, creditable coverage and renewability requirements apply except in a few limited situations. However, HIPAA does not require an association plan to accept for coverage individuals who are NOT members of the association.

State Requirements

States are allowed to impose their own requirements but HIPAA requires that state laws do not prevent the application of its consumer protection provisions. On the other hand, state laws that regulate rating of risks are exempt from HIPAA. The Act's provisions relating to portability override state laws. Exceptions are specific types of state laws that provide for *greater portability* such as state laws that

- ✓ Define a preexisting medical condition to be one that existed for less than six months prior to becoming covered (instead of the 6 months required under the Act).
- ✓ Provide for preexisting medical condition limitation periods shorter than 12 (or 18) months in the Act; and
- ✓ Allow for breaks in continuous coverage longer than the 62-day period specified under the Act.

An example of a state law overriding HIPAA would be where the state mandates a 6-month preexisting condition limitation on enrollees, instead of the 12-month HIPAA limit. Conversely, if the state mandated a 14 month (or period more than 12 months) preexisting condition limitation, this would be overridden by the requirement of the Act.

COBRA CONTINUATION COVERAGE

The Consolidated Omnibus Budget Reconciliation Act of 1985, known as COBRA, requires that businesses with 20 or more employees that offer group insurance to their employees to offer continued group health insurance coverage to employees and their dependents after certain events, which includes a 12 month extension of coverage. The COBRA coverage is considered creditable coverage for individuals who move from one group policy to another group policy or move from a group policy to an individual policy. This would then allow an individual to move from COBRA to a new health plan without having to wait for coverage of any preexisting medical condition under the new plan, providing the individual does not have a lapse in coverage of 63 or more days.

For individual coverage, this is a little more complex. In order to be eligible for guaranteed availability and portability with individual plans, an individual must first have elected and exhausted any available COBRA or other continuation coverage. Eligible persons who do not qualify for COBRA or other continuation coverage may go directly to the individual plans. It should be noted, however,



the insurer who accepts the eligible individual for coverage can charge whatever rate is allowed under state law as the Act does not limit the premiums that insurers can charge.

This is not to say, however, that the Act ignored COBRA, as in fact, they made several changes to the COBRA continuation of coverage provisions.

A disabled qualified beneficiary and all other qualified family members of the beneficiary are also eligible for the additional months of COBRA.

The qualifying event of disability applies in the case of a qualified beneficiary that is determined under the Social Security Act to be disabled during the first 60 days of COBRA coverage,

A qualified beneficiary for COBRA coverage includes a child who is born to, or placed for adoption with, the coverage employee during the period of COBRA coverage; and

COBRA can be terminated if a qualified beneficiary becomes covered under a group health plan which does not contain any exclusion or limitation affecting a participant or his or her beneficiaries because of the requirements of the Act.

Under the Medical Savings Account provisions (discussed earlier) individuals can withdraw funds from their MSA to pay their COBRA premiums, without penalty.

GROUP HEALTH INSURANCE MARKETING

Groups insurance basically is nothing more than a method of marketing, although in some ways the product differs from the individual plans. Group marketing must be addressed by itself if for no other reason than the developments in the product, tax incentives and, ergo, marketing techniques.

Agents

Agents are the mechanism that sells the group health products, just like in individual health sales, however there are some differences. Agents that market group health insurance are often licensed to sell individual health insurance and many do sell both individual and group. However, group requires more than simple product knowledge, so it is more common for agents to be employees of the insurer or for more than one agent to share in the commission. Agents who work for one company or who are employed by the insurer, are usually provided with office space, clerical and backup services, training and fringe benefits.

Some insurers are too small to have their own group representatives, so they designate all sales and services responsibilities to contracted agents and brokers.

Some insurers do not use agents or brokers and only approach prospective policyholders through their salaried employees, such companies are known as direct writers.

Brokers

Technically, brokers are independent salespersons, although usually the agent is thought of as representing the insurer and the broker represents the purchaser. In actual practice, however, this relationship is more complex. Sometimes a broker will recommend advice and assist employers in purchasing the best coverage for their particular situation; they can sometimes receive fees from employers for their service. But, if an agent sells an insurance plan to an employer, he is then acting as a representative of the insurer and receives compensation—as an agent.

A group broker may act as a *Third Party Administrator (TPA)*—a firm that is neither the insurer nor policyholder of a group insurance plan but who takes responsibility for the administration of that plan. This is generally used in self-insured plans.

Employee Benefit Consultants

Employee Benefit Consultants are individuals or firms that specialize in group benefits for employees. They act like brokers inasmuch as they advise employees in finding the right group coverage and they receive a fee from the employer. The difference is that in most cases, a broker assists his client in purchasing a group policy, but the consultants focus on making recommendations to the employer upon which the employer then takes action. Actually, the difference between brokers and employee benefit consultants get rather hazy at times.

Group Representatives

Basically, group representatives are employees of the insurer that are responsible for the marketing and servicing of group insurance. In some companies, group representatives are responsible for sales and group service representatives are responsible for providing service to the clients.

THE SALES PROCESS

The actual process of marketing group health insurance consists of several steps which may be taken individually, or combined with other steps, depending upon the situation.

Prospecting

As with any type of sales, before something can be sold, there must be someone to purchase the product. This is regarded by many as a special *science* and is usually done by agents and brokers, except for large groups, group representatives will often do their own prospecting, but generally, at this stage, they are involved in informing agents and brokers about their programs, motivating them to sell them, and providing support when needed.

Sometimes, not often, an employer may issue a request for proposals (RFP) which notifies insurers that they are seeking coverage and invites them to propose a plan. The RFP is usually issued by large employers' benefits section. At this point, it is more of an actuarial contest as generally for the large employer, there is flexibility in benefits not available to the small or medium size group.

Proposal

Once an employer becomes a "prospect," and the necessary information obtained, the first decision of importance at this point is whether to proceed to the next step—designing a health insurance plan that meets the needs of the prospect and then packaging the plan into a proposal to be presenting to the prospect. This is the decision of the home office of the insurer in most cases, although the recommendation of the group representative is very important as the group representative is the one that must make the determination that the proposal meets the expectations of the prospect, whether the prospect meets the standards of the insurer's underwriting standards, and whether there is a good chance of making the sale (or not).

If the decision is made to make the presentation, then the plan is designed—usually with the involvement of the group representative and the home office personnel (underwriting and actuarial primarily). They must evaluate the needs of the prospect, design a plan to meet those needs, underwrite the plan, and determine the appropriate premium. Obviously, more detailed information from the prospect is necessary at this time, such as claims and premium experience of the prospect, particular hazards present, the objectives of the prospect, and their financial condition.

If the employer is unionized, any collective bargaining agreements affecting the coverage is useful, if not necessary.

The completed proposal is comprised of a description of coverage in the plan and the premiums for each coverage, plus information on the insurer (financial strengths and accomplishments, and a list of well-known group policyholders [if any]). For the large group, a cost illustration must show what part of the premium is used to pay benefits and expenses, and how much can be returned to the policyholder in the way of an experience refund—not presented to smaller groups as they usually are not eligible for experience refunds.

Presentation

The proposal presentation may be made by an individual agent or broker, by the agent and broker, by the agent and group representative, or by the group representative. Often the proposal must be submitted to the prospect's broker or consultant, whose job it is to then analyze the proposals submitted by several insurers and make recommendation to the prospect. As a general rule, group representatives of the insurer are allowed to participate only by small brokerage firms

Often, there will be changes in the proposal to meet the requirements or expectations of the prospect and/or the insurer. When the prospect evaluates the proposal and the reputation and capabilities of the insurer, and agrees with the proposal, then the sale is made.

Employee Enrollment

The next step after the acceptance of the proposal by the employer is the enrollment of the employees. If the participation is optional—the employees have the option of contributing to the premiums and receiving coverage, or not participating—enrollment is required in order to determine whether a sufficient number of employees will participate under the participation requirements of the plan. However, even if the employees do not have this option, enrollment is necessary for adequate administration and records.

When an insurer takes over an existing plan provided by another insurer, employees will often be already enrolled, however often it is still necessary to re-enroll employees. If a new coverage—such as dental or vision coverage—is added, or if the employee contribution is increased which then gives the employee the option of whether they want to continue, then enrollment is necessary. Even if there is no particular reason for re-enrollment, some insurers will want to re-enroll anyway so that the employees will be aware of the plan and to introduce themselves as the new insurer.

Regardless, the new insurer will provide information about the new plans, either in the form of letter(s) or pamphlet. If enrollment is going to be required, the active support of the employer's personnel is necessary for the insurer to be provided with all of the enrollment cards.

Installation of Group

After the enrollment process has been completed, the insurer's group representative sends the policyholder's signed application, the employee enrollment cards, and the first month's premium to the insurer or field office, for the final acceptance. It is possible at this time that the sale might "fall through" as there may not be an acceptable participation of employees or for some other reason. Otherwise, the insurer then issues the group policy and the group representative (usually in the company of the agent or broker) reviews all administrative aspects of the plan with the po-

licyholder, such as premium billing and accounting, claims procedures and benefits. Administrative procedures are established and then the plan goes into effect and is installed.

Servicing of the Group

The group representative (or service representative) make periodic services calls on the policyholder to assist in the proper administration of the plan. Usually, a check-off list is completed that reviews administrative practices and then administrative procedures are established. The agent is often given responsibility for providing administrative assistance and other necessary services to small and medium-sized groups.

Group Sales Attractive to Agents

As a passing thought, group sales are attractive to many agents for a variety of reasons, which include:

An agent who sells group insurance makes contacts with prospects for other business or individual insurance. An agent who services the account that he has sold has opportunities to market other insurance products, even, in some instance, property and casualty insurance product (by obtaining proper licensing for these products) or working with others who have the P&C expertise.

Conversely, there are agents already marketing other products to business clients, and now has the opportunity to add group health and a complete line of products and service. An example would be an agent who markets payroll deduction plans, perhaps cafeteria type plans, such as dread disease policies, short term disability, etc., and can become familiar with the employees and employer, and may have an opportunity to “look at” or review their group benefits overall, in particular their group health insurance plan. There have been situations where an agent was able to convince the client that the agent should become the “agent-of-record” for the company, thereby eliminating (for the employer client) the need to be “bothered” by all of the insurers who are trying to sell him a variety of products, and, in effect, having a unpaid consultant working for the employer making suggestions and analyzing risk problems. If handled right and *professionally*, the agent-of-record situation can be beneficial for both the agent/broker and the employer.

And, of particular interest to those agents who are married, selling group insurance is mostly a daytime, 9-to-5 type of position, as opposed to agents who sell individual insurance as they must sell when the individuals are at home, including weekends and holidays.

GROUP UNDERWRITING

Underwriting is the process of examining, accepting, or rejecting insurance risks and classifying those selected, in order to charge the proper premium for each. Underwriting for group health insurance is dissimilar to individual health insurance underwriting except for some medical information areas as discussed. In all cases, the information that is used for underwriting in the home office is broadly applicable to the underwriting often performed by agents and field sales personnel. The following discussion addresses medical expense and disability income insurance, but the same principles apply for all health insurance coverages.

Predicting Claims

Underwriting is the process of determining whether to offer coverage and on what terms. And (as suspected by some agents) the first step is to try to determine if there is any reason that the insurer should NOT offer coverage. Past that, what terms are necessary in order to accept the

risk—“terms” meaning the benefits to be provided, the premiums that are charged, and the overall provisions of the contract.

In actual practice, as opposed to individual health insurance, the group underwriter focuses mostly on the terms as in most cases, an offer has been made. The underwriter must devise a policy that has sufficient benefits for the benefit of the prospect, with benefits, premiums and other provisions so that the insurer will make a reasonable profit. In order to make such an offer, the underwriter must have fully considered the risks that will be taken and what the level of claims can be expected. Therefore, it is fair to say that the very heart of underwriting is the prediction of claims.

In group health insurance, it is nearly impossible for a plan to be in force without having claims, therefore the fact that there will be claims is a “given,” so the determination must be as to how many and in what amounts the claims will occur. The underwriter then determines what the premiums must be to cover such claims experience and make a profit, and what benefit provisions must be included in the policy so that the claims do not go above the predicted level.

Claims prediction is simply predicting with a fair degree of accuracy, the incidence of illness in a group by looking at past experience and projecting it forward. Therefore, past experience is the most critical piece of information needed by an underwriter. If the underwriter is looking at a 300-person group and they can find groups of the approximate size, operating in a business quite similar to the prospect, with a comparable mix of male & female, with similar payrolls, they will have a good indication as to how the prospect’s claims experience will perform.

It may be noted that the underwriter does not factor in solely the experience of groups of approximately the same size, but they take into consideration many other factors. For example, if the prospect business has a younger average age than like groups, health claims experience should be better, however if the younger group were heavily female, then there could be more maternity benefits paid. If the company was more sedentary, such as technical persons—accountant, computer technicians, data entry staff, etc.—than a similar sized group that was engaged in construction, then better health claims experience could be expected. The disparities between groups can cause all kinds of detailed exploration in the search for comparable experience.

In the majority of cases, however, actual claims experience is available and the group is not seeking insurance for the first time. Therefore, the underwriter can analyze claims experience and project that forward under the assumption that the past experience will be repeated.

Adverse Selection

Adverse selection is the “grinch” in group health insurance underwriting (and other types of underwriting also). If, for example, the eligible members have the option of having coverage and paying premiums, or declining the coverage, the members who elect for coverage are more likely to become ill than those that decline coverage because those that accept coverage are older and/or in poorer physical condition than the average employee in the group. This can go even further if the premiums paid by the employee are increased because of the claims experience of the group, in which case the number of non-participants will increase, leaving a smaller number of employees covered and those that are covered are, in all likelihood, expecting to use the benefits in the near future.

If the expected claims are based upon the statistical average, adverse selection can destroy the assumptions upon which premiums were based. This is a major responsibility of underwriters—to avoid adverse selection.

Statistical Averages

If a group is newly formed and has no claims experience, then statistical averages must be used. Actual experience, as indicated before, is always a more accurate predictor than statistical averages. Conversely, if the body of experience is rather large, then the statistical averages could be more predictive as experience would be based upon a much larger base of insureds.

For small groups, the actual claims experience of the group may be useful, but since it is such a small sample, it would not be as accurate a predictor as the average experience of many similar groups. As an example, if the group is 10 lives, it would not be at all unusual for the group to go for a year without any person having a serious illness. Conversely, it would not be unusual for any one person to have very expensive medical treatments and care. If in one year the experience was very low, and the next year very high, in both cases experience could be changed by the health condition of only one person. For large groups the claims experience is usually roughly the same for every year and the experience can be used to project claims data for each year.

For small groups insurers may combine the experience of many small groups to establish an experience pool and claims projections are derived from such a pool. This allows the underwriters for the small group to have one of the advantages of large-group underwriters; that of the ability to base claims projections on a large body of actual claims experience.

Claims projections for large groups are, therefore, more accurate, but that does not necessarily guarantee a profit. An inaccurate claims projection for a large group would have a greater impact on the insurer's profit, than inaccuracy in projecting claims experience on small groups. For a small group, a 20% higher-than-projected claim ratio would not be the disaster that a 20% higher claims ratio would be for a large group with a million-dollar annual premium.

Premium Rates

Premium construction is similar to projecting claims by the use of averages for small groups, which are derived from rating manuals that have been compiled by rating organizations or actuarial firms. Often standard rates for small groups are used, with adjustments (usually annually) for actual claims experience.

Competitive Benefits and Premiums

Nearly always, the demon of competition arises, particularly if the group is large and the premiums are substantial. The underwriter must get sufficient premium to make a profit, but at the same time, they must be competitive with other insurers who would just *love* to have the business. The balancing act is very difficult for an underwriter and at times, an insurer will just “fly in the face of experience” and become competitive just so as not to lose market share.

While this competitiveness can reduce the profit on a group, from the viewpoint of the policyholders, it is a good thing as terms are more favorable if the insurer is more competitive. There have been instances (and there will probably always be instances) where an insurer will write a large group on a low-profit or even, no-profit, basis, in order to keep the volume of insurance in force higher (helping the value of the company stock usually). In many large groups, there is an experience refund whereby the policyholder will share in the profits on the group.

Adverse Selection in Small Groups

Adverse selection is of considerable concern for small groups. An example which has been the situation in many small group cases, a small business owner does not have a group health program for his employees. One of his family members becomes seriously ill and will require expensive treatment. The employer then gets group coverage for his employees and offers family coverage so his family members will be covered. In a large group, the experience of a single individual does not have much of an impact on claims experience, but in a small group there are not so many persons that can balance the experience of one individual and one such expensive claim can create a significant increase in claims.

Many insurers have addressed the problem of adverse selection in small groups by excluding preexisting conditions or by requiring evidence of insurability from the individual in the group and sometime from covered family members also. However, HIPAA and state laws limit the use of preexisting condition exclusions and prohibit the exclusion of individual employees because of health conditions.

SMALL GROUP REGULATIONS

HIPAA and the small group market reforms that have been enacted by many states in the early 1990s require that insurers that write small group health insurance plans must accept any small group that applies and that is eligible under the law. Therefore, under these laws, the underwriting function of deciding whether or not to accept a group for coverage has been eliminated since the insurer does not have a choice. So, in these situations, underwriting includes only ascertaining whether the group is eligible and determining the terms that will be offered.

Since the insurer is required to accept those in poor health insured in a group health insurance plan, obviously the claims experience is going to be much higher that it would have been if there were more flexibility in accepting those in poor health. Since the claims experience is going to be higher, the premiums are going to be higher also. A person who had been a member of a large group and who had participated in the premiums, then goes to a smaller company where they discover that their premium was much higher, may have a hard time understanding why it is more expensive in a small group—especially since they, personally, have never had a large health claim. Because of these regulations, in some cases individual health insurance can be less expensive than the individual's share of the group premium. However, the employer usually pays part of the group health premium so the higher cost to the employee is usually not that substantial.

