IMPORTANT

This book is designed as a learning program. BISYS Education Services is not engaged in rendering legal or other professional advice, and the reader should consult legal counsel as appropriate.

We have tried to provide you with the most accurate and useful information possible. However, the content of this publication may be affected by changes in law or industry practice, and, as a result, information contained in this publication may become outdated. This material should in no way be used as an original source of authority on legal matters.

Any laws and regulations cited in this publication have been edited and summarized for the sake of clarity.

Any names used in this publication are fictional and have no relationship to any person living or dead.
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SUGGESTED STUDY GUIDE: GENERAL INSURANCE FOR SELF-STUDY OR CLASSROOM PREPARATION

INTRODUCTION

To assist you in adequately preparing for your producer licensing exam, the following study schedule has been specifically developed to provide you with a step-by-step approach that guides you through the entire program. Each section of your text contains a separate study schedule. The study program for this section of the text is based on a five day schedule. It is appropriate for both self-study and preparation for classroom instruction. It is important that you follow these steps as closely as possible to maximize your comprehension, retention and ability to apply the information to specific circumstances.

Due to the need to cover a significant amount of information in the time frame provided, it is important that you remain on schedule. If you fall behind, you will need to extend your study time, rather than planning to simply “make up” the time in the later units. As you proceed through the program, you should monitor your progress by checking off each item as you complete it.

STUDY COMPONENTS

This study guide pertains only to the General Insurance section of the course. However, it assumes that you have purchased a Total Package, containing all of the following components:

- Textbook*
- State-specific insurance law digest*
- Exam Workbook
- Explanation Of Answers—Exam Workbook
- Exam Review audiotape
- Exam Review (diskette or online—both versions not required)

*Required Component
If the package you ordered does not contain one of the components referred to in the Study Guide, go to the next step. If you would like to order one of these components, contact BISYS Education Services’ Customer Service Department at 1.800.428.4215.

**STUDY SCHEDULE: GENERAL INSURANCE**

**Day 1**

**Unit 1—Introduction To Insurance**

1. Review the Learning Objectives for this unit.
2. Read the entire unit.
3. Complete the Review Questions at the end of the unit; reread the appropriate material for any questions that you missed.
4. Listen to the Unit 1 segment on the Exam Review audiotape.
5. Complete the Unit 1 review exam on the Exam Review diskette/Online Review.

**Day 2**

**Unit 2—Insurance Regulations**

1. Review the Learning Objectives for this unit.
2. Read the entire unit.
3. Complete the Review Questions at the end of the unit; reread the appropriate material for any questions that you missed.
4. Listen to the Unit 2 segment on the Exam Review audiotape.
5. Complete the Unit 2 review exam on the Exam Review diskette/Online Review.

**Day 3**

**Unit 3—Insurance Law**

1. Review the Learning Objectives for this unit.
2. Read the entire unit.
3. Complete the Review Questions at the end of the unit; reread the appropriate material for any questions that you missed.
4. Listen to the Unit 3 segment on the Exam Review audiotape.
5. Complete the Unit 3 review exam on the Exam Review diskette/Online Review.
Day 4

Unit 4—Underwriting Basics
1. Review the Learning Objectives for this unit.
2. Read the entire unit.
3. Complete the Review Questions at the end of the unit; reread the appropriate material for any questions that you missed.
4. Listen to the Unit 4 segment on the Exam Review audiotape.
5. Complete the Unit 4 review exam on the Exam Review diskette/Online Review.

Unit 5—Group Insurance
1. Review the Learning Objectives for this unit.
2. Read the entire unit.
3. Complete the Review Questions at the end of the unit; reread the appropriate material for any questions that you missed.
4. Listen to the Unit 5 segment on the Exam Review audiotape.
5. Complete the Unit 5 review exam on the Exam Review diskette/Online Review.

Day 5

State-Specific Insurance Law Digest Unit 1
1. Read the entire unit.
2. Complete the Unit 1 Review Questions in the last unit of the digest; reread the appropriate material for any questions that you missed.
3. Complete the state-specific review exam on the Exam Review diskette/Online Review.

Exam Review Diskette/Online Review
1. Begin taking the practice final exams for Section One in sequential order as was done with the unit review exams.
2. Continue this exam sequence until you have scored 70% or higher on each individual exam. As you score 70% or higher on an exam, skip that exam in subsequent rounds.
UNIT 1

INTRODUCTION TO INSURANCE

LEARNING OBJECTIVES

After completing Unit 1—Introduction to Insurance, you will be able to:

1. Define the following key terms: insurance, insurer, premium, insured, policy, claim, loss, risk, hazard, peril, indemnity, law of large numbers.
2. List and describe two types of risk.
3. List and describe four methods for managing risk.
4. Describe five characteristics of insurable risk.
5. Describe the following types of insurers: stock insurers, mutual insurers, nonprofit insurers, reciprocal insurers, fraternal insurers, Lloyd's associations, assessment insurers, reinsurers, excess and surplus lines insurers.
6. Describe the role of the federal government in providing insurance.
7. List the two main insurance distribution systems, and describe each.
8. List the five main types of insurance producers, and describe each.
WHAT IS INSURANCE

The future is notoriously unpredictable. Every day, each of us faces the possibility that something might happen that would result in a personal financial loss. Sickness, disability, premature death, damage or loss of property are all examples of things that might cause a financial loss. We know that these things will happen to some people and not to others, but we do not know which things will happen to any particular person. In the face of this uncertainty, the idea and business of insurance developed as a means for spreading the result of a financial loss among many persons so the cost to any one person is small.

Farmers in ancient China knew that some of the boats carrying crops to market would run into trouble and sink, but had no way of knowing which boats. Instead of taking the chance that any one family in the community would lose their entire crop in an accident, the farmers began spreading their crop among several boats. That way, if one boat went down, only a small part of each crop would be lost. This spread the cost of the loss among several families, but each family’s loss was manageable.

Insurance contracts originated in the 13th century with shipowners who wanted to make the possibility of loss manageable. Everyone knew that some ships would be lost at sea, but nobody knew which ones. A group of wealthy individuals agreed to take a definite amount of money from each shipowner in exchange for a promise that when a ship was lost, the wealthy individual would pay the costs of the loss. So, instead of a small possibility of losing everything, each shipowner paid a definite fee in exchange for the security that a catastrophic loss wouldn’t mean the end of any future prospects for success.

As these examples illustrate, insurance is a social device for spreading the chance of financial loss among a large number of people. By purchasing insurance, a person shares the chance for loss with a group of others, reducing the individual potential for disastrous financial consequences.

The basic mechanism behind insurance is relatively simple. The insurance company or insurer receives relatively small amounts of money, referred to as premium, from each of the large number of people buying insurance. A large uncertain loss is exchanged for a specific small amount of premium.
The agreement between the insurer and the **insured**, the person who is covered by the insurance, is established in a legal document referred to as a contract of insurance or a **policy**. The insurer promises to pay the insured according to the terms of the policy if a loss occurs. **Loss** is defined as reduction in the value of an asset. To be paid for a loss, the insured must notify the insurer by making a **claim**. The claim is a “demand” for payment of the insurance benefit to the person named in the policy.

Insurance plays an important role in maintaining society. Due to the sharing, or pooling, of a large number of similar risks, insurance coverage is available to most individuals for a reasonably affordable premium. When losses occur, insurance helps individuals to maintain their standard of living, which helps the whole economy. In the absence of insurance, a major disaster (such as fire or earthquake) could cripple the entire economy of local communities. If medical bills wiped out family savings and people did not have the funds to rebuild damaged homes, the uninsured losses could lead to a decline in all areas of consumer spending. Insurance is the device that allows individuals and society in general to recover from unexpected losses.

**RISK**

To really understand insurance and how it works, you must first understand risk. **Risk** is the possibility that a loss might occur and is one of the reasons that people purchase insurance. Notice that risk is not the loss itself, but the uncertainty of loss. There are some losses that are certain to happen eventually, such as when a rug finally wears out after years of use, or a car runs out of gas if you stop refueling. Such losses are not risks because they represent a certainty, instead of uncertainty, of loss.

There are two types of risks, only one of which can be covered by insurance.

**Speculative risk** is a risk that offers the opportunity for gain as well as the possibility of loss. Gambling is a common type of speculative risk. Insurance is not designed to protect against speculative risks. It is this type of risk that insurance and its underwriting practices are designed to avoid. Examples are found in new business ventures, stock market investments, and race track bets. There is a chance that the new business will not succeed, that the stock will not go up, or that the horse will not win, place or show. However, there is a chance that in each of these instances the speculator will make a profit.

**Pure risk** is the possibility of loss only and is the type of risk that insurers accept; for example, the possibility of financial loss due to an accident, sickness, or premature death. The purpose of insurance is to make the person whole again, to restore the insured to his or her original financial position. Insurance is not designed to provide a person with the opportunity of making a gain or profit.

**Perils And Hazards**

A **peril** is the cause of a potential loss. Accident, fire, explosion and flood are common perils which may be covered by insurance.
A hazard is a condition which increases the seriousness of a potential loss or increases the likelihood that a loss will occur. Slippery floors, unsanitary conditions, and improperly stored gasoline are hazards that might increase the severity or frequency of losses caused by perils. Actually, there are four types of hazards which may contribute to losses:

- **Physical hazards** arise from material, structural, or operational features of a risk situation. Slippery floors or unsanitary conditions would be physical hazards.
- **Moral hazards** arise from people's habits and values. A moral hazard means that a person might create a loss situation on purpose just to collect from the insurance company. Filing a false claim is an example of moral hazard.
- **Morale hazards** arise out of human carelessness or irresponsibility. This means that an individual, through recklessness or thoughtless action, can increase the possibility for a loss. Failing to wear a seatbelt while driving is an example of morale hazard.
- **Legal hazards** arise from court actions which increase the likelihood or size of a loss. Legal hazards are illustrated by the growing tendency of people to file lawsuits and of courts to award enormous sums for alleged damages, or to require insurance payments which were not intended.

Once the risks and hazards are identified, they must be evaluated and analyzed, and then steps to reduce the loss exposures must be examined and implemented. Finally, the results must be analyzed and techniques modified if appropriate.

### Managing Risk

We spend our entire lives coping with risk: crossing a street, going swimming, traveling by plane. These risks sometimes result in small losses, such as a stubbed toe or lost pocket comb, that we accept as a normal part of life. But risks may also result in serious financial losses, such as when a person is injured in a car accident, or contracts a fatal disease.

There are four ways of managing risk. A risk may be avoided, reduced, transferred or retained. The first method is to avoid risk. For example, a person might avoid the risk of being in an automobile accident by never getting into a car.

However, not all risk is avoidable. Risk may be reduced, or controlled, by examining the perils and seeing which ones can be eliminated. For example, a person reduces the risk of health problems by living a healthier lifestyle.

A risk is retained when a person decides to assume financial responsibility for certain events. The deductible amount on a health insurance policy is one way the insured retains some portion of the risk. In addition the premium may be reduced because he or she retains some of the risk.

The final method of managing risk is to transfer the risk to another party. This may be done through any of a number of legal mechanisms, such as hold harmless agreements or lawsuits. However, for many risks, the best way for individuals to transfer them is through insurance.
**Law Of Large Numbers**

When an individual purchases insurance, the risk is transferred from the individual to the insurer. To make a successful business of accepting the transfer of individual risk, the insurer needs to have some idea of how many losses will actually occur.

Insurance companies cannot predict the losses expected for any given individual. However, using the **law of large numbers**, insurers are able to predict how many losses will occur in a group. The basic principle of this law is that the larger the group, the more predictable the future losses in the group will be for a given time period. The insurance company cannot reliably predict which people will die, but with a large enough population, statistics can accurately predict how many people in the group will suffer a loss. For example, experience might show that out of a group of 100,000 people aged 40, about 325 will die each year.

For the law of large numbers to operate, it is essential that a large number of similar risks, or exposure units be combined. **Exposure unit** means the item of property or the person insured. The exposure unit in life and health insurance is the economic value of the individual person's life. In property and casualty insurance it is the number of cars, homes, etc.

The degree of error in predicting future losses decreases as the number of individual exposure units in a group increases. Thus, the larger the group, the more closely the predicted experience will approach the actual loss experience. Insurance companies deal only with averages, in the sense of establishing actuarial predictions of loss experience. By providing for the average risk, the extremes in loss experience cancel each other out.

**Actuaries** are mathematicians who study and compile statistical data regarding exposure units and risks. This data is the basis for mortality and morbidity tables used to predict probable losses due to death (mortality) or sickness (morbidity) of large groups of people.

Insurance companies collect premiums to cover expenses, profits, and the cost of expected losses. The expected losses are based upon the past experience of the average risk. The fact that some people never experience an automobile accident or that some live well beyond their life expectancy is immaterial, for other people are involved in accidents or die prematurely. Those insureds who suffer loss are compensated, while many other insureds do not experience sizable losses.

**Insurable Interest**

In the early history of insurance people profited by obtaining insurance on complete strangers. If the stranger died, the policyholder obtained the benefit of the policy with no appreciable emotional or financial loss. At best this was a form of gambling and at worst it was an incentive to murder. For obvious reasons, this practice is now illegal in all states and provinces.

To avoid similar situations in the future, a basic rule governing insurance states that before an individual can benefit from insurance, that individual must have must have a legitimate “interest” in the preservation of the life or property insured. This requirement is called **insurable interest**.
A person is presumed to have an insurable interest in his or her own life. An individual is also considered to have an insurable interest in the life of a close blood relative or a spouse. In these cases insurable interest is based on the love that individual would have for the family member and a real interest in protecting the life of that family member.

Insurable interest can also be based on a financial loss that will take place if an insured individual dies. Examples are two partners in a business, each of whom brings substantial expertise to that business. If one partner dies, the business could fail, resulting in a loss to the other partner.

For life insurance, insurable interest must exist at the time of the application for insurance, but it need not exist at the time of the insured's death. This prevents the insurer from needing to obtain proof of such emotional issues as existing love and affection in the emotional time following a death. In contrast, property and casualty insurance generally does require an insurable interest to exist at the time of loss. Loss of property is not generally as emotional as the loss of a life, and the existence of an insurable interest in property is more easily determined.

Insurable interest affects who may purchase a policy, but not who may benefit from a policy. For example, an individual could purchase life insurance on his or her own life, and name a charitable organization as the beneficiary. Because every person is presumed to have an insurable interest in his or her own life, the policy would be valid. As another example, a doctor who benefits from medical expense reimbursement payments may not have an insurable interest in the health of the insured, but the policyowner, usually the insured or the insured's employer, does have a personal or financial interest in keeping the insured healthy.

**Insurable Risks**

Not all risks are equally insurable. Insurable risks have certain characteristics that make the rate of loss fairly predictable, allowing insurers to adequately prepare for the losses that do occur. The more closely a risk aligns with the following characteristics, the more insurable it is.

**Large Numbers Of Homogeneous Units**

The expected loss experience of a group of exposure units cannot be predicted with any certainty unless there are a large number of exposure units in that group. Risks are not considered insurable unless the insurance company has a large enough number of similar (homogeneous) risks and knows enough about their previous loss experience to be able to reliably predict possible future losses.

**Loss Must Be Ascertainable**

Since the purpose of insurance is to reduce or eliminate the uncertainty of economic loss, the insurer must be able to place a monetary value on the loss. In life insurance, monetary value is placed on the insured's human life value or ability to earn an income. In health insurance economic loss is measured by lost wages, or by actual medical expenses incurred. The potential loss must be measurable so that both parties can agree on the precise amount payable in the event the loss occurs. If the insured cannot determine the amount of his or her loss, the law affords no remedy.
Loss Must Be Uncertain

Since the purpose of insurance is to reduce or eliminate uncertainty, it is obviously not in the public interest to permit the writing of insurance for intentional acts, such as a man jumping off a skyscraper two days after purchasing an insurance policy. Uncertainty arises out of not knowing what is going to happen or being unable to predict what is going to happen to the individual exposure unit. If insurance is provided for certain losses, the element of chance is not a factor. Nor is there any element of uncertainty in losses occasioned by natural wear and tear or deterioration, depreciation, or defects in property covered under insurance. Losses are expected in these situations, therefore such losses would not be uncertain.

With life insurance, the uncertainty rests not with whether a certain individual will die, but rather with when that individual will die, and what financial obligations will be left behind when death occurs. With health insurance, the uncertainty rests less with whether a certain individual will have an accident or become ill sometime during his or her lifetime, but rather with how much expense will be incurred when an illness or accident occurs.

Economic Hardship

The nature of the loss must be such that an economic hardship would occur should the loss occur. There would be little point in obtaining insurance to cover occurrences so minor that a loss would not produce economic hardship. For example, if a person loses two days pay because of an injury, a loss occurs, but it is not significant enough to be covered by insurance.

The nature of the loss must be of such magnitude that it is worthwhile to incur the premium cost to cover potential loss. It must be economically feasible to insure. Thus, a comparison of the potential loss with the cost of premium is a major consideration to the insurance buyer.

Exclusion Of Catastrophic Perils

While the ability to predict future losses with a reasonable degree of accuracy is critical to the insuring function, certain types of perils do not lend themselves to prediction. Such perils, when they cause losses, do not establish a pattern of predictability that can be relied upon for future predictions of anticipated loss. Accordingly, these perils are usually excluded from coverage. Examples of excluded catastrophic perils are war, nuclear risk, and floods.

Coverage Concepts

Indemnity

The concept of indemnity states that insurance should restore the insured, in whole or in part, to the condition he or she enjoyed prior to the loss. Restoration may take the form of payment for the loss, or repair or replacement of the damaged or destroyed property.

In life and health insurance, the concept of indemnity has a slightly different meaning in that a person’s economic value or human life value is the individual’s present and future earning power. For example, a family is indemnified
for the financial loss of the breadwinner by being provided with life insurance proceeds with which to replace present and future income and thus enable the family to maintain its lifestyle. An individual is indemnified for the financial loss of a broken arm by being provided with health insurance proceeds to pay the medical bills and perhaps to cover wages lost due to the injury.

**Limit Of Liability**

While the term limit of liability is not used in the life and health insurance field as commonly as it is in the property and casualty field, it means the maximum amount the insurer will pay for a specified insured contingency.

Life insurance policies usually use the term face amount to refer to the maximum liability of the insurer for a death claim. However, the face amount may not always be the maximum amount payable. In the case of a double indemnity provision, the limit of liability for an accidental death may be expressed as “twice the face amount” shown on the face of the policy.

Health and disability policies are more likely to specify a maximum benefit amount or period instead of a limit of liability. Basic medical insurance often has a maximum benefit amount (such as $10,000), and major medical insurance usually has a lifetime maximum benefit (such as $1 million). Disability income policies often limit benefits to a specified maximum benefit period (expressed in weeks or months). Within the maximum benefit limits found in health and disability policies there may be various sublimits—such as daily dollar limits on covered room and board charges, scheduled maximum amounts for various surgical procedures, and weekly dollar limits for disability income benefits.