Nothing to do with “regulation” per se, but it should be pointed out that small groups have a higher administrative expense than large groups, therefore insurers usually try to keep the expenses under control by offering simple plans with limited benefit provisions.

“TURNED DOWN”

Although regulations usually prohibit an insurer from refusing coverage to a small group, there still are situations where an underwriter will recommend that the insurer not offer coverage. Note that although regulations may prohibit an insurer from refusing coverage to a small group, there is no restriction as to the premiums that may be charged for the coverage and in some cases, a high premium may be tantamount to declining to offer coverage. The reasons for not wanting or accepting a group can be found in the following four reasons:

Low Participation

If only a small percentage of eligible employees enroll in a plan, the enrolled group will have a much higher number of those with health problems—adverse selection.

Fictitious Groups

A “fictitious group” is a group that is formed for the purposes of obtaining insurance for its members. Underwriting statistics are based upon the assumption that any group considered for coverage is a random sampling of persons; therefore the group contains a mixture of healthy and unhealthy people. If a group is formed for other reasons—such as a common employer—this is the situation. Conversely, if the group is formed just to get insurance, the group will consist of many persons who have a much higher probability of incurring medical expenses. Adverse selection again

Imagine the situation where insurers must accept a group, whether they were formed for insurance purposes only or for other reasons. Associations of persons with certain medical conditions, such as multiple sclerosis, muscular dystrophy, leukemia, etc., would form groups just so their medical care could be shared with the insurers. Soon there would be no such thing as group health insurance (or health insurance companies).

Administration Difficulties

If a policyholder does not perform the required administrative duties on a timely basis, such as enrolling employees late or does not keep adequate records of terminations, the insurer can have frequent and expensive difficulties. If the history of the group, or if because of other information, indicates that the policyholder cannot perform the required administration, the underwriter may recommend that coverage be denied.

Persistency

Insurance companies rely heavily upon proper persistency for profitability. Persistency is the length of time that an insured risk stays with the insurer. It must be remembered that an insurer incurs considerable first-year expenses when a group is first insured because of first-year commissions, other sales expenses and administrative (including underwriting) expenses. The premium for the risk is based upon persistency assumptions that the risk will remain with the insurer for a length of time whereby the insurer can recoup its high early year expenses. For most group health insurance plans, a minimum of three years is necessary.

If the group does not stay with an insurer for a reasonable period of time, then an underwriter would recommend that the group not be accepted because of poor persistency history. Frequently a newly-formed business may have difficulties in obtaining insurance if their financial basis is not strong or if their particular type of business does not stay in business very long, historically. This is one of the reasons that underwriters usually ask for detailed financial information.

PROJECTING CLAIMS EXPERIENCE

Premiums depend upon projected claims experiences, and for small and medium-sized groups, they are based upon standard averages adjusted for the general characteristics of the group. The characteristics that are taken into consideration consist mostly of the following:

Age

Obviously this is important as older people create more medical expense and disability claims than younger persons. Adjustments are made on the average age of the group.

Sex

As a generality, women have more health problems than men and have a higher percentage of disability—25% higher than men. Men's claims are usually a factor only for accidental death and dismemberment insurance. Adjustments are made based on the proportion of men to women in the group.

Dependent Coverage

Most groups include dependents so the percentage of the group members who are dependents has considerable impact on claims experience because dependents are children and spouses, and age and sex affect claims. In recent years, the proportion of dependants has changed rather dramatically mostly because of the increase in single-parent households and the decrease in the average number of children in a family. Also, the increase in the number of working women has had a substantial impact, such as the fact that dependant participation may fall below acceptable levels if many employees have coverage from their spouse's employer. This is particularly noticeable if the company has a high proportion of married women whose husband's insurance covers the children.

This "duality" of family health insurance in recent years has had an effect on participation rules and many plans now do not take into consideration those employees who have health coverage under their spouse's health insurance in determining the required participation level.

Type of Business

Health insurance, in most cases, does not provide coverage for illnesses and accidents resulting directly from the employment of the person as these expenses are usually covered under the employer's Workers' Compensation insurance. However, illnesses that result indirectly from work activities or the physical environment of the workplace are usually covered under the group health insurance plan. Back problems from sitting in place for long periods of time, or colds and other respiratory problems caused by temperature of the workplace, etc., are all factors that must be taken into considered in underwriting.

Another situation that must taken into consideration, is the fact that some businesses have higher paid employees than other businesses, and those in the lower-paying businesses will hire the less-healthy individuals as a general rule, so these employees do not meet the general health standards of other companies, and adjustments must be made for these types of groups. For instance, restaurants do not pay as well as a technology company and restaurant employees (as a general rule) would not be as "healthy" overall.

Income

Those with higher-than-average income generally get more frequent and better medical care, which means for underwriting purposes that a group with a large number of high-income employees will have higher medical claims. Conversely, though, as indicated previously, lower-paying jobs may involve working conditions that indirectly cause health problems, so groups with a large number of low-income workers may also have high claims.

Geographical Area

As a general rule, the geographical location of a business has little affect on the number of claims made, it does affect the cost of claims as charges for medical care vary widely by geographical areas. For instance, medical expenses in New York are much higher than in, as an example, Des Moines.

Other Problem Indicators

There are a wide variety of group characteristics which are addressed by experienced underwriters, and any unusual characteristic comes under close scrutiny. For example, if a business has a higher-than-average age for businesses of that type because the business hires very few new employees, then a “red-flag is raised” because this could be an indication of financial difficulties. Conversely, a younger-than-average-age group could show high turnover, which would mean that the insurer would have a higher-than-average administrative cost for the insurer. An underwriter also looks for often and/or radical changes in turnover of employees which could dramatically change the characteristics of the group, therefore premiums might be inadequate.

STUDY QUESTIONS

1. The stated principal reason for HIPAAS was
 - A. the profitability problems of health insurance.
 - B. the portability problem of an employee moving from one group to another and losing his Health insurance.
 - C. to extend the benefits of COBRA.
 - D. to allow Long Term Care Insurance to be treated as health insurance for tax purposes.
2. Under HIPAA, a group health plan
 - A. has no restrictions as to preexisting conditions.
 - B. is prohibited from imposing more than a 12-month preexisting condition limitation period.
 - C. must not have any different requirements for eligibility for late enrollees.
 - D. premium must not exceed 120% of the average premium for a group the same size within the same geographical area.
3. “Continuous coverage” is defined by HIPAA as
 - A. coverage with no lapses of 63 or more days.
 - B. coverage with no lapses of 30 or more days.
 - C. coverage with no lapses of 6 months or more.
 - D. coverage with the same insurer and same agent.

4. John goes to work for Acme Metal Co. and is eligible to join their group health program 90 days after his date of employment. John buys a new car and therefore he feels he cannot afford his share of the health premium, so he waits for another 90 days to enroll in the plan when his diabetes gets out of control.
 - A. John may have to wait for as long as 18 months before preexisting coverage is covered.
 - B. The employer must cover his preexisting condition after 90 days whether he enrolls then or not.
 - C. John will never be able to get his preexisting condition covered under the new employer's health plan.
 - D. Under HIPAA, John is guaranteed an individual policy that will cover preexisting conditions immediately, at the same premium his group premium would have cost him.

5. If an employer offers family coverage,
 - A. the employer may restrict coverage for employee's children if one of them is ill.
 - B. the family coverage must have a higher deductible and copayment than the employee.
 - C. the employer may restrict coverage for as long as 6 months after the employee enrolls.
 - D. the same protection must apply to a spouse and dependants and coverage cannot be denied because a family member is sick.

6. For an individual to be eligible for individual coverage that had formerly been covered under a group health plan, one of the requirements is that
 - A. the employer must pay the entire premium.
 - B. the individual must still be eligible for COBRA.
 - C. there has been no breaks in coverage for 63 days or more.
 - D. he maintained creditable health insurance for 3 months prior.

7. The portability provisions of group-to-individual coverage
 - A. applies to any individual who has lost their coverage, regardless of whether the coverage was individual or group or association.
 - B. applies only to individuals whose most recent coverage was provided through traditional employer-based group arrangements, governmental plans or church-sponsored plans.
 - C. is the same in all states.
 - D. included for coverage, in particular, military (CHAMPUS and TRICARE), Veteran's Administration, Medicare or Medicaid plans.

8. HIPAA states that individuals that engage in high-risk recreational activities cannot be denied enrollment than those that do not engage in such activities, however
 - A. but waiting periods can be considerably longer.
 - B. it does not address benefits under the plan, so there is no requirements to treat treatments for injuries associated with the high risk activity even if the treatments are otherwise covered under the plan.
 - C. commissions cannot be paid on the plan if there is a recognized high-risk activity.
 - D. for family members, these non-discrimination provisions do not apply.

9. Small employers are addressed separately under HIPAA, and are defined as
- A. any group of 50 or more employees regardless of location of the group.
 - B. two to 50 employees, however some states allow guaranteed issue for groups of one.
 - C. employer groups with total payrolls of less than \$500,000 per year.
 - D. groups of not more than 10 employees.
10. Underwriters of group health insurance plans try primarily to avoid
- A. large groups.
 - B. groups from metropolitan areas.
 - C. adverse selection.
 - D. charging more than competitors.

ANSWERS TO STUDY QUESTIONS

1B 2B 3A 4A 5D 6C 7B 8B 9B 10C



CHAPTER FIVE - DISABILITY INCOME INSURANCE

DEFINITION AND OVERVIEW

Disability Income Insurance is health insurance that provides income payments to the insured wage earner when income is interrupted or terminated because of illness, sickness, or accident. Basically, there are two types – Long-term and Short-term, the difference being the length of time that income can be paid. There are other differences also, as will be discussed in this text, but most Long-term policies are sold on a Group basis, whereas Short-term policies are sold on an individual or Association Group insurance.

Disability Income policies are difficult to discuss in general terms and to compare with similar products. Disability Income policies are specifically designed to allow for maximum flexibility and to provide for the maximum coverage of the individual needs of the insureds. This flexibility is provided through the availability of benefits and optional coverages. The benefit provisions must be related closely to each other, otherwise there could be unexpected claims. Actuaries involved in policy designs for life and health insurance products agree that there is probably no other type of insurance that relies so much upon the differences and distinctions in the benefits and in the language that is used to describe the benefits.

In today's high-tech society, there are constant changes – some changes involving disability risks. Remember carpal tunnel syndrome that was a result of computer terminal operators spending long hours at data entry? The modern methods of medical treatment and diagnosis have changed the practical application of “disability” terminology and with the rapid development of treatment for many diseases and impairments, there is little doubt that benefits and provisions will continue to change. Regardless, there are basic criteria that can be used for analyzing and evaluation of all health insurance policies.

Disability Income policies that are sold to individuals are issued either on a Guaranteed Renewable or Noncancellable basis, or in some cases, Conditionally Renewable.

Conditionally Renewable

This category is used for Disability Income and medical expense insurance. It gives the insured a limited right to renew the policy to age 65 (or some later age) by the process of simply paying the correct premium on time. The insurance company may refuse to renew coverage but only for reasons that are stated in the policy. If the insurer is not going to renew under these provisions, the insured must be notified 30 days in advance of the due date of the premium. The insurer retains the right to change premiums and benefits *for all insureds of the same class*.

The reasons for not renewing the policy are clearly stated in the policy and vary according to the type of insurance. The insurer cannot refuse to provide coverage because of a change in the health of the insured once the policy has been issued. The company may refuse to renew a specific class of insureds (such all those insured under the policy form residing in the state) or may decide to discontinue a policy series for all insureds in a single jurisdiction.

On an individual basis, the insurance company may refuse to renew the policy when/if the insured changes to a more hazardous occupation. They may refuse to renew if the economic need for the policy changes, such as the insured becoming incorporated. In particular, with Disability Income insurance, if the insured becomes over-insured through purchasing other

insurance that will provide benefits in excess of the expected loss, the insurer may decline to renew. This prevents “stacking” of policies, which could lead to an anti-selection situation where the insured would make more money on disability than by working.

The Conditional Renewable provision is used mostly in specialized business disability income policies (other than overhead expense insurance). In these specialized policies, the insurer retains the right not to renew on an individual basis when the covered business risk no longer exists, or when other specific and specified events occur. In these policies, the insurer may retain the right to change benefits, but typically, it guarantees that the premium rates will not change.

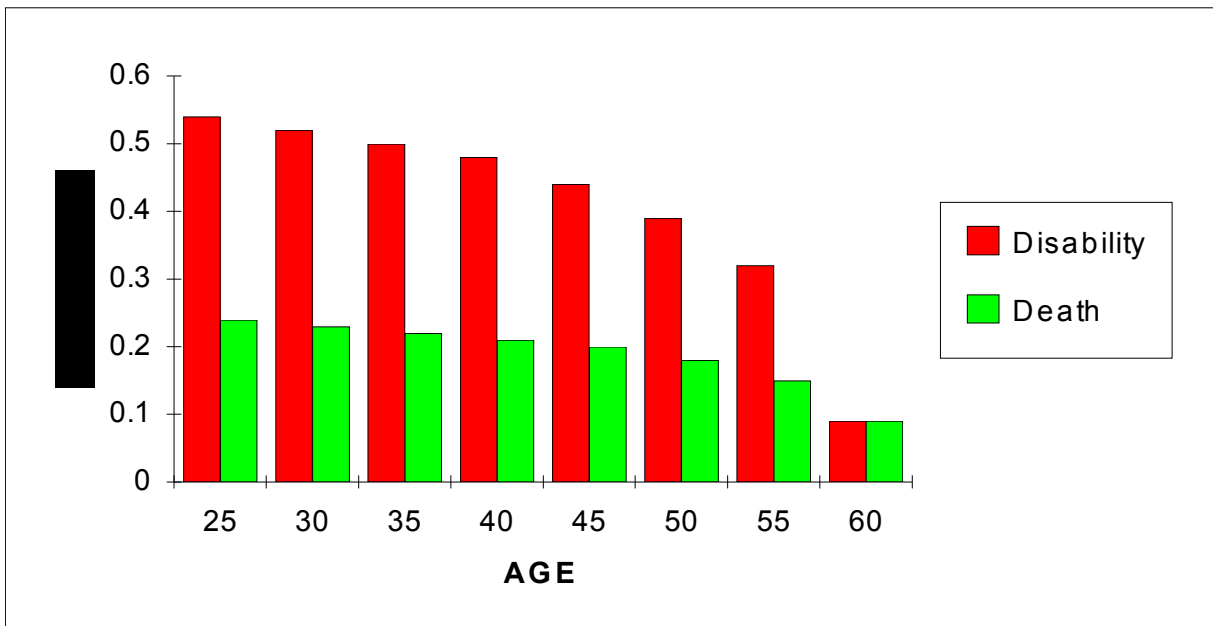
This renewal provision is used traditionally in those noncancellable and guaranteed renewable Disability Income policies which provide continuous coverage from age 65 to age 75 while the insured continues to be employed full-time. The premiums for this period are usually the renewal premiums for persons of the same attained age and risk classification (see later discussion of risk classifications). During this period (called “Conditional Renewal period”) the monthly indemnity amounts are usually not reduced, however, the benefit period is usually limited to two years.

THE NEED FOR DISABILITY INCOME INSURANCE

The perception of the general public has been in the past and will probably continue in the future, that Disability Income insurance is not as useful or necessary to most individuals as Medical insurance or even, life insurance. Most of the wage-earning population purchase, many times with the assistance of their employer, insurance that will provide medical coverage for themselves and their families. Large proportions of the wage-earning population purchase group or individual life insurance.

A much smaller share of the wage-earning population has either individual or group Disability Income insurance. In fact, only about one in four has any Disability Income insurance of any kind. The attitude seems to be that there is little chance of one losing his income because of a disability, and anyway, if they do become disabled, they will recover completely in a short period of time.

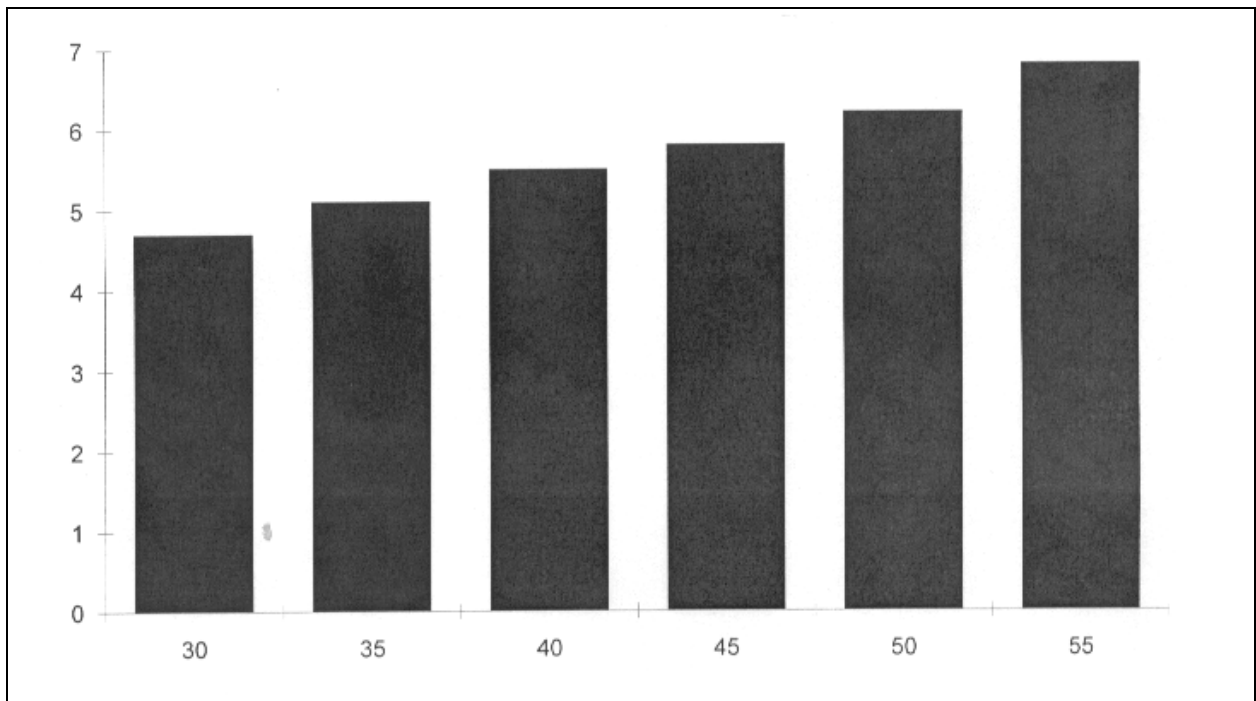
Most disabilities are of the Short-term variety, usually lasting less than one month. However, *the probability of sustaining a disability that lasts for 3-months or more is high during the wage earning years.* The probabilities of Disability for periods of 90 days or more and Probabilities of Death prior to Age 65 (based on 1980 CSO Mortality Table) can be best illustrated by the following graph.