**Deductibles**

Deductibles are a common feature of medical insurance coverages (the term has no application in life insurance). A deductible is simply the initial amount of a covered loss (or losses) that the insured must absorb before the insurer begins to pay for additional loss amounts. For example, if a basic medical expense policy only pays losses above a $250 deductible and an insured incurs $1,000 of covered medical expenses, the insured would have to pay the first $250 and the insurer would then pay the additional $750 of expenses.

Although the term is not used in disability income policies, disability insurance usually has a “time deductible.” It is called the “elimination period” or a “waiting period,” but the concept is similar to a deductible. The elimination period is simply a number of days that an insured must be disabled before disability income benefits become payable. For example, if a policy specifies an elimination period of seven days and an insured is disabled for 30 days, the policy would only pay benefits for the 23 days following the elimination period.

The purpose of a deductible is to minimize small nuisance claims and to keep premiums down. It might cost an insurer much more just to process the paperwork on $10 and $25 claims than the amount of the claims. Naturally, these costs would have to be reflected in insurance rates if such small claims were covered. Deductibles help eliminate this problem and keep rates down. Insurers usually offer a standard deductible, but give applicants the option of purchasing higher deductibles which result in even lower premiums.
**NOTES**

**Coinsurance**

Coinsurance is another concept commonly found in medical insurance policies. It means that within a specified coverage range, the insured and insurer will share the allowable expenses. It is usually expressed in percentages (such as 20%/80%). For example, if a policy has a $500 deductible and a 20%/80% coinsurance provision for the next $10,000 of expenses, a $5,500 medical bill would be settled in the following manner: the insured would pay the first $500 (the deductible amount) and $1,000 of the additional expenses (the insured’s 20% share); the insurer would pay the remaining $4,000 (the insurer’s 80% share).

A coinsurance provision is also designed to keep insurance premiums down, but it does so primarily by discouraging unnecessary or excessive treatments. An insured who is faced with paying 20% of the bill is more likely to question the doctor about whether proposed treatments are necessary, and whether there might be less costly alternatives.

**Exercise**

A. Which of the following is a risk?
   ( ) 1. A car may need to have new brakes installed after several years of regular driving.
   ( ) 2. An individual may need medical attention after slipping on the ice and falling.

B. The term used to describe the individual who is covered by the insurance is
   ( ) 1. insurer.
   ( ) 2. insured.
   ( ) 3. policyowner.
   ( ) 4. risk.

C. The application of the law of large numbers enables actuaries to:
   ( ) 1. estimate the future losses of a class or group of people.
   ( ) 2. predict the future losses of specific individuals.

D. The estimation of future losses is more accurate when information is from:
   ( ) 1. a small select group.
   ( ) 2. a large group.

E. Name the conditions of insurable risk that must exist for the concept of insurance to apply:

___________________________________________________________________
___________________________________________________________________
___________________________________________________________________
___________________________________________________________________
___________________________________________________________________

Answer:  A. 2. An individual may need medical attention after slipping on the ice and falling; B. 2. insured; C. 1. estimate the future losses of a class or group of people; D. 2. a large group; E. large numbers of homogeneous units; ascertainable loss; uncertain loss; economic hardship; exclusion of catastrophic perils
TYPES OF INSURANCE

Insurers market a variety of insurance products. The most common products offered are property, casualty, life, and health insurance, and annuities.

**Property insurance** protects the insured against the financial consequences of the direct or consequential loss or damage to property of every kind. It includes a wide variety of insurance contracts for personal and business situations. Property insurance policies cover the risk of damage or loss to property. Property includes building, equipment, stock or contents. Property insurance also includes many related and contingent property losses, such as business interruption.

**Casualty insurance** protects the insured against the financial consequences of legal liability, including that for death, injury or disability of damage to real or personal property. It includes insurance policies covering losses resulting from a number of occurrences. Casualty insurance contracts include automobile policies, general liability policies, workers compensation coverage, crime insurance and suretyship coverages, boiler and machinery coverages, and many others.

Almost every insured has a need for both property and casualty insurance coverage, whether personal or business (commercial). Some of the property and casualty coverages are sold together in special policies called “packages.”

**Life insurance** is insurance coverage on human lives including benefits of endowment and annuities, and may include benefits in the event of death or dismemberment by accident and benefits for disability insurance. It is designed to protect against the risk of premature death—dying too soon. Premature death exposes a family or a business to certain financial risks such as burial expenses, paying off debts, loss of family income and business profits.

An **annuity** is a guaranteed income for the life of an annuitant. Annuities are designed to protect against the risk of living too long; that is, outliving one’s financial resources and income during retirement.

**Accident and Health or sickness** protects the insured against financial loss caused by sickness, bodily injury or accidental death and may include benefits for disability income. It may reimburse the insured for actual medical expenses incurred due to an accident or illness (hospitalization insurance) or it may provide protection for loss of income experienced by the insured during periods of disability due to accident or sickness (disability income insurance). Health insurance can be written on either an individual or group basis and may include medical expense, hospital indemnity, major medical, hospital, surgical, disability, cancer, accident, dental expenses, eyeglasses, prescription medication and other health-related expenses.

**Variable life and variable annuity products** include insurance coverage provided under variable life insurance contracts and variable annuities. Variable products carry investment risk, that is, the insured may lose money due to a decrease in the price of the securities underlying the policy. For this reason, individuals selling such products are required to carry a Securities license as well as an insurance license.
Credit is a limited line of insurance, protecting the insured, who is usually a creditor, against the financial consequences should a debtor be unable to pay his or her debts due to illness or death.

Other types of insurance, such as title insurance or crop insurance, may be authorized in individual states. These limited lines of insurance are more narrowly focused than the types of insurance listed above, generally falling within the broad scope of one of the types of insurance listed above.

**TYPES OF INSURERS**

Insurance is provided to the public by three major sources: private commercial insurers (profit-making), private noncommercial insurers (nonprofit service organizations), the United States Government (special nonprofit). Other types of private insurers include reciprocals, fraternals, Lloyd’s, reinsurers and self-insurers.

Private life and health insurers are in the business to make a reasonable profit, and are, therefore, called commercial insurers. Stock and mutual insurers are private insurers. Private noncommercial service organizations, like Blue Cross and Blue Shield, operate on a nonprofit basis. A nonprofit status exists when profits are returned to subscribers in the form of reduced premium or expanded benefits (similar to mutual insurers).

**Commercial Insurers**

**Stock Insurers**

A stock insurance company, like other stock companies, consists of stockholders who own shares in the company. The individual stockholders provide capital for the insurer. In return, they share in any profits and any losses. Management control rests with the board of directors, selected by the stockholders. The board of directors elects the officers who conduct the daily operations of the business. Capital stock companies control two-thirds of the premiums in the property and liability field and nearly one-half of the premiums in life insurance. If the board of directors declares a dividend, it will be paid to the stockholders. Often a stock company is referred to as a non-participating company because policyholders do not participate in dividends.

**Mutual Insurers**

In a mutual company, there are no stockholders. Formation funds must be contributed by someone or some group. Because of the difficulties involved today in obtaining the funds to organize a mutual company, many mutual companies start as stock companies and then mutualize.

In a mutual company, ownership rests with the policyholders. They vote for a board of directors which in turn elects or appoints the officers to operate the company. Funds not paid out after paying claims and not used in paying for other costs of operation are returned to the policyowners in the form of policy dividends. As such, mutual companies are sometimes referred to as participating companies because the policyowners participate in dividends.
Although in theory, policyowners should share in losses as well as profits, these losses are actually only felt in the discontinuation of dividends. Mutual companies write nearly one-third of the property and liability business in the country and one-half of the life insurance business.

**Nonprofit (Service) Organizations**

Service insurers are unique to the health insurance field, and technically they are not insurers. They are organizations providing prepaid plans for hospital, medical, and surgical expenses. They do not provide cash benefits (except under certain limited conditions) to the plan subscriber, but instead pay the provider of medical services used by the plan subscriber to the extent covered in the contract. Best known of the service insurers are the various Blue Cross and Blue Shield plans. Blue Cross plans cover hospital expenses and Blue Shield plans cover medical and surgical expenses.

The “Blues” are a cooperative group of separate insuring organizations loosely coordinated by a national association, the Blue Cross and Blue Shield Association, that sets standards and seeks to enforce those standards by authorization or denial of use of the Blue Cross or Blue Shield designation. Originally, Blue Cross and Blue Shield had separate associations. As a result of the merger of the national associations on July 1, 1982, some local Blue Cross and Blue Shield associations have merged into one association for Blue Cross and Blue Shield. Blue Cross and Blue Shield associations are, with very few exceptions, incorporated under special legislation in most states.

**Other Types Of Private Insurers**

**Reciprocal Insurers**

Reciprocal insurers are unincorporated groups of people providing insurance for one another through individual indemnity agreements. Each individual who is a member of the reciprocal is known as a “subscriber.” Each subscriber is allocated a separate account where his or her premiums are paid and interest earned is tracked. If any subscriber should suffer a loss provided for by the reciprocal insurance then each subscriber account would be assessed an equal amount to pay the claim. Administration, underwriting, sales promotion, and claims handling for the reciprocal insurance is handled by an attorney-in-fact. The attorney-in-fact is often controlled and overseen by an advisory committee of subscribers.

**Fraternal Insurers**

Fraternal benefit societies are primarily life insurance carriers that exist as social organizations and usually engage in charitable and benevolent activities. Fraternals are distinguished by the fact that their membership is usually drawn from those who are also members of a lodge or fraternal organization. They operate under a special section of the state insurance code and receive some income tax advantages. One distinctive characteristic of fraternal life insurance is the open contract, which allows fraternals to assess their certificateholders in times of financial difficulty.
**Lloyd’s**

Lloyd’s of London is not an insurance company, but may be compared to a stock exchange. Just as an exchange provides facilities for its members but does not buy or sell securities itself, Lloyd’s provides a meeting place and clerical services to its members who actually transact the business of insurance. Members may be individuals or corporations.