Probability of Disability and Death at various ages

It should be noted that the probability of a Long-term disability (90 days or more) is considerably greater than the likelihood of death until age 60, when they are about the same.

Also, it should be noted that if a person is disabled for at least three months, the average duration of disability ranged between five to seven years, as shown in the graph below.



Years

Age at inception of disability (1985 Commissioners Disability Table)

The need for Disability Income insurance has increased for the same reasons that the need for Long Term Care insurance coverage has increased, which is basically the fact that as society develops economically, support for family members that was formerly provided by other family members, declines. Many medical advances have substituted disability for what would have previously been death.

From these basic statistics, it is obvious that the financial implications of disability can be a terrible burden for many people, and is even more financially difficult on the family than death. A point missed by many in this discussion is that the expenses of a disabled person not only continues, but in most cases, increases. With death, all expenses cease. Medical expenses are generally covered by insurance, but only Disability Income insurance can cover the loss of the income stream.

DEFINITIONS

Definitions under the policy may be part of the benefit provisions, but usually they are separate. The definitions are used to evaluate claims and control the benefit payments. The most important definitions are those of injury, sickness, preexisting conditions and disability.

INJURY

Under a Disability Income policy, the word “injury” is defined as accidental bodily injury, occurring while the policy is in force. Originally this definition used “accidental means,” but the latest wording uses “results” language. This may seem like nit picking, but not all accidental bodily injuries result from accidental means.

Accidental Means vs. Results

When “accidental means” is used regarding a bodily injury, there are two requirements that must be met if the loss is to be covered: Both the cause of the injury and the result (the injury) must be unexpected and unforeseen. In addition, the event must not be under the control of the insured that results in the bodily injury. Most states prohibit the use of the accidental means clause in any health insurance contract.

SICKNESS

The definition of “sickness” is not entirely uniform among companies and their products, but generally it is defined to mean sickness or disease that first manifests itself during the time that the policy is in force. Some insurers extend the “first manifest” language to mean a sickness or disease that is first diagnosed *and treated* during the time that the policy is in force. There is little difference, actually, and the intention in either case is to cover only sickness that is first contracted during the time that the policy is in force.

If the Disability Income policy contains either a “first manifested” or “first diagnosed” sickness definition, the policy will contain a preexisting condition limitation.

PREEXISTING CONDITION

It usually applies to the first two policy years and is used to exclude benefits for any loss that results from a (medical) condition—sickness or disability—that had not been acknowledged or reported by the insured, and that occurred prior to the policy date.

Preexisting condition provisions are tightly regulated in most states and therefore there are some variances from state to state. Typically the definition would be similar to the following:

“A pre-existing condition means a medical condition that exists on the Effective Date and during the past five years either (1) caused you to receive medical advice or treatment; or (2) caused symptoms for which an ordinarily prudent person would seek medical advice or treatment.”

DEFINITION OF DISABILITY

Unquestionably, the most important definition in a Disability Income insurance policy is the definition of “disability.” Individual Disability Income policies have been called “loss of time” insurance because of the definitions of occupational disability. A disabled person insured under a Disability Income policy must have suffered a loss of income because they cannot perform the duties of their job. The definitions of total disability and of partial disability depend upon the inability of the insured to perform certain occupational tasks.

Partial Disability vs. Residual Disability

(Permanent) partial disability is a disability in which a wage earner is *forever* prevented from working at full physical capability because of injury or illness.

Residual Disability is the inability to perform one or more important daily business duties or inability to perform the usual daily business duties for the time period usually required for the performance of such duties.

RESIDUAL DISABILITY INCOME INSURANCE

If Residual Disability Income coverage is provided, benefits are usually provided for the unused portion of the total disability benefit period, up to age 65. If an individual is at least age 55 at the time of disablement, and total disability lasts less than a year, residual benefits are payable for the unused portion of the benefit period for up to 18 months, but not beyond age 65.

If there is at least a 25% loss in current earnings, the residual benefits will equal the percentage of loss times the monthly benefit for total disability.

In most policies, the Residual Disability concept has replaced the partial disability provision as a means of paying a portion of the benefits to an insured who works at reduced earnings as a result of sickness or injury. It should be noted that the residual concept differs from the usual indemnity plans as it stresses the protection of the income, rather than the protection of “occupational performance.”

TOTAL DISABILITY

There are two different definitions used by insurance companies to describe total disability. The “any gainful occupation” definition, called “any occ” in the industry which is the most liberal coverage – and the most expensive. The other is the “own occupation” definition, which is called “own occ” in the industry.

OWN OCCUPATION

The “own occupation” clause defines an insured as totally disabled if he cannot perform the major duties of his regular occupation. Under this definition, an insured could be working in some other capacity and still be entitled to policy benefits if he cannot perform the important tasks of his own occupation in the usual way. In most cases, the own occupation coverage is limited to clients in the highest occupational classes, such as professionals and business executives.

This definition can vary by policy and company. Frequently the own occupation definition defines one as being totally disabled if

- (a) They cannot perform the major duties of their regular occupation, or
- (b) Are not at work in any other occupation

Under this variance, if the insured is disabled and cannot perform his regular job, disability benefits can be terminated if he voluntarily chooses to work at some other occupation. However, if this provision is used, the insurer cannot require the insured to resume work in another suitable occupation. This coverage is also known as *regular occupation* coverage.

The most comprehensive definition as included in a few policies, could read similar to: "The inability to perform the major duties of your occupation; the insurance company will consider your occupation to be the occupation you are engaged in at the time you become disabled." They will pay the claim even if the insured is engaged in another occupation

The modern trend seems to be to include both definitions in the Disability Income insurance policy by using an "own occupation" definition for a specified period of time (usually two to ten years), and then thereafter, "any occupation" definition comes into play.

Many insurers will offer own occupation coverage to age 65 for certain preferred classes of insureds, but this more liberal definition seems to be losing favor with insurers.

Physician Requirement

Nearly all Disability Income insurance policies require that an insured must be under the care of a physician to qualify for disability benefits. It might be said that this requirement is "taken with a grain of salt" as obviously an insurer could not deny benefits if medical care is not essential to the recovery or well being of the insured. Courts have frequently so stipulated also. The insurance company simply cannot require that an insured maintain a doctor-patient relationship just for the purpose of certifying a disability.

PRESUMPTIVE DISABILITY

If a Disability Income policy provides benefits for total disability (as most do), it is quite common to also include a definition of presumptive disability. Under this provision, an insured is presumed to be totally disabled (even if he is at work) if sickness/injury results in the loss of the sight of eyes, the hearing from ears, the power of speech, or the use of any two limbs. Generally the insurer will waive the medical care requirement and will start paying benefits immediately upon the date of the loss. The insured can work in any occupation and benefits will still be paid to the end of the policy benefit period, as long as the loss continues. With the developments in new prosthetic devices, mechanical functions of the hands and legs can be restored so as in some cases, the individual can resume their regular occupation.

ANY GAINFUL OCCUPATION

If the policy definition were "any gainful occupation" (or "any occ"), the insured would be considered as totally disabled if he cannot perform the *major duties* of any gainful occupation for which he is *reasonably suited because of education, training, or experience*. Since the insured can work at other jobs, this is obviously a more restrictive definition of disability than the "own occ" definition. Primarily, it limits the benefits. Used primarily in Group Disability Income insurance, this provision may read: "Because of sickness or injury, you are unable to perform the material and substantial duties of your occupation, or any occupation for which you are deemed *reasonably qualified by education, training and experience*."

INCOME REPLACEMENT APPROACH

The definitions of disability often revolve around the insured's ability (or inability) to perform certain tasks. Several companies now use an *income replacement* approach to defining disability wherein insureds are reimbursed when they lose a percentage of their earned income, usually 20 or 25%. The earned income must be lost due to an injury or sickness that requires a doctor's care.

POLICY PROVISIONS BENEFITS


The Benefit provisions of a Disability Income insurance policy may be divided into three areas regarding the payment of benefits. These areas of benefits form the base of a Disability Income insurance policy, and other provisions related to them are used to expand or limit benefits. A policy may be judged as to its liberalism (generally making it more marketable) or its conservatism (generally making it less marketable) by the way that benefits relate to these areas of benefits.

ELIMINATION PERIOD

The elimination period is the number of days at the beginning of a disability during which no benefits are paid – often referred to as the “waiting period.” For those who are familiar with other lines of health insurance, it is similar to a deductible in other types of policies. The purpose of the elimination period is to exclude illnesses or injuries disabling the insured for only a few days and therefore, can be met by the insured from their own funds.

The typical Disability Income insurance policy elimination period – or at least the most common – is 3 months or 90 days, however periods from 30 days to as long as 720 days are available. It is important to remember that benefits are paid at the *end* of the elimination period, therefore, using a 90 day elimination period as an example, the insured would not receive the first benefit payment for 120 days after the sickness began or the injury was suffered, which disabled the insured. Most Long-term Disability Income insurance policies have the same elimination periods for sickness or injury. Conversely, most Short-term Disability Income insurance policies will have a longer elimination period for sickness but for accident the waiting period is either waived or for a relative short period of time, such as 7 days.

 **The longer the elimination period, the lower the policy premium.**

 **Some Disability Income insurance policies require that the elimination period be satisfied with total disability only, or with consecutive days of disability. Most experts feel that an elimination period must be satisfied with either a residual or a total disability.**

Voluntary Interruption of Elimination Period

Most of the major Disability Income insurers offer a provision that allows the insured to return to work for a brief period of time without penalty before the end of the elimination period. The recovery period is usually limited to either 6 months, or if the recovery period is less than 6 months, to the length of the elimination period. If the insured is then disabled because of the same *or different cause* after this interruption, the two periods of disability will be combined to satisfy the elimination period.

THE BENEFIT PERIOD

The Benefit Period is simply the maximum amount of time that the benefits will be paid under the Disability Income insurance policy. In most policies, the Benefit Period will be the same for disabilities caused by sickness, or caused by injury. The length of the period is usually offered for two years, five years or to age 65. Benefits may be provided for “lifetime”, but the disability must be total, continuous and begin prior to age 55 (some policies go to age 60, or 65).

As discussed earlier, most disabilities are Short-term and statistics show that 98 percent of all disabled persons recover before one year has lapsed, and the majority recover within 6 months from the start of the disability. Conversely, if the disability lasts longer than 12 months, the chances of the insured being able to return to work diminishes drastically. The chance of returning to work is even lower at the older ages. Therefore, a prudent choice would be for the insured to have as long a benefit period as is available, and of course, affordable.

Recurrent Disability Provision

Most, if not all, Disability Income insurance policies include a provision that determines if a recurrent or consecutive disability or episodes of disability are to be considered as a new disability(s) or as a continuing claim. This provision typically provides that recurrent disabilities *from the same cause* will be considered as one continuous period of disability, unless each period of disability is separated by recovery for a period of not less than six months.

This provision is usually contained in Disability Income insurance policies that have a benefit period to age 65 (or longer). The advantage of this provision to the insured is that a new elimination period is not required for disability that recurs between 6 months and one year after a brief recovery in a Long-term claim. This provision eliminates the prospect of multiple elimination periods and the result would be that benefits for a recurring loss *due to the same cause* is payable to the insured immediately for the portion of the original benefit period that has not been used.

Conversely, if the disability results from a *different* cause after an earlier disability, or if the loss recurs due to the same cause after twelve months after recovery, then the insured would have a new benefit period and a new elimination period.

THE BENEFIT AMOUNT

For personal Disability Income insurance policies, the amount of the disability income is payable on a monthly indemnity basis for a fixed amount. In essence, the disability income policy is an indemnity policy. (For general reference, an indemnity agreement is designed to restore an insured to his or her original financial position after a loss.) One of the fundamental principles of indemnity is that the insured should neither profit nor be put at a monetary disadvantage for incurring the loss. Since the purpose of Disability Income insurance is to reimburse the insured for loss of income due to disability; therefore, in order to understand this product, these fundamentals should be kept in mind.

Taking this one step further, for total disability under the Disability Income insurance policy, the indemnity is usually written on a *valued* basis. This means that the policy benefit as stated in the policy is assumed to equal the actual monetary loss suffered by the insured because of the disability. This amount is stated on the policy and is not adjusted to the earnings of the insured, or for any other insurance payments, at time of claim for either total or partial disability. If residual disability is involved, the benefit can be reduced in proportions to the loss of earnings of the insured.

The benefit amount is extremely important in these policies because of the possibility of adverse selection as indicated previously. Insurers limit the disability income that an individual may purchase to not more than (normally) 85% of the insured's earned income. The 85% is usually used for those in lower incomes as determined by company practices, and will be graded downwards to 65%—or in some cases, 50% (or even less) for those in the highest income tax brackets.

The benefit amount limits take into consideration any other income to the insured, such as from other type of sick-pay plans offered by the employer, Government (SSI) disability plans, and other types of personal &/or group insurance. The limits may also be reduced if an insured has a significant amount of unearned income, or if they have a high net worth (such as \$3-5 million).

Limits may seem severe, but the purpose is to eliminate as much as possible the adverse selection and moral hazard of over insurance. If the benefits of a Disability Income policy equals or exceeds the amount of income without the disability, there could be very little reason for an insured to return to work in case of a claim, with the result that recovery can be stretched out for a long period of time, or never be attained. As with other insurance products, insurance laws weigh heavily in favor of the insureds and provide very little recourse for an insurer at time of claim, therefore the limits of benefits at time of underwriting is about the only control an insurer has to eliminate the over insurance hazard. And when the insured is aware of undisclosed sources of income or knows how much he will need to maintain his present standard of living and is able to purchase benefits equal or nearly equal to that amount, the element of anti-selection rears its ugly head.

One thing to keep in mind where the employer pays the premiums: The monthly benefit will usually be higher because the benefit is taxable to the employee so the net result will be approximately the same. If the insured has unearned income, such as dividends, interest, etc., the monthly benefit may be offset by all or some portion of the unearned income.

Having said all this, the fact still remains that under limits regularly used by Disability Income insurance carriers for personal insurance, an insured in the most favorable risk classifications and with adequate income, may acquire up to as much as \$20,000 indemnity a month for total disability. It should be noted that this amount is usually separate from the limits of special business Disability Income insurance policies – for example, overhead expense insurance.

Participation Charts

Most companies use a “participation chart” which determines the maximum monthly benefit according to the applicant's annual income. Limits have grown over recent years, and whereas it used to be 50 or 60 percent of compensation with a monthly cap of \$6,000 or so was normal, these limits are much higher in today's market.

BASIC BENEFIT PROVISIONS

There are different benefit provisions for total disability and a benefit for waiver of premium, and they are used by all insurers in spite of any other coverage that may be included in the policy. The benefit provision will define loss, the method of benefit payment, and determination as to termination of benefits.

Rehabilitation Benefit

This benefit is used as an inducement for a disabled insured to return to work. It provides for payment of a specified amount (typically 12 times the total of the monthly indemnity and any

other supplemental indemnities) to cover the costs, when not paid by other insurance or public funding, when the insured enrolls in a formal retraining program that will help the insured return to work. However, the rehabilitation is not mandatory in the greatest majority of the policies.

Non-Disabling Injury Benefit

This benefit pays “up-to” a specified amount which helps to reimburse the insured for medical expenses incurred for treatment of an injury that did not result in total disability. The amount generally is in the range of 25% of the monthly indemnity benefit. The benefit of this provision to the insured is obvious – additional medical expenses paid – and for the insurer, the payment can possibly and logically eliminate a disability claim by making it possible for the insured to treat the injury before it becomes a disability.

Transplant Benefit

A relatively new benefit, this benefit actually is two-fold. If an insured becomes totally disabled because of the transplanting of an organ from his body to that of another, the insured will be considered as totally disabled because of sickness. Further, this benefit provides that cosmetic surgery performed to correct appearance or a disfigurement would be considered as a total disability because of sickness.

The wording of this benefit will vary by those companies offering it. It immediately raises the question as to whether cosmetic surgery coverage would include such (frivolous to many) surgery as breast implementation. One must remember that there is an elimination period involved, and since it would be treated as a “sickness,” the insured would be deemed to have been “cured” in most cases. However, in the case of reconstruction augmentation surgery because of breast cancer, it fulfills an important personal and social function.

Principal Sum Benefit

As in many other types of life and health policies, this benefit pays a lump sum accidental death benefit amount if the insured is killed in an accident. The death must be caused by injury, both directly and independently, and it must occur within (usually) 90 (or 180) days of the accident.

It also pays a dismemberment or loss of sight benefit in the form of a lump sum, typically 12 times the monthly indemnity plus any additional indemnities. If sickness or injury results in the dismemberment or loss of sight, however, the insured must survive the loss for 30 days. This payment is in addition to any other indemnity payable under the policy and will pay the benefit for two such losses during the lifetime of the insured. However, it is generally limited to the irrecoverable loss of one eye, or the complete loss of a hand or foot because of severance above the wrist or ankle.

OPTIONAL BENEFITS

Most insurers offer optional or supplemental benefits and some insurers may include one or more of these benefits in their policy, but usually they are available for an additional premium.

RESIDUAL DISABILITY BENEFIT

This benefit provides a lower monthly indemnity in proportion to the insured’s loss of income, when the insured returns to work at lower earnings. If the policy’s definition of total disability is “own occupation,” the residual benefit is paid only when the insured has returned to work in his “own occupation.” It is interesting to note that about 35% of all Disability Income insurance claims either start or end in a residual claim.

In most Disability Income insurance policies, the insured may be *either* totally or residually disabled for purposes of the elimination period and waiver of premium. In order to determine residual disability, most policies use test of time and duties, combining both occupational and income requirements.

The “specialty” definition of total disability is often used during residual disability in those situations where the insured is considered as totally disabled for his professional specialty, but is at work earning a lower income in a general practice. Usually, the specialty type of definition is used only for regular occupations to avoid equivocation when the definition of total disability is based upon the “own occupation” provision.

Typically, a prior period of total disability sustained is not required prior to claiming the residual benefits, therefore it is possible for a residual claim to commence on the date of the claim and the reduced indemnity is payable at the end of the waiting period and will continue for the length of the benefit period. Until recently there was a qualification period. Which was a period of time (30 to 90 days usually) that the insured must have been *totally* disabled. Today, most policies allow the insured to combine periods of total and / or partial disability to satisfy any qualification period. Practically, however, residual claims nearly always follows a period of total disability, but in any event, they make up a very small percentage of disability claims, either from incurrence date or following a period of total disability.

Residual disability payments are payable for the policy benefit period, or until the loss of income is less than 20% (or 25%) of the insured’s prior income. Residual disability payments usually cease at age 65.

Practically speaking, of the two major types of residual claim – loss of income only, or loss of time and duties – most experts feel that the loss of income type of residual claim provision is better for the consumer, as under the loss of time and duties, benefits cease when the insured returns to work. However, many people that return to work after disability, do not immediately start making the income that they did prior to the disability. While in some occupations, such as technical and some professional jobs, a person is able to immediately start at the same income after a disability, but if, for example, the insured is in marketing or sales, it will take some time for him to return to his previous level of performance after a disability.

PARTIAL DISABILITY BENEFIT

There is a distinct similarity between the Partial Disability Benefit and the Residual Benefit, and most policies have replaced the partial benefit with residual benefit provisions for professional and white-collar occupations. However, many insurers maintain a partial disability provision for less-favorable occupations.

Typically, the Partial Disability Benefit provides 50% of the monthly benefit amount payable for total disability, and is paid for the lesser of (1) six months, or (2) the remainder of the policy benefit period, provided the insured has returned to work on a limited basis after a period of covered total disability. Partial Disability is usually defined in terms of occupation, and refers to both time and duties.

SOCIAL INSURANCE SUPPLEMENT (SUBSTITUTE)

The Social Insurance Supplement (SIS) was created in response to problems in underwriting Disability Income insurance because of the disability benefits available through workers’ compensation insurance, or for disability and/or retirement under Social Security. These benefits can be substantial and most insurers take these amounts into account in arriving at a benefit amount.

Most companies limit the amount of Disability Income insurance that will be available to those with incomes of less than \$35,000 per year and in particular, those in less-favorable occupations.

These riders are usually issued in amounts of \$600, \$800, or \$1,000 per month. Keep in mind that this rider is designed to provide additional income if the client CAN NOT QUALIFY for Social Security benefits.

Many times the insured will not qualify for the social insurance benefits because, for instance, a loss is covered by workers' compensation insurance. In addition, the requirements for total and permanent disability under Social Security are very restrictive. This would mean that if the insurer had limited the benefit amount under a Disability Income insurance policy, the insured could be underinsured each month by several hundred dollars – or even more.

The Social Insurance Supplement benefit meets this gap in coverage as it provides a monthly benefit amount that approximates the amount of Social Security Disability benefits for total disability. Obviously, the SIS is paid when the insured is totally disabled according to the policy definition, but *is not receiving benefits from any social service plan*. Benefits are paid at a fixed amount, but if at a later date, the insured starts receiving income from a social service plan, the insurer will either terminate the benefit payments, or terminate the benefits on a dollar-for-dollar basis with the social insurance plan. If the latter method is used, there usually is a “floor” below which the SIS benefit will not be reduced while the insured is on total disability.

In actual practice, purchasing this rider is more cost-effective than purchasing the same amount of base disability coverage. Therefore, since the insured will probably never receive Social Security Disability Benefits, the insured can receive additional income at a lower premium.

As far as the insurance company is concerned, this rider can help protect the company against over-insurance. An insured could (conceivably) receive 60 percent of income in benefits in *addition to* Social Security Benefits. This would hardly provide an incentive for an insured to return to work.

Some insurers now offer **Social Insurance Substitute Benefits** that operate in the same fashion except they cover other federal, state or local benefits the insured receives, such as Civil Service or Workers' Compensation, etc., benefits.

INFLATION PROTECTION

The Cost of Living Adjustment (COLA) benefit under a Disability Income insurance plan provides for benefits to be adjusted each year during a Long-term claim, to reflect the changes in the cost-of-living from the time that the claim started. Various methods of determining the COLA are used, but the most typical are those using the U.S. Consumer Price Index. Originally, using fixed percentage increases provided the inflation protection, but these plans could increase the benefit amount faster than the rate of inflation, leading to the over insurance moral hazard problem.

The calculation itself can be rather complex, but simply put; the index for the current claim year is compared with the index for the year in which the claim began. If the index increased or decreased since the claim period began, the benefits for the next 12 months are adjusted by whatever percentage change there was in the index. This percentage change would be limited to a specified rate of inflation, generally ranging between 5 and 10 percent (compounded annually).

With these calculations depending upon an index that can rise or fall with the economy, the adjusted benefits of the policy can increase or decrease each year, however the policy provides that the benefits cannot be reduced beyond an amount stated and specified in the policy on the

policy issue date. Some policies are capped so as to limit the increase in benefits to a maximum of 2 or 3 times the original benefit amounts, but others have no limit on the amount that the benefits can increase before insured reaches age 65.

Many professional Disability Income insurance agents will not recommend this rider if the insured is over age 45, as after that age, an individual is not as much at risk for inflation as at the younger ages, when a permanent disability would be tragic.

Some COLA riders are “capped,” usually at double or triple the monthly amount, but other COLA riders allow benefits to increase until the insured is age 65.

There can be a “buy-back” provision, i.e., if the insured returns to work after suffering a disability and receiving monthly benefits, which increases according to the COLA benefits. If the client returns to work and then suffers another disability, the monthly benefit payment would return to the original amount (prior to COLA increases). With the buy-back provision, the coverage for the new disability can be what he was receiving under the previous disability with the COLA advances, by paying an additional premium (depending upon his age).

SUPPLEMENTAL PROVISIONS FOR INCREASED FUTURE BENEFITS

Automatic Increase Benefit Provision

This benefit provides for increased benefits as provided by a specified table, in the monthly benefit payment. Usually these increase in each of 5 consecutive years, at a published fixed rate (usually 5% or 6%). There are increases in premiums also, with each increase in benefit being paid for at the attained age rate (for the portion of the benefit that was increased). Usually the insured has the choice of accepting or rejecting each increase over the five-year period. If he does so, he usually has the option of continuing the automatic increase over another five-year period. This option is often provided with no extra charge on policy issue date but other companies may charge an additional premium for the rider.

When (if) the insured recovers, the benefits usually revert to those benefits that were in-force on the date the policy was issued. Some insurers allow the insured, after recovery, to continue permanently the adjusted benefits that he received during the last claim payment year, but the insured will have to pay the required premium for the age and amount.

Guaranteed Insurability Option

This option, also referred to as a “Future Increase Option,” is similar to that offered in life insurance, i.e., it allows the insured to purchase additional Disability Income insurance at future policy anniversary dates without evidence of insurability. This type of option would be expected to have some anti-selection elements, as it would more often be purchased by those who expect to suffer claims and among those whose insurability is questionable. The increase in benefits available under this rider varies greatly among insurers, but usually is limited to twice the monthly indemnity the insured has in force *among all insurers* on the *original policy issue date*.

The purchase options are available annually to the insured, on the policy anniversary date, usually until age 50 or 55. The amount of the benefit is limited to the insurer’s limitations of disability income in relation to the earned income, and can also be limited by amount – such as \$500. Some policies allow the purchase of all or part of the total purchase option, on any policy anniversary date prior to the insured’s age 45 – annual increases thereafter are usually limited to a maximum of one-third of the original total.

If the insured is disabled on an option date, the insured can purchase the additional monthly indemnity but the additional amounts will not apply to the current claim. If the insured is dis-

abled on the date that they could exercise the increased benefit option, the future increase options are immediately payable. Income requirements, in these situations, are based upon earned income at the start of the claim, and immediate benefit payments are subject to an elimination period, beginning on date of issue of the *additional insurance coverage*.

TYPES OF GROUP DISABILITY PLANS

Disability Income insurance is one of the two medical plans available to employees or members of an organization that qualify for group insurance, the other being Medical insurance. Group Disability Income insurance consists of two types: Short-term and Long-term.

SHORT TERM DISABILITY

As a general rule, Short-term Disability Income insurance is simpler in many respects than the Long-term plans. Typically, the Short-term Disability Income plans places a maximum dollar amount on the benefits that will be paid in case of disability, regardless of the earnings of the insured. Some Short-term plans and the majority of Long-term plans apply benefits as a percentage of the total earnings of the insured excluding bonuses and overtime.

Short-term plans may provide a maximum dollar amount of benefits, regardless of how much the insured draws in income. For instance the Short-term plan offered might provide a benefit equal to 75% of earnings, with a maximum of \$250 per week. It is common to provide Short-term benefits on a weekly basis. If the group is large enough, or if the earnings vary greatly among the various levels of employees, the group policy may have a schedule of benefits that would so indicate the variances, and the maximum benefit would often be graded by occupational classes, rather than by strictly income.

In the discussion of elimination periods, it was noted that in most Long-term plans, the waiting period for sickness and injury was the same. There is no elimination period because of disability resulting *directly* from an accident, but there would be a waiting period for sicknesses (usually one to seven days). The reasoning is that most sicknesses are of short duration and this would eliminate many “nuisance” claims – otherwise premiums would be higher because of the short waiting period for injuries caused by accident. There are actually several other combinations of elimination periods offered by various companies.

The benefit period for both accident and sickness caused disabilities, are usually payable for up to a range of 13 to 52 weeks. Twenty-six (6 months) weeks is the most common benefit period.

NOTE: Federal law requires that pregnancy be treated the same as sickness under all fringe benefit plans (which include disability income insurance) for employers with 15 or more employees. Various states have even stricter laws in this respect, and the impact of these laws on the cost has been substantial.

MARKETING OF GROUP SHORT-TERM DISABILITY PLANS

One of the most successful methods of marketing Group Short-term Disability Income insurance is by what is termed “Workplace Marketing.” As the name connotes, the plans are sold at the employers place of business and usually also include other types of insurance, such as Cancer policies, life insurance, accident policies, etc., with the premiums being paid by the employer and/or by the employee through payroll deduction (which is usually the case).

This type of marketing is not true “group” marketing, but would more precisely be called “Endorsement Group” or “Franchise Group.” The employer endorses the programs offered by the agent and/or company, who then makes individual presentations of the products at the workplace to each employee and it, is usually done during, before or after working hours. Many times the enrollment of the employees in these Short-term Disability Income insurance and other plans coincides with the enrollment of the employees in an employer-sponsored group health plan, thereby providing minimum disruption of the employee’s time.

MARKETING OF GROUP LONG-TERM DISABILITY INCOME PLANS

With Group Long-term Disability Income Insurance, the benefits are provided to fulfill the need for income during a Long-term disability from either sickness or accident, and *regardless if it is job connected*. Normally, in Group plans, the definition of disability is that of total disability, but a few companies will include a residual disability benefit clause in their policies, and some also offer a presumptive disability clause (as discussed earlier).

If the group policy has a residual benefit provision, the insured does not have to be totally disabled to qualify for benefits, e.g., if the insured suffers a disability that reduces his income by (normally) at least 20% in the first two years of disability, then the policy will pay a proportionate benefit. The purpose of this is to be consistent with insurers continuing to place emphasis on rehabilitation services as part of the overall plan benefits. If the presumptive benefit provision is provided in the policy, the elimination period is waived, and the *total* loss of sight, speech, hearing, or two more of limbs (arms &/or legs) will qualify the insured for long term benefits de facto.

Typically, an elimination period of 7 days to 12 months is used. The Long-term policy is actually designed to provide long-term disability income protection upon the expiration of the Short-term disability coverage. Coverage will usually be provided to age 65, however other coverage periods – such as 2 years, 5 years, lifetime accident, etc., - are often used.

The size of the group is the most important factor in underwriting Long-term disability income policies, as a large group will allow much more flexibility in underwriting. Another important factor in group underwriting for this coverage is the nature of the work that the group performs. Some insurers refuse to write blue-collar groups, or at least underwrite them much more cautiously.

TAXATION OF GROUP DISABILITY INCOME BENEFITS

Taxation of health insurance benefits are consistent among various types of health insurance whereas the premiums contributed by the employer for disability income insurance for employees, are tax-deductible (usually) for the employer and are not taxable income to the employee.

Employee contributions are not tax deductible by the employee. Therefore, the payment of benefits under an insured plan (or a noninsured salary continuation plan) are treated as taxable income by the employee, but only to the extent that the benefits that are received are directly attributable to the employer’s contributions.

FLEXIBLE BENEFIT PREMIUM PLANS

Flexible Benefit Premium Plans are a result of Title 26. IRS Code Section 125, usually called “Cafeteria Plans.” The entire program is beyond the scope of this text but it is used so frequently in the marketing of Short-term Disability Income insurance products that a brief description of the program is in order.

Flexible Benefit plans may offer group and/or individual policies, but usually the benefits offered in the Disability Income insurance area, are supplemental benefits – supplemental to group health (usually major medical plans), pension plans and life insurance, and not necessarily supplement to group Disability Income insurance, although they certainly can be and are frequently offered. Supplemental Disability Income insurance is usually written on an individual basis with payroll deduction, so even if the policies are individual policies, the payment of premiums to the insurer by the employer (payroll deduction to the employee) and the fact that marketing is performed at the worksite and during, before or after work, puts a “group face” on the product.

Section 125 was created by Congress in the Revenue Act of 1978 and added to the Internal Revenue Code because of the changes in the work force and the increasing cost of health benefits. Basically, it allows employers to establish flexible benefit plans, or cafeteria plans, under which employees can choose between tax-free benefits and taxable benefits.

Qualified benefits can include:

- Accident and Health Insurance (Medical and Disability Income)
- Group Term Life Insurance
- Dependent Care Reimbursement Account
- Medical Reimbursement Account
- 401(k) plans
- Vacation Days
- Health Reimbursement Arrangements (HRAs)

ANNUAL CLAIM COSTS FOR DISABILITY INCOME POLICIES

The annual claim costs that are used in premium calculation for a disability income benefit varies considerably by occupation class. The following table shows the annual claim costs for one type of Disability Income insurance policy. As explained below, the costs vary according to age, sex, occupation class, elimination period and maximum duration. It should be pointed out that if the elimination period and the maximum duration of benefits are different for sickness than for accident benefits, separate claim costs will have to be developed taking each into consideration.

The following statistics are derived from the Society of Actuaries publication, 1998, and are used for illustrative purposes only. These annual claim costs are for \$100 of monthly disability income benefit with a seven-day elimination period and reflect experience for years 1986-1991. These statistics use basically two occupational classes, white-collar jobs and blue-collar jobs.

Attained Age	Male Occ. Class I White-collar	Male Occ. Class II Blue-collar	Female Occ. Class I White-collar
Under 30	-	17.44	-
30-34	3.58	17.26	4.44
35-39	10.73	16.35	27.98
40-44	12.63	21.62	14.52
45-49	19.25	21.43	20.07
50-54	28.25	79.63	29.31
55-59	32.45	38.28	27.70
60-64	35.90	53.03	70.30
65-69	43.05	103.28	27.84

MEASURING MORBIDITY

In determining a premium, the first step is to provide a measure of the expected net annual claim cost per policy in an established line of business. In order to predict future claims costs, the best source of this information is from the insurer's own files, if they have been in business for a while. Otherwise, the Society of Actuaries publishes morbidity tables for this purpose as well as studies by other insurance industry organizations. These studies analyze claim costs for various types of benefits.

There are only a few Disability Income insurance companies that are able to do their pricing based upon their own experience. The NAIC publishes public disability morbidity tables, and the Society of Actuaries publishes annual updates on disability experience. The final analysis, of course, must come from the actuary developing the product and their interpretation as to the value of the various sources of information available.