Members are grouped into syndicates but they remain individually liable and responsible for the contracts of insurance they enter into. Their individual fortunes and resources are pledged as the capital behind their assumption of risk. A syndicate is represented in a Lloyd’s Organization by an underwriter. Lloyd’s of London assures full and adequate performance by its members through a governing committee and rules of eligibility. Such things as character, experience, business integrity, and amount of capital (funds held in trust at Lloyds and personal wealth) are factors considered for any new member.

**Assessment Insurers**

An assessment company retains the right to charge policyholders additional premiums if those paid in are insufficient to meet claims. Some go one step further and charge nothing until a loss occurs and then charge each member his or her pro rata share. Such a policy is referred to as an open-end contract.

**Reinsurers**

Reinsurance is a form of insurance between insurers. It occurs when an insurer (the reinsurer) agrees to accept all or a portion of a risk covered by another insurer (the ceding company). In many cases, the original insured has no knowledge of the transaction. In the event of loss, the insured has no claim against the reinsurer. The ceding company is responsible for the coverage it has written, but it will have a legitimate claim against the reinsurer for any portion of its own loss that is reinsured.

Companies often use reinsurance to reduce the risk of a catastrophic loss. Insurance against loss by earthquakes, floods, and aviation accidents might not be available if a single carrier had to assume all of the risk. Large life insurance cases are also often reinsured. For example, a $1 million life insurance policy on an insured may be shared through reinsurance with one or more insurers. Reinsurance makes it possible for a carrier to issue a policy and then share the risk with another insurer or a group of insurers. Another reason for reinsurance is that it helps carriers avoid capacity problems. Insurers must keep unearned premium reserves and certain levels of surplus in relation to premiums written. A shortage of capacity occurs when the ratio of premiums to surplus and reserves gets out of balance. By reinsuring a risk, many insurers are able to avoid or minimize capacity shortages.

Specific, or facultative, reinsurance is negotiated on an individual risk basis. The reinsurer retains the “faculty” to accept or reject each risk offered by a ceding company, so there must be an offer and acceptance on each reinsurance contract. Some carriers form agreements under which they engage in treaty reinsurance, which involves an automatic sharing of risks assumed by the ceding company. Whether reinsurance is facultative or on a treaty basis, it
may be written on an **excess of loss** basis, which means the reinsurer will pay only the portion of loss which exceeds a threshold retained by the ceding company, or on a **quota share** basis, which means that the insurers will share loss on a pro rata or fixed percentage basis.

**Excess And Surplus Lines**

Occasionally, it may be difficult to place a risk in the normal marketplace. If the risk is very large or unusual in nature, typical carriers may be unwilling to assume it. For some special risks, the only market may be with specialty carriers. Excess and surplus lines is the name given to insurance for which there is no market through the original producer, or which is not available through authorized carriers in the state where the risk arises or is located. Such business must be placed through a licensed excess or surplus lines broker, who will attempt to place it with an unauthorized carrier.

**Self-Insurers**

Self-insurance is a means of retaining risk. For a risk to be truly self-insured, two important characteristics will be present:

1. a large number of homogeneous exposure units, so that the law of large numbers can be used to predict expected losses, and
2. sufficient liquid assets to pay claims and other costs of retaining risk.

The advantages of self-insurance are that money can be saved if losses are less than those predicted, expenses may be reduced by the elimination of such things as administrative costs and commissions, and the self-insurer has use of the money that would normally be held by the insurance company. The main disadvantages of self-insurance are that actual losses may be more than predicted, and expenses could be higher than expected if additional personnel have to be hired to administer the program.

**The United States Government As Insurer**

The federal government provides life and health insurance through various sources. The federal government has offered a variety of military life insurance plans including United States Government Life Insurance (to veterans of World War I), National Service Life Insurance (in 1940) and Servicemen’s Group Life Insurance. Additional occupations are eligible for federal government insurance provided through the Railroad Retirement Act, the Civil Service Retirement Act, and the Federal Employees’ Compensation Act.

Because private insurance policies exclude catastrophic risks, the federal government has stepped in to provide War Risk Insurance, Nuclear Energy Liability Insurance, National Flood Insurance, Federal Crime Insurance, Federal Crop Insurance, and insurance on mortgage loans. At the state level, governments are involved in providing unemployment insurance, workers compensation programs and second-injury funds, and state-run medical expense insurance plans.
Federal, state and local governments provide social insurance to a segment of the population who would otherwise be without disability income, retirement income, or medical care.

Social Security provides survivor benefits in the event of death of a covered worker. These benefits include a lump sum burial amount of $255 plus monthly income benefits to eligible survivors. Social Security also provides disability benefits in the event of the total disability of a covered worker. In addition, the program also provides retirement benefits to covered workers at age 65 or earlier if elected by the individual. The Medicare program is also part of Social Security and accordingly provides medical expense benefits for covered workers beginning at age 65. All of these programs will be discussed in more detail in later chapters.

Medicaid is primarily a state governmental program which provides health care benefits for the financially needy. Medicaid is financed by the states with some federal subsidies.

Social insurance is distinguishable from private insurance in four significant areas:

- Participation is mandatory and automatic for all eligible citizens.
- Benefits are not provided under a contract or policy, but are prescribed by law. Individuals do not elect changes to the benefit plan. Any changes to the benefit structure and provisions are made by changes to the law.
- Social insurance seeks to be adequate, to meet the needs of the public, rather than equitable. As income is redistributed through the governmental system, insureds who put less into the system (the poor, the elderly, and those with many dependents) get proportionally greater benefits.
- The government, as an insurance provider, has a clear, and strong monopoly.

DOMICILE AND AUTHORIZATION

Insurer’s Domicile (Domestic, Foreign And Alien Insurers)

An insurer is defined not only by its corporate status, but also by where it is located, or its domicile of incorporation. If an insurer is conducting business in the state where it is incorporated, that insurer is a domestic insurer in that state. If an insurer conducts business in a state where it is not incorporated, the insurer is a foreign insurer in that state. If an insurer is conducting business in a country where it is not incorporated, it is an alien insurer in that country. Therefore, an insurer incorporated in California is a domestic insurer when it is conducting business in California. The same company is a foreign insurer when it is conducting business in New York, and an alien insurer when it is conducting business in Canada.
**Authorized Vs. Unauthorized (Admitted Vs. Nonadmitted)**

Before an insurance company can conduct business it must, by law, receive the authority to do so. Insurance statutes require a company to secure a license from the department of insurance to sell insurance in a particular state. Once the insurer receives the license, it is considered **admitted** into the state as a legal insurer, and is **authorized** to transact the business of insurance. Those insurers not licensed to transact insurance within the state are referred to as unadmitted or nonadmitted. This licensing power (sometimes companies are referred to as licensed and nonlicensed) is used to regulate company activities. Licenses may be issued to domestic companies, foreign companies, or alien companies. Stricter requirements are often imposed on alien and foreign companies because of their inaccessibility.

**Exercise**

A. What type of policy is designed to protect against the risk of living too long?

( ) 1. Casualty  
( ) 2. Life  
( ) 3. Annuity  
( ) 4. Medical expense

B. The ZYX Insurance Company is incorporated in Alabama. While doing business in Texas, it is

( ) 1. a domestic insurer.  
( ) 2. a foreign insurer.  
( ) 3. an alien insurer.  
( ) 4. an export insurer.

C. The ZYX Insurance Company is incorporated in Mexico. While doing business in Texas, it is

( ) 1. a domestic insurer.  
( ) 2. a foreign insurer.  
( ) 3. an alien insurer.  
( ) 4. an export insurer.

D. Self insurance is an example of which method of handling risk?

( ) 1. Acceptance  
( ) 2. Transference  
( ) 3. Avoidance  
( ) 4. Reduction

E. Which of the following is used to denote insurance companies?

( ) 1. Broker  
( ) 2. Exchange  
( ) 3. Corporation  
( ) 4. Insurer
F. Which of the following is a type of insurance company owned by its shareholders?

( ) 1. Mutual
( ) 2. Stock
( ) 3. Lloyd’s
( ) 4. Reinsurer

G. Name at least five different types of insurers.

1. _________________________________________________________________
2. _________________________________________________________________
3. _________________________________________________________________
4. _________________________________________________________________
5. _________________________________________________________________

Answer: A. 3. Annuity; B. 2. a foreign insurer; C. 3. an alien insurer; D. 1. Acceptance; E. 4. Insurer; F. 2. Stock; G. The types of insurers are stock, mutual, reciprocal, fraternal, service, government, Lloyd’s, and assessment

TYPES OF DISTRIBUTION SYSTEMS

Insurance companies market their products generally in one of two ways: by using producers to sell their products or selling directly by mass marketing. The vast majority of policies are sold through producers.

Agency System

Companies that use producers to sell their products vary by whether the producers are employees or independent sales representatives.

Independent Insurance Producers sell the insurance products of several companies and work for themselves or other producers. They sell their clients the policy that fits their needs best among the many insurers they represent, and are paid a commission for each sale. The independent producer owns the expirations of the policies he or she sells, meaning that that individual may place that business with another insurer upon renewal if in the best interest of the client.

Exclusive or captive producers represent only one company, and have an agency relationship with that company. These producers are sometimes referred to as career agents working from career agencies. Most often, these captive or career producers are compensated by commissions. A career producer’s compensation will normally consist of first year commissions and renewal commissions in subsequent years. Usually, the first year commissions may represent 50% or more of the first year life insurance premium. Thereafter the renewal commissions will usually be 10% or less each year.