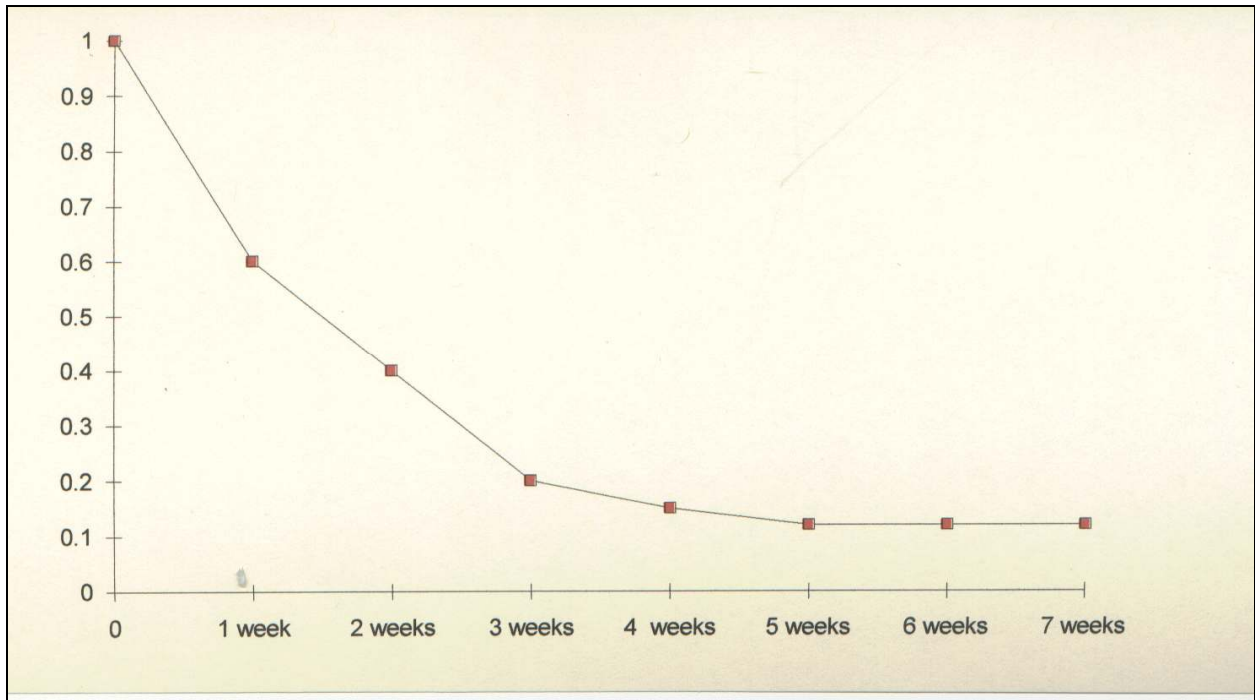
As in any technical determination in insurance, a formula is used to determine the annual claims cost. This is based upon a "Unit Benefit Cost," which is the frequency of claims multiplied by the amount of the average claim. The net annual claims cost is the unit benefiting cost by the benefit amount. In Disability Income insurance, the unit of exposure would be \$1 of monthly benefit amount.

Continuance Tables

The expected claim frequency amount persons insured and the average claim value are important determinations that must be made by the actuaries. However, since an elimination period is used in Disability Income insurance, there would be variance of claims costs based on the elimination period. The actuary then develops a "Continuance Table" which is the probability of claims continuing for various durations or amounts.

The elimination period has a very dramatic effect on rates, as illustrated in the following table:

Probability of Continuation of Disability per 10,000 disabled lives or age 40, adult males



↑ Probability of Continuance

Duration of Disability →

LOSS RATIO

Loss ratio is another term that is “thrown about,” particularly in health insurance. If one has to explain why premiums are higher for one class of insured than for another class, or if there is a premium increase on the same policy form, the theory usually is that it is because the “loss ratio” is higher, or in case of an increase, higher than expected.

Loss ratio is actually a method of establishing the level of morbidity costs based upon the ratio of *claims incurred to premiums earned*. Really quite simple in concept

Without getting too technical, there actually are two types of loss ratios, permissible loss ratio and incurred loss ratio:

Permissible loss ratio is the portion of each premium dollar that is used to pay claims. The remainder of the premiums is assumed to pay taxes, expenses and profits. Another way to put it is that the permissible loss ratio is the *expected* loss ratio; and

Incurred loss ratio is the portion of each premium dollar that is *actually* used to pay claims.

Therefore, if the permissible loss ratio is compared to the incurred loss ratio, the result will be the percentage that is necessary to bring the pricing in line with the experience.

GROSS PREMIUMS

The Gross Premiums can be simply explained as the premium that must provide for not only benefits to be paid (net level premium), but also for expenses, taxes, and funds held for contingency purposes in case claims and expenses are higher than expected. They are usually computed on the assumption that they will be paid annually, although premiums can be paid on other basis.

Premium rates for Disability Income insurance benefits consist of morbidity, provider payment arrangements, expenses, taxes, and persistency, interest and profit/contingency margins.

Morbidity

For comparison purposes, in calculating premiums for life insurance the actuaries only have to consider the number of deaths during a year compared with the total number of persons exposed in the same class. For Disability Income insurance, however, in measuring morbidity, the annual claim cost for a given age/sex/occupational class is, as described earlier, the annual frequency of the disability and the average claim when the disability occurs.

Generally, morbidity tables used in Disability Income insurance for benefits exclude the experience during the calendar year in which the policy was issued. There is not the importance of a “select” period (the period of time that it takes a newly underwritten insured to reach the experience of all of the insureds), as there is in life insurance.

Disability Income insurance has rather unique morbidity statistics. For instance, there appears to be considerable adverse selection by those who apply for Disability Income policies with short elimination periods and long maximum-durations. Applicants, who purchase insurance in the 20-30 age ranges, develop a higher level of morbidity after age 50, than those who become insured after age 50. To further complicate it for the actuaries, experience varies considerably among various benefits.

Expenses

Expense assumptions used in premium calculation for Disability Income insurance include premium taxes, agents’ commissions, policy issue costs, underwriting costs, claim costs, and investigation/legal costs. These expenses are much higher the first year (administration-underwriting-issue costs plus the higher first year commissions), and are relatively constant after the first year – except for inflation, of course.

Persistency Rate

Persistency is the length of time that a policy stays on the books (in force). It is expressed as a ratio of the number of policies that continue coverage on the date of premium due, to the number of policies in force as of the previous policy due date. Persistency improves with policy duration, and after, for instance, five years; the persistency rate is usually in the 90 percentile with many types of policies.

Interest

While low interest rates are good for many industries, it is a double-edged sword for insurance, as premiums are based upon assumed interest on the investments of the insurance company. If interest is higher than assumed, benefits can be increased, better and less expensive policies can be introduced, and dividends are paid (if mutual company). On the other hand, as in today’s economic climate, when interest rates are at a historic low, the insurers are not making the money on their products that they had assumed because of the difference in the assumed interest rate and the actual interest rate being collected. With the present interest rates, many companies have had to divest themselves of investments in order to meet their profit objectives and pay claims.

With Disability Income insurance, interest is very important to consider the interest in measuring the average claim cost and the value of the disability annuity can be significantly reduced because of the interest discount.

On occasion, when discussing Disability Income Insurance, the terms “disability annuity” or “claims annuity” are used—the “annuity” refers to the amount that must be paid out for a specified period of time. In essence the insurer creates an annuity that pays out the monthly income payments at time of claim, using annuity statistics and cost of money, etc.

Profits Contingency Assumptions

If the premium-rate calculations do not assume a profit and a reserve for contingency, then there will be no profits. There are several methods of producing these assumptions, one of the simplest is to calculate the premium without the profit/contingency assumption, and then add a certain percentage of the premium to the premium for this purpose.

MISCELLANEOUS PREMIUM VARIABLES

Changing, adjusting and monitoring costs are very important for Disability Income insurance because under a noncancellable policy, the insurer is in effect guaranteeing the premium for the life of the policy.

If the policy is guaranteed or conditionally renewable Disability Income insurance policy, the insurer may raise or adjust the premium in certain circumstances. If the experience of an entire block of policies experiences higher claims costs than assumed, the insurer can raise the premiums on the entire block of policies – *but not separately for individual policies*.

One of the difficulties in creating a premium that meets assumptions is that the inability to work because of the result of sickness or injury is subjective and involves an attitude in addition to a physical or mental impairment. Therefore, many factors come into play at time of claim – such as the level of unemployment, individual’s work ethics, the attitude of the insured in respect to retirement, attitudes of physicians who certify the disability, and last but not least, the attitude of the insurance company.

FINAL DETERMINATION

Even though the calculation of the premium may appear complex, there are several other factors that must be taken into consideration that are beyond the scope of this text. However, one of the most important factors is simply that of actuarial judgment. Actuaries may voice this factor in different ways, but simply put, after the premiums have been determined, they look at it and ask if it makes sense and will it do the job intended, and further, how does it stand up to competition.

There have been more than a few instances where an actuarial department has slaved to develop a new product, and then when it is announced, discover that another company offers a similar or nearly-the-same product, but at lower rates and/or higher commissions. This is called, “Back to the drawing board!”

While agents certainly are not required to understand the entire premium-making and/or product development process, it is important to note that new products are almost always a result of a request of the marketing department and agents’ requests. Then once the product is introduced, it is the marketing department and agents who really determine whether the product performs as intended. Insurance company files are full of policy forms and rates of products that the agents could not or would not sell.

BUSINESS OVERHEAD INSURANCE

A specialized but very important area of Disability Income insurance used for business purposes is that of business overhead expense insurance. This provides for the needs of the *business*

if the owner (or principal) becomes disabled and is therefore not able to perform their important role in the business or to generate most of the sales.

This type of coverage is of importance to self-employed professionals, and to business owners and entrepreneurs as they must continue to meet payroll each month, pay the rent, utilities, taxes, insurance premiums, etc., etc. even if they become disabled and are no longer able to actually contribute to the business.

If such should happen, they may try to stretch out their payment of these obligations, even though it would eventually hurt their credit. Of course, one of the first things that would come to mind is the expenditure of personal savings and other personal assets to keep the business afloat. This could very easily put their family's well being in jeopardy and possibly even lose their home. A personal Disability Income policy usually covers only the personal costs of the disabled person, so any expenditure of those funds would again cause a cash crunch on the family.

The business owner could try to hire a replacement – usually very difficult to do, but even if successful, it would take considerable funds. Therefore, they would likely start liquidating inventory at prices designed to move the product quickly, which is a good situation for consumers, but almost always a death knell for the company. Employees will have to be let go and eventually the business owner will have to close the business.

Business overhead insurance is not attractive to large corporations as they usually have several sources of income and the loss of one Key Employee is not that crippling to the corporation. But to a doctor or dentist or sole proprietor of a small business where the owner brings in most, if not all, of the firm's revenue, what will happen if they become disabled?

These policies used to be issued to professional persons primarily, and were called "professional overhead policies." However, they now are issued to manufacturers, wholesalers and retailers, and the name "business overhead" now encompasses all policies of this type.

The policy concept is rather simple. When the business owner becomes disabled, the policy pays a monthly benefit. The benefit is based upon the overhead of the business, and not on the insured's personal earnings (gross) or anticipated profits. However, the business owner can also insure (up to) 100% of the company's tax-deductible expenses (as opposed to the limits of 60%-70% of an individual's gross earnings).

The "eligible" expenses are those that are necessary for the operation of the business, and can be considered "usual and customary" such as rent or mortgage payments, salaries of employees, office supplies, legal fees, etc.

Expenses that are usually not covered include the cost of goods or services used in the business, income taxes, cost of furniture, tools or equipment used in the business, any salaries or income paid to the insured owner or his family members if they were hired after the owner's total disability started, profits forecast or anticipated, income taxes and any expenses that the owner was not responsible for prior to his disability

THE BUSINESS OVERHEAD POLICY

The policy form is rather simple and not at all complicated. There are only a few basic policy provisions that need to be discussed. With these policies, the definition of disability simply states that benefits are payable if the insured is unable to perform his duties in the business, which is basically the own-occupation type of definition.

Elimination periods are typical 30, 60 or 90 days, with benefit periods of 12 to 24 months under the theory that if the insured is disabled for more than two years, it is more than likely that the business does no longer exist or is awaiting sale.

The *amount* of the benefit depends entirely on the expenses that the firm anticipates and the income flow from the business. One should keep in mind that the more the revenue from the business is likely to decline due to disability of the owner/principal, the larger the benefit amount that is needed.

This policy has a provision that states that the maximum monthly overhead expense benefit is the maximum amount of benefit that will be paid to the insured during a given month of disability. If the actual expenses of overhead are less than the policy maximum, the insurer will pay only the actual expenses up to the maximum amount (making this an indemnity policy – the insurer pays for the actual loss to the insured, but does not allow the insured to profit from a loss). Therefore, the monthly benefit would depend on the overhead business expenses for that particular month.

Carryover of Monthly Benefits

This situation can be best explained by illustration. Assume that the policy is a 12-month policy with benefits of \$1,000 per month (for simplicity). Further assume that when the insured is disabled, the overhead expenses actually only totals \$800 per month. The question is obviously, what happens to the other \$200 per month.

An insurance company could just pay the \$800 per month, and at the end of the year, \$2,400 of benefits would be lost.

The most logical approach and that offered by some insurers, is that in the above situation the policy may allow for a carryover whereby the benefit period is extended in order to “use up” the unused maximum monthly benefit that has accumulated. In the above example, this would extend the benefits for an additional 3 months of coverage.

Accumulation Provision

Using another example, the actual expenses are \$800 one month, \$1,000 the next month, and \$1,200 the next month. With some policies, the benefits for the month when expenses exceeded the policy benefits would not be paid. In other policies, there is an accumulation provision that, using the example above, the additional \$200 of benefits not paid the first month, could be used to pay the \$200 excess in the third month. In other words, the months in which the total benefit is not used, it can accumulate and be used when the expenses exceed the policy benefits. If there were still unused benefit “credits” at the end of the policy period, the policy would automatically be extended until all the benefits are used.

Partial Disability

Partial disability in these policies varies from the typical definition of partial disability in individual policies because the insured is usually able to earn some income during the disability period – especially if the insured owns the business. Partial disability is defined as a disability that follows a period of continuous total disability for which benefits are payable.

Typically, the insured may receive 50% of the benefits that would be payable if the insured were totally disabled. It is usually paid for a period not to exceed 6 months if the insured is working at his regular occupation and can perform a portion (but not all) of these duties. They may also provide that benefits are paid if the insured can perform all of his duties for his “regu-

lar” occupation, but not for more than half of the time every day that was previously required to perform the functions.

TEMPORARY REPLACEMENT

Some overhead expense policies will pay for the salary of a temporary replacement that specifically is hired to perform the duties of the disabled person, after disability is incurred. This is generally limited to others than members of the insured’s family, and the amount cannot exceed the maximum monthly benefit and overhead expense maximum.

There are also provisions for survivor’s benefits, conversion rights to an individual policy if the business is sold, in which case the insured has the option of increasing benefits (to keep up with inflation) in the maximum monthly benefit and in the overhead expense maximum.

Technically, premiums are paid by the business and the premiums are allowed as a business expense, therefore any benefits will be taxed. However, since business overhead expenses are tax deductible, practically speaking, there are very little, if any, taxes due.

BUSINESS CONTINUATION

Business continuation insurance is primarily of interest to closely held companies as business continuation in case of disability (or death) of a principal and/or owner is of primary interest. These problems arise because the owners of the business generally manage the company and work on a salary basis. Most closely held corporations are owned by a few persons, usually less than 10, and because of this, their ownership interest is not traded on an exchange so there is no ready market for their interest. Since others outside of the business are usually not interested in purchasing and running the business, those who would be interested are other owners. Frequently competitors are also very interested in these businesses.

Not only is the survival of the business in case of disability (or death) of a principal of interest to other owners, it also is of critical interest to family members.

PARTNERSHIP BUY-SELL AGREEMENT

For partnership businesses, disability income insurance is used in case of a Buy-Sell agreement which obligates the surviving partners to purchase the business in case of disability (or death) of the first partner to become disabled, at a stipulated price. It also states the obligation of the other partners to purchase the interest of the disabled partner. The value of the business may be determined by a mutually-acceptable method, such as a pre-determined amount, or by formula.

There are two types of these policies:

1. Indemnity Disability Income policies that pay an amount specified in the policy, regardless of the actual value of the business at time of claim and may be written for amounts as high as \$350,000.
2. Reimbursement Disability Income policies, wherein the policy pays the lesser of the amount specified or the actual value of the business and may be written with a maximum of \$1 million on any one individual.

There are several uses for Disability Income insurance to be used for buy-sell agreements for self-employed businesses, partnerships, or corporations. The buy-sell and other business uses of this product is technical and can be quite complex, plus there are tax implications in nearly all agreements of this type. Therefore, more detailed explanation of using Disability Income insur-

ance for business purposes is outside the scope of this text. If an agent or broker feels that such a plan might suit a particular business, it would be wise to involve an accountant and/or attorney.

STUDY QUESTIONS

1. There are two types of Disability Income Insurance,
 - A. expensive and narrow.
 - B. short-term and long-term.
 - C. guaranteed issue and instance issue.
 - D. commissionable and non-commissionable

2. When the insured has the right to renew the policy to some specified age by the process of the insured paying the premium, this is
 - A. Guaranteed Renewable.
 - B. Noncancellable.
 - C. Conditionally Renewable.
 - D. Limited Cancelable.

3. When “Accidental Means” is used regarding a bodily injury, there are two requirements that must be met if the loss is to be covered:
 - A. accidental and intentional.
 - B. the cause and the result of the injury must be unexpected and unforeseen.
 - C. disabling and casual.
 - D. caused by a common carrier or private vehicle.

4. A disability in which a wage earner is forever prevented from working at full physical capacity because of injury or illness, is
 - A. permanent partial disability.
 - B. total disability.
 - C. residual disability.
 - D. conditional disability.

5. An “own occupation” clause defines an insured as totally disabled if
 - A. the insured cannot perform any work or occupation.
 - B. the insured cannot perform the major duties of his regular occupation.
 - C. the insured can perform the 75% of the major duties of his regular occupation.
 - D. the employer signs an affidavit to that effect.

6. Before an insured can qualify for disability income benefits,
 - A. he must be under the care of a physician.
 - B. his disability must be attested to by two disinterested parties.
 - C. his employer must attest that he can no longer do his job satisfactorily.
 - D. he must leave his regular job and attempt to get employment elsewhere.

7. The insured is considered as totally disabled if they cannot perform the major duties of any gainful occupation for which he is reasonably suited because of education, training or experience, this is defined as
 - A. presumptive disability.
 - B. "his occupation" disability.
 - C. "any occupation" disability.
 - D. qualified disability.