However, frequently these producers may also be paid a training allowance which serves as a salary for a limited period of time during which the new producer is being trained. Generally, this allowance may be paid for several months or possibly a year or two. Most companies will require that the producer validate this training allowance by producing a certain amount of new business each month.
If a producer hires, trains and supervises other producers within a specific geographical area, he or she is referred to as a **general agent or managing general agent** (MGA). The MGA is compensated by commissions earned on business sold by him or herself as well as an overriding commission (overrides) on the business produced by the other producers managed by the general agent.

An MGA may also receive additional compensation for administrative and service functions performed for policyholders. This compensation is paid in accordance with a separate contractual agreement with the insurer. This supplemental agreement may be referred to as an expense allowance as it is designed to help cover some of the agency's overhead expenses.

**Direct writing companies** usually pay salaries to employees whose job function is to sell the company's insurance products. Technically, these salaried employees do not function as producers. Commissions are usually not paid and the insurer owns all of the business produced.

**Mass Marketing**

Mass marketing has grown in general use over the past several years. The most common types of mass marketing systems are direct-response, franchise, noninsurance sponsors, and vending machine sales.

**Direct-Response**

Direct-response marketing is conducted through the mail, by advertisement in newspapers and magazines, and on television and radio. Policies sold using this method have limited benefits and low premiums, such as disability only.

**Franchise Marketing**

The franchise marketing system provides coverage to employees of small firms, or to members of associations. Unlike group policies where benefits are standard for classes of individuals, persons insured under the franchise method receive individual policies that vary according to the individuals' needs.

Franchise plans are attractive to employers who do not, according to the laws of their state, meet the qualifications for a "true group." It allows the employers to offer individual insurance to their employees at a lower premium than for insurance purchased on an individual basis. Premiums may be deducted from the individual's paycheck.

**Noninsurance Sponsors**

Noninsurance sponsors are being used more and more. The most common are banks, and companies that issue credit cards. This marketing system reaches a select group of individuals who have a history of periodic payments. Usually the sponsor is responsible for the billing of premium, and it is added to the billing statement, or deducted from checking accounts.

**Vending Machine Sales**

Vending machine sales have traditionally been of travel accident policies sold from coin operated machines at airports. A large amount of coverage is available at low premiums. The coverage is good only for the duration of a single trip.
Internet Insurance Sales

Advertising and selling insurance through the Internet are relatively recent developments in insurance distribution. Insurance company websites offer information about insurers, the various lines of insurance provided, and links to regulatory information, financial ratings, and quotation services, as well as “locator” services to put the consumer in touch with a local agent. Some companies are using the Internet to solicit leads, accept applications, and even issue insurance policies. Some insurance producers and agencies have also developed home pages advertising products and services over the Internet.

These practices raise some interesting questions about the regulation of Internet sales. Since the Internet essentially dissolves state geographic boundaries, at issue is whether the insurance company is licensed to do business in the state, and whether the agent is properly licensed and appointed for the companies represented. Other challenges include how to track premium taxes, how to ensure the security of disclosed personal information, how to audit Internet transactions, whether Internet advertisements comply with state laws, and what the implications are for state guaranty associations. The NAIC has established an Internet Marketing Issues Working Group to further explore these issues.

PRODUCERS

The term producer is becoming increasingly common for several reasons. Many states have replaced separate agent and broker licenses with a single producer license. In addition, a major law change in 1999 (discussed later in this course) removed prior legislative barriers between insurers, banks and securities brokerages, allowing insurance to be sold by a wider range of professionals. Anyone who produces sales of insurance products is a producer.

Categories Of Producers

Producers may function as agents, representing the insurance company, or as brokers, representing the potential insured. In some states, solicitors are still licensed, and function as insurance producers.

Producers acting as agents are not only categorized by their function in the industry, but also by the line of insurance they sell.

Life and Health Agents

Generally, life and health insurance agents represent the insurer to the buyer with respect to the sale of life and health insurance products. The agents are appointed by the insurer and usually the agent’s authority to represent the insurer is specified in the agency agreement between them, which is a working agreement between the agent and the insurer. Life and health insurance agents generally do not have the authority to issue or modify insurance contracts. Customarily, life and health insurance agents are authorized to solicit, receive, and forward applications for the contracts written by their companies. The agent may receive the first premium due with the application, but usually not subsequent premiums, except in industrial life insurance. The insurance company approves and issues the contract after receiving the application and premium from the applicant through the agent. The agent cannot bind coverage. This means that an agent cannot commit to providing insurance coverage on behalf of the insurance company.
Property and Casualty Agents

Agents appointed by property and liability insurance companies generally are granted more authority. These agents may bind or commit their companies by oral or written agreement. They sometimes inspect risks for the insurance company and collect premiums due. They may be authorized to issue many types of insurance contracts from their own offices.

Brokers

In contrast to the agent-client relationship in which the agent represents the insurer to the purchaser, a broker represents the buyer to the insurer. A broker may do business with several different insurers. Brokers are independent sales representatives who select insurance coverages from these various companies for their clients.

Brokers must be licensed just like agents and generally their routine activities and functions are similar to that of agents. Brokers solicit applications for insurance, may collect the initial premium and deliver policies. Brokers do not have the authority to bind coverages.

Solicitors

A solicitor is a salesperson who works for an agent or a broker. This working relationship is most common in the property and casualty insurance field. Most often the solicitor will be licensed as a solicitor. Depending on the state, the solicitor may obtain a producer's license. Solicitors normally have a working agreement with a producer. In accordance with this agreement, the solicitor’s primary functions are to solicit insurance, collect initial premiums and deliver policies. Solicitors cannot bind coverage.

Insurance Consultants

A very small group of insurance professionals call themselves insurance consultants. Consultants are not paid by commission for the sales of insurance policies. Instead, they work strictly for the benefit of insureds and are paid a fee by the insureds they represent.

REVIEW

1. A social device for spreading the chance of financial loss among a large number of people is the definition of
   ( ) A. hazard.
   ( ) B. risk.
   ( ) C. insurance
   ( ) D. peril

2. Which of the following risks is most likely to be insurable?
   ( ) A. George is concerned about the financial impact his premature death would have on his family.
   ( ) B. Talyn is concerned about the financial impact large betting losses at the horse track will have on his retirement savings.
   ( ) C. John is concerned about the financial impact on his savings when his car eventually becomes worn enough to need to be replaced.
   ( ) D. Jewel is concerned about the financial impact losing her hat would have on her weekly spending money.
3. Roger refuses to travel by airplane. Roger is managing the risk of being in a plane crash by
   ( ) A. reduction.
   ( ) B. avoidance.
   ( ) C. transference.
   ( ) D. retention.

4. Chianna becomes injured in a car accident caused when she took her eyes off the road to answer her cell phone. This is an example of a
   ( ) A. physical hazard.
   ( ) B. moral hazard.
   ( ) C. morale hazard.
   ( ) D. legal hazard.

5. Mathematicians who study and compile statistical data regarding exposure and risks for insurance companies are called
   ( ) A. solicitors.
   ( ) B. insuraries.
   ( ) C. underwriters.
   ( ) D. actuaries.

6. Which of the following would not be an example of insurable interest?
   ( ) A. Jose wishes to take out a life insurance policy on his own life, to provide for his family in the event of his death.
   ( ) B. Ana wishes to take out a life insurance policy on her mother, to ensure that funeral costs will be covered when the time comes.
   ( ) C. Juan wishes to take out a life insurance policy on his neighbor, because his neighbor is a careless driver who Juan thinks is likely to die in a car accident.
   ( ) D. Carla wishes to take out a life insurance policy on her best salesperson, to protect the business from lost sales in the event of the salespersons death.

7. Kim is injured in a house fire. When the bills come, the insurance company pays 80% of the cost, and Kim pays the rest. This is an example of
   ( ) A. coinsurance.
   ( ) B. a deductible.
   ( ) C. extraneous insurance.
   ( ) D. policy limits.

8. Hoosier Insurance Company is owned by the policyholders. Hoosier Insurance is a
   ( ) A. stock insurer.
   ( ) B. mutual insurer.
   ( ) C. nonprofit insurer.
   ( ) D. fraternal insurer.

9. Which of the following people represents several insurance companies but owns the policy expirations?
   ( ) A. Independent agent
   ( ) B. Exclusive agent
   ( ) C. Direct writing agent
   ( ) D. General agent
10. Which of the following can bind an insurance company by oral or written agreement?

( ) A. Property/Casualty producer
( ) B. Life producer
( ) C. Broker
( ) D. Solicitor

Answers:

1. C. insurance.
2. A. George is concerned about the financial impact his premature death would have on his family.
3. B. avoidance.
4. C. morale hazard.
5. D. actuaries.
6. C. Juan wishes to take out a life insurance policy on his neighbor, because his neighbor is a careless driver who Juan thinks is likely to die in a car accident.
7. A. coinsurance.
8. B. mutual insurer.
9. A. Independent agent
10. A. Property/Casualty producer
UNIT 2

INSURANCE REGULATIONS

LEARNING OBJECTIVES

After completing Unit 2—Insurance Regulations, you will be able to:

1. List the three major channels of regulation in the insurance industry.
2. Explain the impact of the following federal regulations: The Privacy Act of 1974, the Fair Credit Reporting Act, Fraud and False Statements, Financial Services Modernization Act of 1999.
3. Explain the role of the Insurance Commissioner in insurance regulation.
4. Describe the requirements imposed in most states in regards to insurer solvency, annual statements, and investments.
5. Explain how the Mandatory Security Valuation Reserve functions and the purpose it serves.
6. Explain how life insurance companies are taxed by the states.
7. Describe the role of company ratings, and how such information may be used with prospects.
8. Explain what market conduct exams are and how they differ from other state examinations.
9. Describe the role of State Guarantee Associations.
10. Describe how GLBA affects producer regulation at the state level.
11. List the qualifications PLMA suggests for receiving a producer license.
12. List the standard exemptions from licensing requirements set out in PLMA.
13. List the suggested requirements set out in PLMA for receiving a nonresident producer license.
14. Explain the purpose of temporary producer licenses, and list situations where a temporary license might be granted.
15. Explain the requirements for maintaining a producer license, as well as the procedure for reinstating a lapsed license.
16. Describe the function of producer appointments.
17. List possible causes for license denial, nonrenewal or revocation as suggested in PLMA.
INSURANCE REGULATION

REGULATION OF THE INSURANCE BUSINESS

Insurance is a public trust because it affects a large percentage of the general public, and it performs what can be construed as a public service by its very nature. The general public has an interest in making sure that insurance activity actually is provided as a service and not a disservice. Insurance is highly regulated to protect the public interest and to make sure coverage is available on an equitable basis.

Another reason the insurance business is regulated is the large amount of money involved in the industry. Insurance companies control vast sums of money. If used unscrupulously, especially in a concentrated effort, this money could disastrously affect the nation’s economy.

Regulation of the insurance industry is divided among a number of authorities. The three major channels of regulation of the insurance industry are:

- Federal regulation
- State regulation
- Self regulation

The National Association of Insurance Commissioners also plays an important role in insurance regulation, which will be explored later in this unit.

FEDERAL REGULATION

Most insurance regulation takes place at the state level, but there are some important regulations at the federal level. Federal jurisdiction applies to individuals or companies whose activities affect interstate commerce, which includes most insurance activity. Federal regulation of insurance is primarily used as a means to oversee those areas not covered by state regulation of the industry. The most important sources of federal regulation are outlined below and include both legislative and judicial aspects.
Paul Versus Virginia

In the case of Paul v. Virginia, an agent working for insurers in New York began to transact insurance in Virginia, where the New York insurers had failed to comply with state law. The case was brought before the Supreme Court in order to determine if the individual states had the right to regulate the business of insurance. The Court’s decision established, as law, that the transaction of insurance across state lines was not interstate commerce and therefore should be regulated by local law. This decision held in case after case for 75 years.

South-Eastern Underwriters Decision

In 1944 the South-Eastern Underwriters Association was indicted for violating the Sherman Antitrust Act. The Association defended its action by stating the fact that federal regulation did not apply to the business of insurance. For the first time in 75 years the issue of transacting insurance across state lines was looked at another way. The issue, this time, related to the effect of an Act of Congress on insurance transactions conducted across state lines.

The Supreme Court overturned the previous decision by saying that insurance transacted across state lines was, in fact, interstate commerce. This decision had the capability of turning the insurance industry upside-down, because for the past 75 years the states had been regulating the industry locally.

McCarran-Ferguson Act

In order to waylay any impending confusion, Congress enacted the McCarran-Ferguson Act in 1945. This act stated that the federal government had the right to regulate the business of insurance, but only to the extent that such business is not regulated by state law. The main intent of the law was to exempt the insurance industry from most of the provisions of the federal antitrust laws.

Privacy Act Of 1974

In the 1970s the Privacy Protection Study Commission was established. The job of the Commission was to study (1) the collectors of personal information, (2) the users of personal information, and (3) the manner in which personal information is circulated. The study found insurers to be one of the major collectors and users of personal information. Because of the abundance of personal information, and the numbers of agencies collecting and using personal information, it became vital that some controls be established to protect the public from inaccurate, or misused information.

The Commission's findings were summarized in a report entitled Personal Privacy in an Information Society. A large portion of the report dealt with the insurance industry. The report outlined three goals:

- To minimize intrusiveness
- To be fair and impartial in collecting, analyzing, and presenting information and reports
- To make it known to the public that they can expect personal information to be handled in confidence
**Disclosure Authorization**

Applicants for insurance must be given **advance notice** of the insurer's practices regarding collection and use of personal information. Notice must be given promptly and in writing. Notice should be given in the following cases and in the following manner:

- If a third party is interviewed, the applicant must be given notice when the collection of information has begun.
- If only the applicant is interviewed, the applicant must be given notice when the policy is delivered.
- If a policy is being renewed, the insured must be given notice by the renewal date.
- If a policy is being reinstated, the applicant-insured must be given notice at the time the request is made.
- If an insured is requesting a change in benefits, the insured must receive notice at the time the request is made.

The notice must give the applicant or insured the following kinds of information:

- The people with access to personal information.
- The kind of information to be collected.
- The kind of information the insurer can receive without the applicant’s prior approval.
- The sources of information.
- The persons to whom information may be disclosed without the applicant’s prior authorization.

Disclosure authorization forms are required by law to be prescribed and approved by the Commissioner. The disclosure form must be written in accordance with the plain language laws of the state, and dated. Disclosure forms state the types of persons authorized to disclose private and personal information (e.g., neighbors, employers, and previous or other insurers); the kind of information which may be disclosed (e.g., personal habits, work habits, health habits such as smoking and drinking). The form must also state the reason information is collected, and how it will be used. For instance, the **reason** personal information is gathered is because the applicant requested a life insurance policy; the information will be used by the underwriting department for the **purpose** of determining the applicant’s risk category.

The applicant’s signature on the disclosure form authorizes the insurer to collect and disseminate information in the manner described in the notice. The authorization is only good for a certain period of time. For example, if authorization is given to an insurer to collect information with regard to a claim settlement, the authorization is good for 30 months. At the end of this period another authorization must be obtained. The applicant or insured may request, and receive, a copy of the authorization form.

Personal information may be disclosed to persons other than the requesting parties under certain conditions. Among those to whom an insurer may disclose information are producers, other insurers, insurance organizations (such as the Medical Information Bureau) and Insurance Departments. This type of third-party disclosure may require authorization, but in some instances authorization is not required, just as long as the applicant or insured has received proper notification of the insurer's information practices. In some cases information is passed on to those conducting scientific research, audits, or marketing approaches.
Penalties

The Commissioner of Insurance has the authority to investigate any insurer, or any agency used by the insurer to collect information, to determine if the company is in compliance with the Insurance Act. If the Commissioner believes that a violation of the Privacy Act has taken place he or she can conduct a hearing to determine the facts. If a violation is found, the Commissioner can issue a cease and desist order, but if the violator continues to violate the Privacy Act, the Commissioner can institute a fine of up to $10,000 for each violation. If the violation is one that happens with such frequency that it appears to be a general business practice, the fine for each violation can be up to $50,000.

The NAIC Model Privacy Act also provides for the enforcement of individual rights. The individual has the right to information concerning himself or herself, and the right to correct inaccurate information, the right to know the reasons for being turned down for insurance, or any other adverse underwriting decision. These rights are those found under the Fair Credit Reporting Act.

A fine of $10,000, or up to one year in jail is the penalty for any person who obtains information that he or she has no legitimate reason to receive.

Fair Credit Reporting Act

When an application is submitted to a life or health insurance company, a consumer reporting agency may be hired to obtain personal information about the applicant to be used in the underwriting evaluation. To protect the consumer’s right to privacy in this situation, the federal Fair Credit Reporting Act was passed in 1970. The Act sets up procedures for consumer reporting agencies to follow in their dealings with businesses to ensure that records are confidential, accurate, relevant and properly used.

Consumer Reports

Consumer reports include written, oral and other forms of communication which a consumer reporting agency has regarding a consumer’s credit, character, reputation, or habits, which is used or collected to determine whether or not a consumer is eligible for credit, insurance, employment or other purposes authorized under the Act. Consumer reports may only be issued to persons who have a legitimate business need for the information. Governmental agencies may also be provided with a consumer’s name, present and former addresses, and present and past places of employment.

Investigative Consumer Reports

An investigative consumer report includes information on a consumer’s character, general reputation, personal habits, and mode of living that is obtained through investigation, i.e., interviews with associates and friends and neighbors of the consumer. Such reports may not be made unless the consumer is clearly and accurately told about the report in writing within three days of the date on which the report was first requested. The consumer must also be notified that he or she is allowed to request additional information. If that person requests such information in writing, the person who caused the investigative report to be made must make a complete and accurate disclosure of the report.
to the consumer about whom it is written. The disclosure must be made within
five days of receipt of the report, or when the report was first requested, whichever date is later. If there is an investigative consumer report prepared subsequent to the first one, any adverse information must be verified, or must have been received during the three months preceding the subsequent report.

**Pretext Interviews**

A pretext interview is an interview whereby a person, in an attempt to obtain information about another person, pretends to be someone he or she is not, misrepresents the true purpose of the interview, or refuses to properly identify him or herself.

Generally, pretext interviews are prohibited. However, such an interview may be conducted when there is evidence of criminal activity, fraud or misrepresentation.

**Consumer Reporting Agencies**

Consumer reporting agencies collect information on individuals, prepare reports, and make the reports available to persons or organizations having a legitimate reason to receive such information. These agencies may operate for profit; for example, Experian or Equifax. Or, agencies may be nonprofit, such as the Medical Information Bureau (MIB) or a credit union.

A consumer may choose to have his or her name and address excluded from any list provided by a consumer reporting agency in connection with a credit or insurance transaction that is not initiated by the consumer. The consumer simply needs to notify the agency that he or she does not consent to any use of a consumer report relating to the consumer in connection with any credit or insurance transaction that is not initiated by the consumer.

Credit agencies are required to provide a notification system, including a toll-free telephone number, to allow consumers to request exclusion of their information. This notification is valid for two years. If notification is made in writing on a signed notice of election form issued by the agency, it is valid until the consumer revokes the request. The consumer may revoke the request at any time.