8. If a Disability Income insured has continuing episodes of disability, the determination as to whether this will be treated as a continuing claim or a new claim will depend upon
 - A. whether the disabilities occurred in the same geographical area.
 - B. what the insured was doing when the disabilities occurred.
 - C. whether the policy was a group or individual policy.
 - D. whether disabilities from the same cause will be considered as one continuous period of disability, unless each period of disability is separated by at least a 6-month recovery period.

9. Because of the possibility of adverse selection, Disability Income policies limit the amount of insured that an insured may purchase
 - A. to an amount usually not more than 85%, graded downward for those with high income.
 - B. 100% of the earned income only.
 - C. a composite of the average of the last three years of earned income.
 - D. an amount equal to earned and unearned income.

10. Business overhead insurance
 - A. cannot use a disability income insurance policy.
 - B. provides for the needs of the business if the owner become disabled.
 - C. is not used by the self-employed.
 - D. the amount of the benefit depends on the business gross sales.

ANSWERS TO STUDY QUESTIONS

1B 2C 3B 4A 5B 6A 7C 8D 9A 10B



CHAPTER SIX - LONG TERM CARE INSURANCE

Long-term care insurance covers long-term care in a variety of settings—not just in nursing homes—which has the distinct advantage of allowing a much broader scope of long-term care and has the effect of allowing an insured to have greater freedom to choose the facility that matches their needs. An insured has more choice now than in the past because the rapidly growing senior segment of the population has demanded facilities other than just nursing home and home health care. LTCI provides flexibility so that the insured can afford other types of care; such as assisted living facilities, or continuing care retirement community, etc. LTCI typically pays a daily rate to the care provider, although some policies pay a weekly or monthly benefit. A “good” LTCI policy will cover all levels of care, particularly custodial and personal care, and will provide benefits for adult day care in addition to assisted living facilities and nursing facilities.

LTCI has been a disappointment to some as it has not grown in popularity as well as was expected, but still, within the past ten years LTCI has grown from paying nothing to 5% or more of nursing home receipts and is increasing in percentage each year. The governments—state and federal—have encouraged private LTC Insurance by tax break legislation for the product, plus offering LTCI for federal workers, military and retirees and their families. Congress continues to encourage the purchase of LTCI plans by various bills, including full deduction of premiums and the passing-through of premiums in cafeteria plans

Policy Definitions

Long-Term Care Insurance Definition

Long-term care insurance is a contract designed to pay for care when necessary due to the loss of one’s ability to function independently in society whether it be due to an injury or sickness or through the natural progression of growing old and becoming frail.”

“Long-term care insurance’ includes any insurance policy, certificate, or rider advertised, marketed, offered, solicited, or designed to provide coverage for diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services that are provided in a setting other than an acute care unit of a hospital and includes all products containing any of the following benefit types: coverage for institutional care including care in a nursing home, convalescent facility, extended care facility, custodial care facility, skilled nursing facility, or personal care home; home care coverage including home health care, personal care, homemaker services, hospice, or respite care; or community-based coverage including adult day care, hospice, or respite care.”

STATUTORY PROVISIONS

HIPAA (PL 104-191) increased the deduction for health insurance that self employed taxpayers may claim, in addition to other changes. It had a definite impact on Long Term Care Insurance (LTCI) by creating new types of LTCI policies—Tax Qualified (TQ).

Prior to HIPAA, the taxability of LTCI benefits was simply not addressed, which meant that technically LTCI benefits could be taxable to the individual receiving benefits. It had never been applied, as far as can be determined because, it is generally accepted, the IRS did not want to tax nursing home benefits of an elderly and ill person. This would have obviously created a hue and cry that would start with the senior lobby, and besides, such taxation would not be fair.

To the credit of the elected politicians, HIPAA “legitimized” LTCI benefit payments by defining LTCI as a “health insurance product” and allowing the benefits to be tax-free as with other health insurance plans. However, Congress expanded this tax-advantaged legislation to specify that these tax advantages could be available only if the LTCI plan met their criteria. The Act created two classes of LTCO policies: Tax Qualified (TQ) and Non-Tax Qualified (NTQ)” plans. In some ways the NTQ benefit “triggers” are more liberal and therefore it is easier to qualify for NTQ benefits. But the spectre of being taxed on benefits created a chilling effect on the “old” policies. Many companies still offer both types of policies, but some states have added to the HIPAA qualifications for TQ policies, discouraging the sale of any LTCI policy except for the TQ plans. LTCI policies in force prior to the HIPAA are grandfathered so the tax possibilities are neutered.

HIPAA says that a Long Term Insurance Contract is an insurance contract that only provides coverage for *qualified long-term care services*.

The contract must:

- Be guaranteed renewable.
- Not provide for a cash surrender value or other money that can be paid, assigned, pledged or borrowed.
- Provide that refunds, other than refunds on the death of the insured or complete surrender or cancellation of the contract, and dividends under the contract may be used only to reduce future premiums or increase future benefits, and
- Generally not pay or reimburse expenses incurred for services or items that would be reimbursed under Medicare, except where Medicare is a secondary payer or the contract makes per diem or other periodic payments without regard to expenses.

Qualified long-term care services:

- Necessary diagnostic, preventive, therapeutic, curing, treating, mitigating and rehabilitative services, and maintenance and person care services, and
- Required by a **chronically ill individual** and provided pursuant to a plan of care as prescribed by a licensed health care practitioner.

Chronically Ill Individual

A chronically ill individual is one who has been certified by a licensed health care practitioner within the previous 12 months as one of the following:

- An individual who, for at least 90 days, is unable to perform at least two activities of daily living without substantial assistance due to loss of functional capacity. Activities of daily living are eating, toileting, transferring, bathing, dressing, and continence, or they must have a similar level of disability as determined by the Secretary of the Treasury in consultation with the Secretary of Health and Human Services.
- An individual who requires substantial supervision to be protected from threats to health and safety due to severe cognitive impairment.

Limit on Exclusion

In addition to the amounts on the following chart, an individual can generally exclude from gross income:

- Employer premiums may be deductible without resulting in inclusion as compensation to the employee, and the policy benefits may not be nontaxable.
- Limited premium deductibility is available for individuals who itemize medical expenses on their tax returns. If an individual does itemize these deductions, there are some limitations on the extent of deductibility based on age:
- Self-employed individuals may add long-term care insurance to their schedule of premium deductibility.
- Long-term care insurance may not be included in a Section 125 Cafeteria plan.
- Long term care insurance policies that pay on an expense-incurred basis will coordinate with Medicare.
- Qualified plans with deductible premiums and non-taxable benefits must offer a non-forfeiture benefit.

Qualified Long-Term Care Insurance

Taxpayers can include premiums paid on a qualified long-term care insurance contract for themselves, their spouse, or their dependents when figuring their deduction. But, for each person covered, they can include only the smaller of the following amounts.

The amount paid for that person, or

The amount shown below - 2004 rates. (Use the person's age at the end of the year)

Age 40 or younger	\$260
Age 41 to 50	\$490
Age 51 to 60	\$980
Age 61 to 70	\$2,600
Age 71 or older	\$3,250
Per Diem Limitation	\$230

Tax Deduction Eligible Long-Term Care Premium Limit by Age Group

Age group	1999	2000	2001	2002	2003	2004
Age 40 or less	\$210	\$220	\$230	\$240	\$250	\$260'
Ages 41 to 50	\$400	\$410	\$430	\$450	\$470	\$490
Ages 51 to 60	\$800	\$820	\$860	\$900	\$940	\$980
Ages 61 to 70	\$2,120	\$2,200	\$2,290	\$2,390	\$2,510	\$2,600
Ages 71 and older	\$2,660	\$2,750	\$2,860	\$2,990	\$3,130	\$3,250
(Per Diem Limitation)	\$190	\$190	\$200	\$210	\$220	\$230
Source: IRS Rev. Proc.	98-61	99-42	2001-13	2001-59	2002-70	2003-85

Type of Policy

LTCI can be broken into three basic types of policies: 1) Nursing Facility and Residential Care Facility Only, 2) Home Care Only and 3) Comprehensive Long-Term Care (Not all insurers offer all 3 types).

NURSING FACILITY AND RESIDENTIAL CARE FACILITY

Residential care facility in most LTCI policies means a facility licensed as a residential care facility for the elderly or a residential care facility. Normally eligible providers are facilities that meet applicable licensure standards, if any, and are engaged primarily in providing ongoing care and related services sufficient to support needs resulting from impairment in activities of daily living or impairment in cognitive ability and which also provide care and services on a 24-hour basis, have a trained and ready-to-respond employee on duty in the facility at all times to provide care and services, provide three meals a day and accommodate special dietary needs, have agreements to ensure that residents receive the medical care services of a physician or nurse in case of emergency, and, have appropriate methods and procedures to provide necessary assistance to residents in the management of prescribed medications.

In many policies, the benefit amount payable for care in a residential care facility must be no less than 70 percent (or some similar amount) of the benefit amount payable for institutional confinement.

TQ policies require that all covered expenses incurred by the insured while confined in a residential care facility, are for long-term care services that are necessary diagnostic, preventative, therapeutic, curing, treating, mitigating, and rehabilitative services, and maintenance or personal care services, needed to assist the insured with the disabling conditions that cause the insured to be a chronically ill individual. Often, there will be no restriction on who may provide the service or the requirement that services be provided by the residential care facility, as long as the expenses are incurred while the insured is confined in a residential care facility, the reimbursement does not exceed the maximum daily residential care facility benefit of the policy or certificate, and the services do not conflict with federal law or regulation for purposes of qualifying for favorable tax consideration provided by Public Law 104-191.

Residential Care Facilities (RCF) and Board and Care homes (RCFE) often do not have the staff to perform all of the needed care for a resident. The law specifies that if this care must be obtained from an independent source that the policy will still pay for the care as long as it was included in the plan of care and the coverage limit is high enough.

In TQ policies or certificates (group LTCI) the threshold establishing eligibility for care in a residential care facility must be no more restrictive than that for home care benefits, and the definitions of impairment in activities of daily living and impairment of cognitive ability are the same as for home care benefits.

HOME CARE ONLY

Policies that are limited to the provision of home care services, including community-based services, are called a 'home care only' policy or certificate. Definitions of home care services are:

Home Health Care

“Home health care” is skilled nursing or other professional services in the residence, including, but not limited to, part-time and intermittent skilled nursing services, home health aid

services, physical therapy, occupational therapy, or speech therapy and audiology services, and medical social services by a social worker.

Adult Day Care

“Adult day care” is medical or nonmedical care on a less than 24-hour basis, provided in a licensed facility outside the residence, for persons in need of personal services, supervision, protection, or assistance in sustaining daily needs, including eating, bathing, dressing, ambulating, transferring, toileting, and taking medications (“Activities of Daily Living”, discussed in detail later).

Personal Care

“Personal care” is assistance with the activities of daily living, including the instrumental activities of daily living, provided by a skilled or unskilled person under a plan of care developed by a physician or a multidisciplinary team under medical direction. Instrumental activities of daily living include using the telephone, managing medications, moving about outside, shopping for essentials, preparing meals, laundry, and light housekeeping.

Homemaker Services

“Homemaker services” is assistance with activities necessary to or consistent with the insured’s ability to remain in his or her residence that is provided by a skilled or unskilled person under a plan of care developed by a physician or a multidisciplinary team under medical direction.

Hospice Services

“Hospice services” are outpatient services not paid by Medicare, that are designed to provide palliative care, alleviate the physical, emotional, social, and spiritual discomforts of an individual who is experiencing the last phases of life due to the existence of a terminal disease, and to provide supportive care to the primary care giver and the family. A skilled or unskilled person may provide care under a plan of care developed by a physician or a multidisciplinary team under medical direction.⁵⁸

Respite Care

“Respite care” is short-term care provided in an institution, in the home, or in a community-based program, that is designed to relieve a primary care giver in the home. This is a separate benefit with its own conditions for eligibility and maximum benefit levels.

Coverage Triggers for Home Care Benefits

TQ Long-term care policies that offer home care coverage must base the insured’s eligibility to receive benefits on either impairment in two activities of daily living or impairment of cognitive ability.

Medical Necessity Not Allowed As Coverage Trigger

This is a TQ provision that tightened up the benefit availability—HIPAA states that requiring “medical necessity” or similar standard as a criteria for benefits is not allowed.

Home Care - Minimum Benefit Limits and Duration

TQ policies, and some state regulations, require that every comprehensive long-term care policy or certificate that provides for both institutional care and home care and that sets a daily, weekly, or monthly benefit payment maximum, shall pay a maximum benefit payment for home care that is at least 50 percent of the maximum benefit payment for institutional care, plus usually there is a min-

imum payment (such as \$50 per day). Insurance products approved for residents in continuing care retirement communities are exempt from this provision. Every such comprehensive long-term care policy or certificate that sets a durational maximum for institutional care, limiting the length of time that benefits may be received during the life of the policy or certificate, will allow a similar durational maximum for home care that is at least one-half of the length of time allowed for institutional care.

Prohibited Limitations for Home Care Benefits

Home care benefits are not to be limited or excluded by any of the following:

- Requiring a need for care in a nursing home if home care services are not provided. Requiring that skilled nursing or therapeutic services be used before or with unskilled services.
- Requiring the existence of an acute condition.
- Limiting benefits to services provided by Medicare-certified providers or agencies.
- Limiting benefits to those provided by licensed or skilled personnel when other providers could provide the service, except where state law requires prior certification or licensure. (In most cases an individual who is defined as “unskilled” provides homemaker and personal care services. A licensed or skilled requirement would greatly increase the cost of delivering these services and adversely impact the availability of these services.)
- Defining an eligible provider in a manner that is more restrictive than that used to license that provider by the state where the service is provided.
- Requiring “medical necessity” or similar standard as a criteria for benefits.

COMPREHENSIVE LONG-TERM CARE

Only those policies or certificates providing benefits for both institutional care and home care may be called “comprehensive long-term care” insurance. A majority of those who purchase LTCI policies, purchase comprehensive policies—normally because the Comprehensive Plan covers care both home-care and care in a facility. While a comprehensive policy is more expensive, most people want to have coverage for care, and do not want to “gamble” on whether the needed care is furnished at home or in a nursing care of other facility. The comprehensive policy represents choices and control to the insured when they need care and provides a financial incentive for the insured to stay out of a nursing home as the benefits are available to pay for care in the least restrictive setting, plus flexibility.

TYPES OF LONG-TERM CARE BENEFITS

Reimbursement Policy

A reimbursement policy pays for the actual services that the insured receives—reimbursement benefits payments by the insurance company to the insured for the actual expenses incurred by the insured, such as medical expenses. For example, if a nursing home charges a patient \$250 a day and the LTCI policy limit is \$200 a day, then the policy will only pay the \$200 per day. If the nursing home charges \$150 a day, then that is what the policy will pay – “*up-to*” is what these policy benefits are sometimes called.

Indemnity Plan

Technically, indemnity is compensation for a loss. The most popular types of Comprehensive LTCI policy uses a “pool” of money concept which determines the insured’s total benefit by determined by multiplying the daily benefit chosen by the benefit period. Simply put, if the policy has a \$200 daily benefit and has a 3-year benefit period (1095 days), the amount of the “pool” is \$219,000. Therefore, under an indemnity policy, if the insured had \$200 a day benefit for every day he was disabled and if he required at least one visit each day from a home care provider who only charged \$100 per day, after 3 years the benefits cease. Under a reimbursement plan, he would have been reimbursed the actual cost, therefore his pool of money would last more than 3 years. This would be important if the insured was still alive and disabled after 3 years (1095 days).

BENEFIT AMOUNTS

Coverage is written on the basis of a daily benefit amount, with a wide span between the minimum and maximum amounts available. The daily benefit amount generally applies to nursing home care and may or may not vary for care in other types of facilities. Nursing home benefits will be discussed first, and then the text will address various ways policies handle benefit payments for care under other circumstances.

An important point about the daily benefit is that this is usually the *maximum* amount the policy will pay for a day of care. Most policies stipulate that the insurer will pay 100% of actual costs incurred up to the daily benefit amount. Policies offer daily nursing home benefits ranging from as little as \$20 per day to as much as \$500 per day with most having a maximum of \$300. Some policies place a minimum on the total maximum benefits, such as \$900,000, and there may be a daily benefit maximum, such as \$10,000 or \$12,000 per month, and others may have no maximum published.

The amount of the daily benefit is one of the critical pricing factors—the higher the daily benefit, the higher the premium, everything being equal.

Daily policy benefits cover room and board and skilled or custodial care which are usually included in the package price from an institution. Anything payable by Medicare is not covered by the policy but Medicaid can pay in addition to insurance. All levels of licensed facilities are covered to include Alzheimer’s facilities, skilled care, intermediate care and custodial care facilities but it is entirely possible to be in a facility, especially an Assisted Living Facility, and not qualify for LTCI benefits.

BENEFIT PERIOD

Determining the exact figure for a specific nursing facility is sufficient only if the policy includes an option to have the daily benefit amount indexed for inflation as discussed later

The benefit period, or length of time for which an LTC Insurance policy pays benefits, is another significant factor in the cost of a policy—the longer the period, the greater the premium, assuming everything else is the same. As a general rule, the periods are 1, 2, 3, 4, 5 years, and Lifetime. Those policies using the “Pool” concept express their benefit periods as the total amount that can be accumulated in the “Pool.” However, they usually also offer an expensive “lifetime” policy, in which case there is no actual Benefit Period – the policy pays the costs of the long-term care up to the Daily Benefit chosen.

A lifetime benefit period might be referred to as “unlimited” or “unlimited lifetime” coverage. Care must be exercised when using “lifetime” terminology as with some policies this means that the dollar amount of coverage that can be used over the insured’s lifetime—a lifetime limit expressed in dollars. Other definitions may show that “lifetime benefit” to mean an unlimited dollar amount of benefits that will last for the lifetime of the insured.