**Prohibited Information**

Consumer reporting agencies are specifically prevented from putting information in their reports about

- bankruptcies over 10 years old;
- suits and judgments over seven years old or in which the statute of limitations has expired, whichever period is longer;
- paid tax liens or accounts placed for collection or charged to profit which are over seven years old;
- arrests, indictments, or conviction of crime reports; and
- any other adverse information which took place seven years prior to the report.

These restrictions are not applicable when the consumer credit report is used in connection with a credit transaction of $150,000 or more, a life insurance policy of $150,000 or more, or when it concerns employment of an individual earning $75,000 or more.
**Consumers’ Rights**

Consumers who feel that information in their files is inaccurate or incomplete may inform the consumer reporting agency of any information in dispute. The consumer reporting agency is then required to reinvestigate and record the current status of the disputed material (unless the agency has reasonable grounds to believe the dispute is frivolous or irrelevant) in a reasonable period of time.

If the agency’s investigation finds that the information is no longer accurate or verifiable, it must be deleted promptly. If the dispute is not resolved after reinvestigation, the consumer may file a brief statement (not more than 100 words) concerning the problem. If this statement is filed, the consumer reporting agency must note it in future consumer reports which contain that information (unless it is determined to be frivolous or irrelevant). If credit or insurance is denied, or charges are increased, based wholly or partially on information contained in a consumer report, the user of the information must notify the consumer of this fact and report the name and address of the consumer reporting agency which made the report. If credit or insurance is denied, or charges are increased, wholly or partially due to information obtained from a person or organization other than a consumer reporting agency, the user of the information must disclose the nature of that information to the consumer if it has been requested within 60 days of the disclosure. It is the responsibility of the user of the information to inform the consumer of his or her right to request this information when the adverse action is communicated to him or her.

**Penalties**

Failure to comply with the provisions of the Act makes the guilty party liable to the consumer for the sum of actual damages sustained as a result of the noncompliance; punitive damages deemed proper by a court; and the costs of an action which enforces liability, plus reasonable attorney’s fees. When the noncompliance is due to negligence, the guilty party must pay the consumer the sum of the consumer’s actual damages, the costs of any successful action to enforce liability, plus reasonable attorney’s fees.

Obtaining consumer information reports under false pretenses may result in a fine, imprisonment, or both. The same penalty is imposed on officers or employees of consumer reporting agencies who have knowingly and willfully provided consumer information to a person not authorized to receive it.

**Fraud And False Statements**

Certain types of false or fraudulent statements have been specifically outlined in federal law as punishable by a fine, a prison sentence, or both. Federal law prohibits persons engaging in the business of insurance whose activities affect interstate commerce from knowingly, with the intent to deceive:

- making any false material statement or report that willfully and materially overvalues any land, property or security in connection with any financial reports or documents presented to an insurance regulatory official or agency, or an agent or examiner acting for an insurance regulatory official for the purpose of influencing the actions of such individual;
• making any false entry of material fact in any book, report, or statement of such person engaged in the business of insurance with intent to deceive any person, including any officer, employee or agent of such person engaged in the business of insurance regarding the financial condition or solvency of such business.

• willfully embezzling, abstracting, purloining or misappropriating any of the moneys, funds, premiums, credits or other property of any person engaged in the business of insurance.

• Corruptly influencing, obstructing or impeding the due and proper administration of the law under which any proceeding is pending before any insurance regulatory official or agency or any producer or examiner appointed by such official or agency to examine the affairs of a person engaged in the business of insurance.

The punishment for any of the offenses described above may include fines, imprisonment or both. If the statement, report or activity was a significant cause of an insurer being placed in conservation, rehabilitation or liquidation by a court, the fine and term of imprisonment may be significantly increased.

The Attorney General may bring a civil action in the appropriate United States district court against any person who engages in unfair and deceptive practices as defined in the law and, upon proof of such conduct by a preponderance of the evidence, the person will be subject to a fine of not more than $50,000 for each violation or the amount of compensation which the person received or offered for the prohibited conduct, whichever amount is greater. If the offense has contributed to the decision of a court to issue an order directing the conservation, rehabilitation, or liquidation of an insurer, the penalty will be remitted to the appropriate regulatory official for the benefit of the policyholders, claimants, and creditors of the insurer. The imposition of a fine under this section does not preclude any other criminal or civil statutory, common law, or administrative remedy, which is available by law to the United States or any other person.

If the Attorney General has reason to believe that a person is engaged in conduct constituting unfair and deceptive practices as defined in the law, the Attorney General may petition an appropriate United States district court for an order prohibiting that person from engaging in the conduct if the court finds that the conduct constitutes such an offense. The filing of a petition under this section does not preclude any other remedy which is available by law to the United States or any other person.

Financial Services Modernization Act Of 1999

Also known as the Gramm-Leach-Bliley Act (GLBA), this legislation was passed in 1999 primarily to remove depression-era barriers between commercial banking, investment banking and insurance. GLBA allows financial holding companies to engage in any activities that are financial in nature. Regulation of these holding companies is managed on a functional basis. This means that regulatory authority is based on what activity is occurring, rather than on what type of company is engaging in the activity. For example, the sale of insurance is regulated by state insurance regulators even if the company making the sale is a bank or securities brokerage.
Financial holding companies have the potential to capture unprecedented amounts of information about their customers. To address these concerns, GLBA also establishes a minimum federal standard for financial privacy. GLBA states that each financial institution has a responsibility “to respect the privacy of its customers and to protect the security and confidentiality of those customers non-public personal information.” The law requires that all of the functional federal regulatory agencies establish appropriate standards for each regulated institution with respect to technical, administrative and physical safeguards:

- “to insure the security and confidentiality of customer records and information;
- to protect against any anticipated threats or hazards to the security or integrity of such records; and
- to protect against unauthorized access to or use of such records or information which could result in substantial harm or inconvenience to any customer.”

Anyone about whom a company collects any information is a consumer. A customer is a consumer who has an ongoing relationship with the financial institution. Different states define ongoing relationship using different guidelines, so be certain you understand what it means in your state.

GLBA protects the confidentiality of personal information. Business information is not covered under this statute. GLBA considers information to be collected when it is organized or can be retrieved by an individual’s name or by an identifying number, such as a policy number. The source of the information is less important than how it is stored and organized.

Information that is publicly available, such as phone numbers listed in a telephone book, is not protected under GLBA. However, the fact that an individual has an insurance policy with a certain company is not public information, so publishing a list of policyholder names and listed phone numbers would not automatically be allowed.

In some cases, consumers and customers are given the opportunity to keep the company from sharing the information it has about them. This is known as the right to opt-out. Health information, such as that acquired during a medical exam, is subject to a stricter opt-in standard, meaning that companies may not share some health information without getting specific permission to do so from the customer or consumer.

The ability to prohibit any information sharing would seriously limit a company’s ability to manage a policy. For this reason, there are several exceptions to an individual’s right to opt-out of information sharing. For example, companies are always permitted to share information with their affiliates.

GLBA requires that a company make two primary disclosures to customers: one at the time of the establishment of the customer relationship, and the second prior to the company disclosing protected information. The first disclosure is to be made at the time a consumer becomes a customer, usually by purchasing a policy. At this point, the company is required to give a clear and conspicuous disclosure to the new customer regarding its policies and procedures for customer privacy. The customer must, at least on an annual basis, receive an updated notice containing the same information.
The second disclosure required by GLBA explains the customers right to opt out of information sharing. Each customer must be given the right to opt out and must be told explicitly how he or she may exercise that right. The notice must identify the products and services to which the opt-out right applies. The only other requirement is that the opt-out agreement must be in writing, and may be electronic if the customer agrees. If the customer does not take advantage of this option within a reasonable time, the company may share the information with others.

A side issue of the opt-out right applies to joint accounts. A single notice of the opt-out right may be sent or given to joint customers, but either of the joint customers may individually opt-out of disclosure. The financial institution has the discretion to apply the opt-out by one person in a joint account to the entire account or to treat each individual separately regarding disclosure of information.

**Other Regulating Agencies**

Some insurance products are regulated by both the federal and state government. For example, the Securities and Exchange Commission (SEC) and the state Insurance Departments regulate variable contracts. Variable annuities and variable life insurance are insurance company products but these products present a degree of investment risk to the buyer and accordingly, they have also been identified as securities in accordance with SEC regulations.

**Exercise**

A. Put the following events in the order in which they were decided.

   ____ South-Eastern Underwriters Decision
   ____ McCarran-Ferguson Act
   ____ Paul vs. Virginia

B. Which of these cases first defined insurance as interstate commerce?

   ( ) 1. South-Eastern Underwriters Decision
   ( ) 2. McCarran-Ferguson Act
   ( ) 3. Paul vs. Virginia

C. The federal government

   ( ) 1. is the primary authority for regulating the business of insurance.
   ( ) 2. does not get involved in regulating the business of insurance.
   ( ) 3. has the right to regulate the business of insurance to the extent that such business is not regulated by state law.

D. Pretext interviews are

   ( ) 1. always illegal.
   ( ) 2. not permitted without a warrant sworn by a sitting judge.
   ( ) 3. generally accepted practice in the industry.
   ( ) 4. not permitted unless some evidence of criminal activity exists.
NOTES

E. A customer is

( ) 1. anyone about whom a company collects information.
( ) 2. anyone with whom a company has an ongoing relationship.
( ) 3. anyone who prohibits the sharing of nonpublic personal information.
( ) 4. anyone who permits the sharing of nonpublic personal information.