HOME AND COMMUNITY CARE BENEFIT AMOUNTS

There are differences among policies as to limitation of the home and community care benefits. Most companies are moving away from daily limits as monthly or weekly limits provide the greatest flexibility for the insured in that they would not be limited to a specific amount per day but could use the entire weekly or monthly benefit as needed. As an example, if an insured had a daily home care benefit of \$50 per day and he was receiving therapy at home three days a week at \$150 per therapy session, he would, under the daily limitation only receive \$150 a week. With some policies, home care is limited to a percentage—usually 50% or 75%—of the daily benefit amount paid to facilities even though home care may actually cost more than facility care.

Home care benefits typically cover the services of licensed nurses, aides and therapists. Policies cover certain activities of non-licensed providers and some even pay a limited benefit to the insured’s own children as providers as well. The options of what is covered and under what circumstances vary from policy to policy. It is important for agents to review and compare policies.

Pay for caregivers are paid by LTCI policies in most cases as described later.

POOLED BENEFITS MANDATED

Nearly all comprehensive policies are written as “integrated policies” or policies with “pooled benefits” which provides a total dollar amount that may be used for different types of long-term care services, subject only to daily, weekly, or monthly dollar limits for covered long-term care expenses. These policies specify that benefits would be “pooled” and then used for whatever form long-term care was needed. To arrive at the “pool” amount, one simply multiplies the daily benefit by the benefit period (in days). With these policies, the insured can use any amount of the total for any of the covered services as long as there is money in the “pool.”

The industry is moving towards every long-term care policy or certificate providing an integrated pool of dollars (a single dollar amount that may be used interchangeably for any home, and community based services, or facility care covered by the policy or certificate). There is no limit on any specific covered benefit except for daily, weekly, or monthly limit set for home, and community based care and for the limits for facility care. Insurers may impose limitations for reimbursement of actual expenses and incurred expenses up to daily, weekly, and monthly limits.

With many policies, and in most states, overall lifetime maximum benefit amount can be used interchangeably between the various covered Home and Community Care, Nursing Facility and/or Residential Care Facility benefits as outlined in this policy. The policyholder could use all of the coverage for facility care, all for home care, all for RCF care or any combination of the three. Except when paying for institutional care, the policy will usually pay a certain amount per day as stipulated in the policy, and conversely, when paying for home and community care, the policy pays a certain amount per day, week or month.

There is no limit on the use of any specific covered benefit, except for daily, weekly or monthly benefit limits that may be set for Home and Community Care benefits and daily benefit limits that may be set for Nursing Facility and Residential Care Facility benefits.

ELIMINATION PERIODS

A long-term care policy's elimination period, sometimes called a *deductible* period, is a period of time during which no benefits are paid immediately after the insured is qualified to receive long-term care. Insurers typically offer elimination periods ranging from zero days (no elimination period) up to 365 days, with different insurers offering different options. Under policies that pay benefits for different kinds of care, a single elimination period usually qualifies the insured for all types of care. When the same elimination period applies to all types of care, this is sometimes called an "integrated" elimination period.

CARE-RELATED ELIMINATION PERIODS

Insureds may be able to choose different elimination periods for different types of care, such as 30 days for nursing home care and ten days for home health care. Some insurers specifies that a 90-day elimination period applies for nursing home care and a 30-day period for home and community-based care, other policies offer elimination periods in a range of zero to 365 days for nursing home care and seven, 20 or 60 days for home health care. Most of the newer policies generally offer the same care-related elimination periods.

OPTIONAL BENEFITS

Shared-Benefit Rider

A shared-benefit rider allows the duration of the benefit to be lengthened if both spouses have coverage, in effect combining their benefits so if one spouse's benefits are exhausted, they may "draw" from the benefits of the other spouse. This Rider may be part of some policies if both spouses have the coverage. The ability for the spouses to share a "pool" consisting of the combined benefits of the two policies is less expensive than two separate policies.

Bed Reservation Benefit

For many elderly persons, it is traumatic if they have to leave the Nursing Home temporarily and then return to another bed, even if it is the same nursing home. This benefit allows a person to return to his "own bed" after a specified period of time. If the insured is hospitalized during a Nursing Home or Assisted Facility stay, and there is a charge for the insured to reserve their bed for a later return, the policy will pay these charges, usually up to a maximum usually of 21 days of hospitalization during a policy year.

Restoration of Benefit

Benefits may be restored under most policies, but the insured must be off-claim before benefits are restored for periods ranging from 180 days to 6 months as a rule, with most policies using the 180 days and usually limited to restoration only twice.

It must be noted that the period before benefits are restored must be as indicated (180 days or 6 months usually) in the policy and the insured must have been treatment-free before the claim or the new claim is for a different cause completely.

Home Modification and Therapeutic Devices

Most modern policies pay for any home modification medically necessary, therapeutic device, and the purchase or rental of equipment which assists the insured so that they can stay at home. These provisions vary by policy and by company.

Caregiver Training

Another recent benefit available but not offered by all plans, is the Caregiving Training feature. Typically, the policy will pay for training of a person to become a Caregiver when the caregiver is going to take care of the insured in his home. Many policies allow for training for family members. The payment for training is typically “five times” the Maximum Daily Benefit.

Many policies include an Informal Caregiver Training Benefit which pays for training an informal caregiver, such as a friend or family member, to care for the covered person at home.

Limited Pay Options

A few policies allow for a paid-up feature, such as single premium plans or those paid up in some specified period of time (3, 5, 10, 20 years typically) or paid up at age 65.

Waiver of Premium

Typically, the insurance company will waive the premiums on the policy and any attached Riders, if the insured *is confined to a Nursing Home or Assisted Care facility* for a period of more than 90 days. This waiver applies to premiums falling due thereafter, on the policy and any Riders. This waiver will continue as long as consecutive days of nursing care benefits are being paid to the insured.

Non-Forfeiture Benefits

The most common non-forfeiture benefit is the “return-of-premium” benefit. Most companies offer this as a benefit, but still it can add from 20% to as high as 100% of the premium—sometimes doubles the cost of the policy.

With a “return of premium” benefit, the policyholder receives cash, usually a percent of the total premiums paid to date after lapse or death. Another approach is a “shortened benefit period,” where the long-term care coverage continues but the benefit period or duration amount is reduced as specified in the policy.

Relatively new is the “contingent nonforfeiture benefits upon lapse,” a feature that gives policyholders additional options in the face of a significant increase in policy premiums. If the insured does not purchase the optional nonforfeiture benefit, then a contingent nonforfeiture benefit is triggered if policy premiums rise by a specified percentage.

Shortened Benefit Period

Actually another form of a nonforfeiture provision, the shortened benefit period, provides a mechanism whereby all of the money put into a policy cannot be lost if the policyowner stops paying premiums at some future date. Since federal laws require that a nonforfeiture provision must be offered to every prospective policyowner, this may be more attractive than the return-of-premium.

REQUIRED BENEFITS

As indicated earlier, HIPAA requires certain other benefits.

30-Day Free Look

Federal and state laws require that the applicant has the right to inspect the policy and, if not satisfied for *any reason whatsoever*, to return the policy directly to the insurer within 30 days for a refund of all money paid. Agents are forbidden to harass or otherwise try to pressure their clients into keeping the policy in force.

Protection against Unintended Lapse

The possibility exists that an insured may become mentally impaired and forgets to make premium payments. This could result in the unintentional lapse of a long-term care insurance policy just at the time when its benefits are needed most. To prevent a mentally impaired insured from forgetting to make premium payments, a policy typically offers a policy provision to protect against unintentional lapse. Premiums paid by bank draft help to alleviate these problems. The policyowner also designates at least one person other than himself to receive notice if the policy is in danger of lapsing. If the policy still lapses, there is usually a provision that will reinstate the policy if the lapse was due to cognitive impairment or loss of functional capacity and within a specified time of lapse.

Renewability Provision

All individual long-term care insurance policies must contain a renewability provision which discloses the term of coverage for which the policy is initially issued, the terms and conditions under which the policy may be renewed, and whether or not the issuer has the right to change the premium.

GRANDFATHERED LTCI POLICIES

The Treasury Department has released guidelines (Notice 97-31) which provide temporary IRS interpretations of what changes can be made to "Grandfathered/Qualified" status. Per the IRS, if a Grandfathered policy is materially changed after December 31, 1996, it loses its Grandfathered/Qualified status.

A material change, per the guidelines, could include any change in the terms of the contract altering the amount of coverage or timing of any item payable by the policyholder, the insured, or the insurance company. (A material change could eventually be determined by the IRS to be any client-requested increase in benefits.)

EXCLUSIONS AND LIMITATIONS

Exclusions are typically the common ones—preexisting conditions, war, alcoholism, drug addiction, participating in a felony, etc.

PREEXISTING CONDITIONS

HIPAA changes the preexisting condition provision of LTCI to basically: "No long-term care insurance policy or certificate, other than a group policy or certificate, shall use a definition of preexisting condition which is more restrictive than a condition for which medical advice or treatment was recommended by, or received from a provider of health care services, within six months preceding the effective date of coverage of an insured person and every long-term care insurance policy or certificate shall cover preexisting conditions that are disclosed on the application no later than six months following the effective date of the coverage of an insured, regardless of the date the loss or confinement begins..."

NO TERMINATION DURING CLAIM

Typically, federal and state laws will state that termination of Long Term Care Insurance shall be without prejudice to any benefits payable for institutionalization if that institutionalization began while the long-term care insurance was in force and continues without interruption after termination. This extension of benefits beyond the period the long-term care insurance was in force may be limited to the duration of the benefit period, if any, or to payment of the maximum benefits and may be subject to any policy waiting period, and all other applicable provisions of the policy.

PRIOR HOSPITAL STAY REQUIREMENT

Federal and state laws generally require that policies may not precondition the availability of benefits on prior hospitalization, conditions eligibility for benefits provided in an institutional care setting on the receipt of a higher level of institutional care, preconditions the availability of benefits for community-based care, home health care, or home care on prior institutionalization or conditions eligibility for non-institutional benefits on a prior institutional stay of more than 30 days.

DISCRIMINATION BASED ON INDIVIDUAL'S HEALTH

Policies may not contain a provision that would cancel, non-renew or otherwise terminate the coverage based on the insured's age or the deterioration of the insured's mental or physical health.

USUAL AND CUSTOMARY STANDARD IS PROHIBITED

Policies may not contain a provision that bases payment of benefits on any standard described as "usual and customary," "reasonable and customary" or other similar words.

OTHER REQUIREMENTS

There are several other requirements by federal and/or state laws, including:

- *Allowing increase in premium due to divorce of policyholder*
- *No Preference for Skilled Care*
- *New Waiting Periods after Conversion or Replacement*
- *No New Preexisting Conditions on Replacement Policies*
- *Reduction of Benefits Due to Out-of-Pocket Expenditures*
- *Value of All Benefits Must Be Disclosed*
- *No Reduction of Inflation Benefit Increase Due To Payment of Claims*

INFLATION PROTECTION

Types of Inflation Protection

Automatic Inflation Protection

Automatic Inflation Protection increases the daily benefit annually on the policy's anniversary *automatically*. The amount of increase is usually based on a predetermined rate—typically 5 percent per annum.

With the automatic protection, the cost of the automatic increase riders is part of the policy's original premium, so, as in most insurance plans, the insureds are prepaying for future benefits. The annual premium that includes an automatic benefit increase rider is be more expensive at the inception, than the other methods wherein the protection is afforded through a Rider or Amendment, but it is considered as the least expensive overall.

Option to Purchase Inflation Protection

Inflation protection may be offered as an option in some plans, whereby the insured may buy additional daily benefit coverage at predetermined and periodic intervals without having to reapply and without evidence of insurability. Typically, the plans offer a 15% increase every 3 years. The premium for accepting the option is calculated at the attained age rate, and added to the premium, therefore when the option is elected, the premium increases. While this system

may be attractive in the early years because the entry premium is lower than with the automatic protection, in most cases it really is not the best way to obtain inflation protection.

QUALIFYING FOR BENEFITS

Perhaps the most drastic and contentious requirement for a Tax Qualified policy relates to qualifying for benefits. HIPAA requires several provisions before the policyholder can be certain that any benefits will not be taxed to the insured—tax qualified.

Chronically ILL Individual

An individual is chronically ill if they have been certified by a licensed health care practitioner within the previous 12 months as one of the following:

- 1) They are unable for at least 90 days, to perform at least two activities of daily living without substantial assistance from another individual due to loss of functional capacity. Activities of daily living are eating, toileting, transferring, bathing, dressing and continence, or
- (2) They require substantial supervision to be protected from threats to health and safety due to severe cognitive impairment.

Non-qualified policies use similar benefit triggers, but usually add a third trigger: “If deemed medically necessary.” These policies also leave out the restrictive language “for at least 90 days.” On the other hand this is offset by the fact that the insurance company often determines eligibility with non-qualified policies; whereas, a third party, impartial, licensed health care practitioner certifies eligibility under qualified policies. Cognitive impairment covers Alzheimer’s, stroke, dementia and other organic nervous disorders under both policy forms.

Tax-qualified policies include a definition, required by the IRS, which lessens the perceived advantage of the non-qualified contracts. TQ contracts define “substantial assistances” as “stand-by” assistance, meaning that this is not “hands-on” care and just verbal encouragement can be considered as substantial assistance. This definition could easily make it simpler to qualify for benefits with a qualified contract than with a non-qualified contract.

Agents should understand and be able to explain the definitions used in the contract under discussion. The difference in transferring or transferring, including ambulating activities, when used as definition for ADLs in a LTCI policy, may make a difference in qualifying for benefits and the kind of benefits received.

Definitions may change but for the present, IRS notice 97-31 provides definitions that are appropriate, including the following:

- “Impairment in activities of daily living” means that the insured needs “substantial assistance” either in the form of “hands-on assistance” or “standby assistance,” due to a loss of functional capacity to perform the activity.
- “Activities of daily living” in every policy or certificate intended to be a federally qualified long term care insurance contract must include eating, bathing, dressing, transferring, toileting, and continence. “ Impairment in activities of daily living” means the insured needs “substantial assistance” either in the form of “hands-on assistance” or “standby assistance,” due to a loss of functional capacity to perform the activity;

- “Substantial assistance” in the performance of ADLs means hands-on assistance and standby assistance. Substantial Assistance must last at least 90 days, or expected to last at least 90 days
- “Hands-on” assistance means the physical assistance of another person without which the individual would be unable to perform the activity of daily living (ADL).
- “Standby assistance” means the presence of another person within arm’s reach of the individual that is necessary to prevent, by physical intervention, injury to the individual while the individual is performing the ADL (such as being ready to catch the individual if the individual falls while getting into or out of the bathtub or shower) as part of bathing, or being ready to remove food from the individual’s throat if the individual chokes while eating.
- A person is “chronically ill” in respect to ‘triggering’ benefits if a licensed health care practitioner has certified that the person is unable to independently perform at least two of the six ADLs for at least 90 days due to a loss of functional capacity.

Tax Qualified Definitions of ADLs

The definitions of “activities of daily living” to be used in policies and certificates that are intended to be federally qualified long-term care insurance, shall consist of the following until such time that these definitions may be superseded by federal law or regulations:

- **Eating**, which means feeding oneself by getting food in the body from a receptacle (such as a plate, cup, or table) or by a feeding tube or intravenously.
- **Bathing**, which means washing oneself by sponge bath, or in either a tub or shower, including the act of getting into or out of a tub or shower?
- **Continence**, which means the ability to maintain control of bowel and bladder function; or when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for a catheter or colostomy bag).
- **Dressing**, which means putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs?
- **Toileting**, which means getting to and from the toilet, getting on or off the toilet, and performing associated personal hygiene.
- **Transferring** -companies may choose between either one of two different definitions.
 - (a) Ability to move into or out of bed, a chair or wheelchair, or
 - (b) the ability to move into and out of a bed, a chair, or wheelchair, or ability to walk or move around inside or outside the home, regardless of the use of a cane, crutches, or braces.

Tax Qualified Cognitive Impairment Trigger

A tax qualified LTCI policy is not required to recognize any ADL in order to determine whether an individual is chronically ill under the cognitive impairment requirement. It is quite possible for a person who is cognitively impaired—indeed, severely cognitively impaired—to perform activities of daily living without assistance, but still they would require considerable supervision.

“Impairment of cognitive ability” means that the insured needs “substantial supervision” due to “severe cognitive impairment.”

“Severe cognitive impairment” means a loss or deterioration in intellectual capacity that is comparable to (and includes) Alzheimer’s disease and similar forms of irreversible dementia; and measured by clinical evidence and standardized tests that reliably measure impairment in the individual’s short-term or long-term memory, orientation as to people, places, or time, and deductive or abstract reasoning.

Substantial Supervision

“Substantial supervision” means continual supervision (which may include cueing by verbal prompting, gestures or other demonstrations) by another person that is necessary to protect the severely cognitively impaired individual from threats to his or her health or safety (such as may result from wandering around).

Non-TQ Benefit Triggers

Individual states may have different requirements for NTQ policies, but generally the insured will qualify for benefits if he can demonstrate

- 1) Impairment in two out of seven activities of daily living; or**
- 2) Impairment of cognitive ability**

Typical Non-Tax Qualified ADL Definitions

“Impairment in activities of daily living” means that the insured needs “human assistance,” or “continual substantial supervision.”

“Activities of daily living” in almost all of the NTQ policies refers to the insured needed assistance in include eating, bathing, dressing, ambulating, transferring, toileting, and continence;

The definitions of the ADLs, as a general rule, are basically the same as those defined in the TQ policies, except that in the definition of “Eating”, below—eating under the TQ ADL definition—if the person could “eat” by using a feeding tube, or by using his fingers, they would not be considered as impaired, but under an NTQ plan, if they could not use a fork or spoon, they would be considered as impaired.

NTQ policies generally follow the following definitions:

- ✓ **Eating**, which shall mean reaching for, picking up, and grasping a utensil and cup; getting food on a utensil, and bringing food, utensil, and cup to mouth; manipulating food on plate; and cleaning face and hands as necessary following meals.
- ✓ **Bathing**, which shall mean cleaning the body using a tub, shower, or sponge bath, including getting a basin of water; managing faucets, getting in and out of tub or shower, and reaching head and body parts for soaping, rinsing, and drying.
- ✓ **Dressing**, which shall mean the putting on, taking off, fastening, and unfastening garments and undergarments and special devices such as back or leg braces, corsets, elastic stockings or garments, and artificial limbs or splints?
- ✓ **Toileting**, which shall mean getting on and off a toilet or commode and emptying a commode, managing clothing and wiping and cleaning the body after toileting, and using any emptying a bedpan and urinal.
- ✓ **Transferring**, which shall mean moving from one sitting or lying position another sitting or lying position; for example, from bed to or from a wheelchair or sofa, coming to a standing position, or repositioning to promote circulation and prevent skin breakdown.

- ✓ **Contenance**, which shall mean the ability to control bowel and bladder as well as use ostomy or catheter receptacles, and apply diapers and disposable barrier pads.
- ✓ **Ambulating**, which shall mean walking or moving around inside or outside?

“Ambulating” is the additional ADL for NTQ policies, however there are semblances of ambulation in the TQ definition of Transferring.

Non-Tax Qualified Cognitive Impairment

“**Impairment of cognitive ability**” means deterioration or loss of intellectual capacity due to organic mental disease, including Alzheimer’s disease or related illnesses that require “continual supervision” to protect the insured or others.

GROUP LONG TERM CARE INSURANCE

The National Underwriter conducted an informal poll in December 2004 stating the assumption that the largest growth in LTCI over the next few years will probably be as a group product sold at worksites and asked readers for comments. 74% of those who responded either agreed somewhat or strongly agreed that the heaviest future growth of LTCI is in the group area. Whether this stands the test of time will depend somewhat on what legislation in the tax area will be passed by Congress in the near future. In any event, this should not be a surprise as Americans generally look to their employers for health benefits, so this, in the eyes of most Americans, is just another health product.

There is little doubt that HIPAA gave new life to Group Long Term Care Insurance as for the first time, the rules in respect to the taxation of employers who provide Long Term Care Insurance for their employees have been published. Several insurers have entered the Group Long Term Care Insurance business as a result of the Act, which specifies:

- Employers who pay LTCI premiums on behalf of an employee will be entitled to deduct that premium as a business expense, as they do for medical insurance.
- LTC Insurance premiums paid by an employer on behalf of an employee will not be treated as income to that employee.
- Long Term Care Insurance is not permitted under Section 125 cafeteria plans; nor can long term care expenses be reimbursed by a Flexible Spending Account, however there have been several bills introduced in Congress that may change that in the near future.
- Long Term Care Insurance premium is, however, an acceptable expenditure for the new medical savings accounts that this law makes available to self-employed and small businesses of fewer than 50 lives.
- Long Term Care Insurance premiums are tax deductible to the self-employed within the overall self-employed deductible limits.

The number of employers offering group LTCI has begun to rise dramatically, with the most noticeable increase being in small businesses with less than 500 employees.

Many of the employer-sponsored LTCI plans in place are located in very large employee environments such as IBM, Ford Motor Company, Proctor & Gamble, and state government employee groups. In addition, most of these plans are not "off the shelf" policies. Instead, they have been designed specifically for a given group through consultation between the employer and the insurance company. Some insurance companies have begun to target small companies

as lucrative markets for their plans, though the numbers show that only a very small percentage of all U.S. employer groups have been affected to date.

THE MAIN FEATURES OF THE GROUP PLANS

With Group LTC Insurance, some of the conventional features of group plans remain intact while other features are more similar to individual insurance policies. First of all, the policies might actually *be* individual LTCI policies. If so, the policies are fully "portable" if the employee leaves the plan and need not be converted in the traditional way. Optionally, the employer-sponsored LTCI plan may be set up like other group coverages, requiring employees who want to continue the insurance to convert to individual policies within a certain period after termination. (This is called a conversion privilege and not all group insurance plans offer it.)

ELIGIBILITY FOR GROUP COVERAGE

A feature that sets group LTCI coverage apart from other types of LTCI insurance is in respect as to who may be covered. Most plans are offered not only to employees and their spouses, but also to the parents of both parties and, sometimes, to children and to retired workers. In most cases, employees are exempt from medical underwriting - they won't have to have a medical exam - but it is likely that other family members must have some type of medical screening. Some insurers require medical underwriting for all parties, including employees, while other group plans might not require medical information about any of the parties. In some cases, even if medical underwriting is required, it is less stringent than for individual policies, especially for older parents. The NAIC's shopper's guide encourages older people to investigate their children's Group LTCI coverage if available, indicating that, while medical screening is likely, group coverage might be more advantageous than individual policies.

The age at which individuals may purchase employer-sponsored LTCI coverage is often earlier than the age minimums for individual policies. Typical existing plans specify ages 30, 35 and 40 as the minimums and at least one plan designed by a large corporation is offered to 20-year-olds. While there are individual policies insuring at these earlier ages, they are fairly rare. Upper age limits vary considerably but generally are similar to individual policies, ages 79 to 85 being typical maximums for purchasing coverage.

GROUP BENEFITS & OTHER PROVISIONS vs. INDIVIDUAL PLANS

Employer-sponsored LTC Insurance may be virtually identical to individual policies marketed and most offer a range of daily benefit amounts, benefit periods and elimination periods. One should always be aware that in many of the existing plans, the employer has worked with the insurance company to decide on the range of features from which employees can choose.

While the employee makes the final choice, the options available may be pre-selected and, therefore, more limited than with an individual policy.

As for the availability of other benefits and provisions that are found in individual policies, group LTCI plans vary considerably but there is a trend toward including more benefits. Some existing employer-sponsored plans include or make available inflation protection, Nonforfeiture or return of premium features, death benefits, reinstatement, restoration of benefits, home care benefits, and others. Group plans usually pay for care at several levels, have no prior institutionalization requirements, and cover care for Alzheimer's and other organic brain disease. Exclusions and pre-existing conditions limits are similar to those in individual policies.

GROUP LTCI PREMIUMS

Another way group LTC Insurance differs from other group coverages is that the rates typically vary by the age of the individual. Although there might be some premium savings over individual policies, this is not always the case, unlike group medical insurance, for example, which may be less expensive than individual medical policies. Depending on the insurer offering the plan, the age of the buyer, and the actual provisions included, group savings might be as little as 2% up to as much as 30%. One major advantage of some employer-sponsored plans, however, is that the premium might be guaranteed for as long as the employee remains in the group, no matter how old he or she is - a real bonus for an employee who can lock in a low premium at perhaps 30 years of age. Not all group plans guarantee rates for life, but in most cases the premiums will increase only if they increase for everyone in the group.

ASSOCIATION GROUP LTC INSURANCE

Group LTC Insurance may also be offered by an association such as the American Medical Association, the American Association of Retired Persons (AARP), and others at both national and state levels. Association plans, which are available only to members of the particular group, vary as widely as other group plans and LTCI coverage in general. Some associations offer more than one type of LTC Insurance policy to members, as is the case with the AARP.

SELF-EMPLOYED SPECIAL INCENTIVES

Because of HIPAA, if an individual is self employed and *had a net profit for the years*, was a general partner (or a limited partnership [LTD] receiving guaranteed payments); or received wages from an S Corporation in which the individual was a *more than 2% stockholder* (and who is treated as a partner); the individual may be able to deduct as an adjustment to income, up to 100% of the amount paid for qualified Long-Term Care Insurance on behalf of the individual, spouse and dependents.

Additionally, if a person is a wage-earner from an S Corporation in which the person is more than a 2% shareholder, they can enter the premium amount on their 1040.

The LTCI plan must be established under the trade or business and the individual cannot take the deduction to the extent that the amount of the deduction is more than the earned income of the individual from that particular trade or business.

As with any wage-earner, the individual cannot take this deduction for any month in which they were eligible to participate in any subsidized health plan or LTCI plan maintained by the employer of the employer of the spouse. This helps to eliminate the possibility of “double-dipping.”

This rule is applied separately to plans that provide Long-Term Care Insurance and plans that do not provide Long-term Care Insurance (plans that provide other health insurance only).

TAXATION TO EMPLOYERS

In a situation where a “regular” C Corporate or 501(c) employer pays premium on insured employee, income exclusion (Code section 106) applies to the entire premium/coverage provided by the employer. Thus, even if the cost exceeds the age-based limit on deductibility for individuals and/or the level of coverage exceeds the periodic limit, the employee will not recognize income from the receipt of employer-provided qualified long term care coverage.

Generally, a corporate employer can deduct all premiums paid for accident and health coverage for its Employees as a general business expense. This deduction also applies to the cost of coverage paid for the spouse and dependents of the employee.

The deduction is available for LTCI paid by the corporation since long term care is now considered accident and health coverage. The corporation's deduction applies to the entire LTCI premium paid even the premium in excess of the age-based limits for the deduction of individuals (and self-employed persons). There is no requirement that the long term care coverage be provided by the employer on a non-discriminatory basis.


The premiums are deductible by the corporate employer whether the coverage is provided under a group policy or under individual policies.

Taxation of premiums to any employer now mirrors the premiums paid for employee benefits for other health insurance benefits. In order for an employer to take advantage of the tax treatments, the plan must be Tax Qualified.

The treatment of taxes for employers should be reviewed with the tax accountant or tax counsel of the business. For instance, Tax Qualified Long Term Care Insurance contracts, which provide benefits on a per diem basis, or other flat amount per fixed period, are treated somewhat differently than indemnity policies. The technicalities are beyond the scope of this text, but it again points out the importance of having professional tax assistance when making presentations to employees for Group Long Term Care Insurance.

TAXATION OF BENEFITS TO EMPLOYEES

With respect to the benefits received under employer provided tax qualified long term care coverage, payments received by the insured are tax free as well, under Code Section 105(b). The employee would have no income from the employer-provided coverage; and any benefits received under the policy would not be taxable.

 NOTE: Tax Laws change frequently, so the client's tax attorney should always review information of this type furnished to a client.

STUDY QUESTIONS

1. The main effect that HIPAA had on the Long Term Care Insurance (LTCI) industry was
 - A. by creating Tax Qualified and Non-Tax Qualified policies.
 - B. to create a government program whereby seniors suffering from Alzheimer's would have their nursing home bills paid by Medicaid.
 - C. to remove LTCI policies from being fully commissionable.
 - D. to take regulation of LTCI policies from the states.

2. HIPAA requires that an LTCI policy be
 - A. noncancellable.
 - B. guaranteed issue.
 - C. guaranteed renewable.
 - D. approved by Medicare.

3. Under HIPAA, one of two requirements to qualify for LTCI benefits, the chronically ill individual who has been certified by a licensed health care practitioner within the previous 12 months as
 - A. at least for 60 days, is unable to perform at least 3 activities of daily living.
 - B. having been confined to a hospital for at least 60 days previously.
 - C. totally insane.
 - D. at least for 90 days, is unable to perform at least two activities of daily living.
4. Long Term Care Insurance
 - A. may be treated as a business expense for self-employed individuals.
 - B. may be included in a flexible-benefit plan.
 - C. may not be included in a Section 125 Cafeteria plan.
 - D. benefits will always be taxed as ordinary income.
5. There are three basic types of LTCI policies, which include
 - A. Retirement Home coverage.
 - B. In-Hospital Indemnification.
 - C. Return-of Premium policies.
 - D. Comprehensive Long Term Care.
6. "Respite Care" is
 - A. short-term care designed to relieve a primary care giver in the home.
 - B. designed to provide palliative care and other discomforts of those in the last days of their life.
 - C. skilled nursing care performed on a short term basis.
 - D. covered entirely by Medicare.
7. A LTCI policy that pays for the actual services that the insured receives, such as medical expenses, is
 - A. an indemnity plan.
 - B. a group certificate.
 - C. a reimbursement policy.
 - D. a comprehensive medical plan.
8. Determining the exact figure for a specific nursing facility is sufficient only
 - A. if it meets the NAIC Model Bill test.
 - B. if the policy is a Non-Tax Qualified policy.
 - C. if the policy contains a daily benefit indexed for inflation.
 - D. if the policy benefits are approved by the insured's accountant &/or attorney.
9. Nearly all comprehensive policies are written as
 - A. integrated policies, or policies with "pooled" benefits.
 - B. Non-Tax Qualified policies.
 - C. indemnity policies.
 - D. zero-deductible policies.

10. HIPAA Tax Qualified LTCI policies require certain provisions, including
- A. daily benefits of at least \$250 per day.
 - B. contingent nonforfeiture benefits upon lapse.
 - C. a 30-day free look.
 - D. restoration of benefit provision.

ANSWERS TO STUDY QUESTIONS

1A 2C 3D 4C 5D 6A 7C 8C 9A 10C



REFERENCES

- The Health Insurance Portability and Accountability Act (HIPAA), Overview & Analysis*
Novinka Publishers, 2004
H.R. Chaikind, J. Hearne, B. Lyke, S. Redhead, J. Stone, C. Franco & G.M.Stevens
- The Health Insurance Portability and Accountability Act of 1996, (PL 104-101) (42 USC §1320d)*
Internal Revenue Service
- The Health Insurance Primer*
America's Health Insurance Plans
John Boni, Elizabeth Denning, Marilyn Finley, Terry Lowe & Bernard Peskowitz
- Disability Income Insurance*
Dearborn Financial Services
Allan B. Checkoway and Harry J, Lew
- Personal Finance Planning Guide*
John Wiley and Sons, Publishers
Ernst and Young
- Principles of Insurance Production*
Insurance Institute of America
Kensicki, Smith, Marshall, Waranch, Close
- The New Life Insurance Investment Advisor*
Irwin, McGraw Hill
Ben G. Baldwin
- How to Insure Against Your Income*
Merritt Editors
Silver Lake
- Balancing Security and Opportunity; The Challenge of Disability Income Policy*
Jerry Mashaw
Virginia Reno
- Disability Income, the Sale, the Product, the Market*
National Underwriter Co.
Jeff Sadler
- Disability Income and Health Insurance, 2d Ed.*
National Underwriter Co.
Price Gaines

Occupational Classifications, Health and Life Insurance
Colonial Life and Health Insurance Co.

Life Insurance Selling

Evaluating for a High Quality Disability Plan, by Brian Hayes
A Producers Guide to Individual Disability Income Insurance, 2002
Prospecting for Supplemental Disability Income Ins., by Dennis Mullin
Resources at Claims Time, by John O'Hara and Craig Seminara
Various compilations of articles re. Disability Income insurance, 2001 and 2002.

Medicare & You, 2005&Medicare & You, 2006

US Govt. Printing Office
Department of Health and Human Services, Centers for Medicare & Medicaid Services

"Life and Health Insurance"

Black and Skipper
13th Edition, Prentice Hall

J. K. Lasser's "Choosing the Right long-Term Care Insurance"

Benjamin Lipson
John Wiley and Sons

"Long Term Care Insurance Made Simple"

Les Abromovits
Health Information Press

Long Term Care: A Growing Market

AMC Publishing Company

"The Ernst & Young Tax Guide, 2004"

Wiley Publishing Co.

"Wall Street's View of Nursing Facilities"

The Center for Medicare and Medicaid Services (CMS)
Nursing Facilities
U.S. Govt. May 20, 2003

Do You Need Long-term-care Insurance

Consumer Reports, Nov. 2003

Indiana Long Term Care Program Statute

Indiana Administrative Code 760-2-1

Bush's Unheralded Health Care Agenda

Merrill Matthews

The Weekly Standard 12/27/04

Insurance Code Section 790-790-15 State of Florida

The Financial Strain of Aging – Long-Term Care

Lothar Vasholz, CLU, ChFC, LLIF
Life Insurance Selling, Aug. 1997

Senior Markets

Continuing Education Course 359
Clearwater Insurance School

Long Term Care Insurance Seminar

Benefit Services
Reistertown, MD

The Pie in the Sky, Targeting the Group LTC Client

Christine McCullugh
Life Insurance Selling, 7/3/2004

Dictionary of Insurance Terms

Harry W. Rubin, Ph.D., CLU, CPCU
Barron's Business Guides

Black's Law Dictionary

West Publishing Co.

Producers Guide to Long-Term Care, 2004

Life Insurance Selling, Dec. 2004

Sample Policies and Rates from several Long-Term Care Insurance Carriers,
Including Penn Treaty and GE Capital

The Consumers Guide to Long-Term Care Insurance

Stephan R. Rasoley
First Books Library

Understanding Long-Term Care Insurance

Jeff Sadler
HRD Press

Long-term Care Insurance, How to make decisions that are right for you

Dr. Penelope S. Tzougros, ChFC, CLU
Wealthy Choices

The Legal Environment of Risk Management and Insurance”

Mallor, Barnes, Bowers, Phillips, Langvardt
McGraw Hill

NAIC Shopper's Guide

National Association of Insurance Commissioners, 1998

Expanded Damages in Elder Abuse Cases

American Bar Association Journal, Jan 1998, P. 39

Report, Findings, and Recommendations of the Working Group on Long-Term Care.

U.S. Dept. of Labor, Advisory Council on Employee Welfare & Pension Benefits.

November 14, 2000

Who buys long-Term Care Insurance in 2000?

Life Plans, Prepared for HIAA, October 2000

Long-Term Care Premiums Vary Widely: Policies Too Complex

Weiss Ratings, June 4, 2001

Internal Revenue Publication 502 (Medical & Dental Expenses)

Internal Revenue Publication 969

<http://www.irs.gov/publications/p969/ar02.html>