Answer: A. 1. Paul versus Virginia, 2. South-Eastern Underwriter’s, 3. McCarran-Ferguson; B. 1. South-Eastern Underwriter's Decision; C. 3. has the right to regulate the business of insurance to the extent that such business is not regulated by state law; D. 4. not permitted unless some evidence of criminal activity exists; E. 2. anyone with whom a company has an ongoing relationship.

STATE INSURANCE REGULATION

Most insurance regulation takes place at the state level. The body of laws at the state level is called the Insurance Code. State regulation consists of statutes, and rules and regulations. Statutes are the body of law developed by the Legislative branch of government. They outline, in general terms, the duties of the Commissioner and the activities of the Insurance Department. Rules and regulations are developed by the Insurance Department to expand upon statutory requirements and carry out legislative intent.

Commissioner’s Scope And Duties

The Insurance Code of each state authorizes the establishment of an Insurance Department to administer and carry out the insurance laws. In each state, a public official will head the Department—the title of the official will be the Commissioner, Superintendent, or Director of insurance. The titles differ state-to-state. A majority of the states use the title “Commissioner.” In all cases, the public official in charge of the Insurance Department has broad powers to supervise and regulate the insurance affairs within the state. The insurance laws of the state usually confer upon the Commissioner all of the following powers and duties:

- To conduct investigations and examinations
- To make reasonable rules and regulations
- To hire employees and examiners, and delegate any power, duty, or function to such persons
- To examine the accounts, records, documents, and transactions of any insurer, agent or broker
- To subpoena witnesses and administer oaths in order to further any examination, investigation, or hearing on insurance matters
- To issue orders and notices on decisions made or matters pending
- To issue insurance licenses and Certificates of Authority
- To impose penalties for violations of the Insurance Code, including but not limited to fines, suspensions or revocations of licenses and Certificates of Authority, and requesting that the Attorney General prosecute a violator
- To approve insurance policy forms sold within the state
- To approve rates and rate increases for regulated lines of insurance
Notice that the Commissioner does not make the insurance laws, he or she is simply in charge of making certain all insurance operations within the state are in compliance with the laws made by the State Legislature.

**REGULATING INSURANCE COMPANIES**

The State Insurance Code prescribes the procedures that must be followed in order for an insurance company to be formed. It specifies the manner in which the company must be organized, the requirements for incorporation, such as, the amounts for minimum capital and surplus requirements for a domestic stock insurer; and the minimum surplus requirements and securities deposit for a domestic mutual insurer. While the bulk of the Code pertains only to domestic insurers, some of the laws regulate foreign and alien insurers' eligibility to transact insurance business as well as establishing requirements for maintaining assets and liabilities.

Before individuals can form an insurance company they must receive approval from the Insurance Department to organize. They must meet the requirements for incorporation, certificates of intention and bylaws just like any other corporation. They are required to draw up a charter which states the proposed name of the insurer, the location, the lines of insurance to be sold, and method of operation. The Insurance Department will also conduct an investigation to ensure that the organizers are of good moral character.

The majority of individual life and health insurance is written by stock and mutual companies. A mutual company must have a minimum number of applications for insurance, the advanced premium payment for each application, and a surplus. A stock company must have a specified amount of capital, which is invested, and a surplus amount. In many states domestic insurers must deposit securities which insurance regulations specify as relatively stable and safe, such as government bonds.

**Insurer Solvency**

Insurance companies collect premiums before losses are paid. If the insurer later becomes insolvent, customers will have paid for protection the company is no longer in a position to provide. Protection against insurer insolvency is one of the principal concerns of the insurance industry. Insurance insolvency regulations govern such areas as the organization and ownership of a new company, capital and surplus requirements, reserves, accounting, investments, annual statements, and the rehabilitation and liquidation of impaired insurers. If an insurer gets into trouble, the Insurance Department will attempt to rehabilitate the company, or if this fails, handle the liquidation. In addition, Insurance Departments in many states have adopted regulations for the establishment of guaranty associations in the event that an insurer does, in spite of regulations and precautions, become insolvent.

The Insurance Department has the right to compute the reserve liabilities of a company; to value its assets; to approve or disapprove its investments, dividends, and expenses; and the power to require it to deposit securities to cover its liabilities in the state.
Various state statutes impose capital and surplus requirements, the preparation of annual financial statements, and require periodic examinations of insurers by the Insurance Department. These laws establish initial financial requirements and help in the early detection of financial problems.

Each insurer’s capacity to write new business is limited by the levels of capital and surplus it currently maintains. Most states discourage or prohibit the writing of net premiums in excess of some multiple of an insurer’s existing surplus. Without such controls, a carrier might assume excessive amounts of risk, experience losses beyond the capacity to pay claims, and become insolvent.

Despite checks on policywriting capacity, there are a number of other factors which could undermine or improve the financial status of an insurer. Insurance always carries an element of uncertainty, and above average underwriting profits or losses might cause a company’s financial status to shift. Investment income or loss is another factor that can have a profound impact on an insurer’s status. Producers and insureds therefore have an interest in having coverage placed with carriers who have a sound financial condition.

**Annual Statement**

Each insurance company must report its financial condition in an annual statement. The annual statement generally reports the following information:

- Summary of company assets (listed by type)
- Summary of company liabilities
- Summary of company surplus, and other funds
- Summary of company operations
- Analysis of operations (listed by line of business)
- Analysis of reserve increases
- Statements regarding changes in financial condition

**Investments**

All states have regulations that are intended to assure that insurers invest only in high quality assets to prevent insolvencies. Life insurance companies may invest funds in concerns that are fairly stable in value. These safe investments include municipal bonds, corporate bonds, real estate mortgages, and even policy loans.

Regulations require that all investments and loans be approved by the company’s board of directors, and that no board members have a personal interest in the investment being made. Committee meetings where discussion of investment or loans has been undertaken must have minutes recorded. Such minutes will be open to inspection by the Commissioner.

Foreign companies seeking a license to transact business in a state must meet investment requirements similar to those required of a domestic insurer.

**Valuation Of Assets**

The Mandatory Security Valuation Reserve (MSVR) was created in 1951 to prevent radical changes in policyholder surplus from fluctuations in the value of securities and other investments. The MSVR absorbs the smaller changes
in the values of security investments up to a maximum amount. When the
maximum is reached, the surplus is increased or decreased, depending upon
whether there was a gain or a loss in the value of the security. Other regula-
tory bodies and state statutes regarding assets are intended to assure that
insurers invest only in high quality assets to prevent insolvencies.

Taxation Of Life Insurance Companies

Life insurance companies are taxed on both their investment income and
underwriting profits. For stock insurance companies, investment income is
taxed in the year it is earned, while 50% of underwriting profit is taxed during
the year earned, and the other 50% is taxed when paid out to stockholders.
The one-half of the underwriting income that is taxed becomes shareholders’
surplus, and the half that has not been taxed becomes policyholders’ surplus.
Both types of surplus are collectively known as the earned surplus of an
insurance company.

Mutual insurers pay out their underwriting income as dividends to policyhold-
ers, so this tax regulation does not generally apply.

Company Ratings

Producers have a responsibility to place coverage with financially sound carri-
ers. Evaluating the financial health of an insurance company is a complex
task. There are several organizations that rate the financial strength of insur-
ance carriers, based on an analysis of a company's claims experience, invest-
ment performance, management, and other factors. These organizations
include A.M. Best Company, Standard & Poor's Insurance Rating Services,
Moody's Investors Service, Duff & Phelps Credit Rating Company, and Weiss
Ratings. These ratings are one of the most widely used indicators of financial
health (or the lack of it) in the insurance industry.

The firms don’t all rate every company, and each firm has a different criteria
for which companies will be rated. Each firm also uses a different methodology
for evaluating the financial strength of insurance companies. There are at
least four different rating scales in use among the five firms.

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<th>SCALES IN USE BY FINANCIAL RATING SERVICES</th>
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Consumers might find a rating meaningless, or even misleading, if it is not presented in the context of the scale. For example, an A+ rating sounds like it belongs at the top of the scale, but only one rating service considers it the top possible rating. From other services, it may be the third or even the fifth highest rating.

**Examination Of Insurers**

The state Insurance Department must examine the financial affairs, transactions, and general business records of domestic insurers in accordance with specific state insurance laws. Generally, these laws will state that the Commissioner of Insurance may examine the insurer’s records as often as necessary but at least once every three to five years.

The non-financial regulatory activities of an insurance department fall under the broad heading of **market conduct**. Proper market conduct means conducting insurance business fairly and responsibly. A market conduct examination is when state insurance department investigators examine the business practices and operations of an insurer and its agents in order to determine their authority to conduct insurance business in the state. During a market conduct examination, state examiners investigate the records and practices of an insurance company and determine whether the company is in fact in compliance with state laws regulating the sales and marketing, underwriting, and issuance of insurance products. Some states conduct market conduct exams in conjunction with their regular financial examinations of insurers; others conduct independent market conduct exams.

As part of these examinations, the insurer’s records of commissions paid to agents will be reviewed to determine if commissions were paid in accordance with state statutes. Most states require that commissions may only be paid or shared with licensed producers. Generally, producers may share commissions with other producers provided they are both appointed with the same insurer and licensed in the same lines of insurance.

**Rehabilitation And Liquidation**

Despite regulatory controls, some insurers become insolvent, or find themselves in financial difficulty. In this event the Department has the authority to assume control over company funds and management. If an insurer becomes impaired (in financial difficulty) the Department will attempt to put the insurer back on a sound financial standing. If an insurer becomes insolvent (unable to meet financial obligations) the Department will attempt to make the insurer solvent again. Rehabilitation efforts are undertaken if the Department believes that an impaired insurer has a chance of restoring solvency. Liquidation proceedings are instituted when the insurer is insolvent and cannot be restored to solvency.

The 1977 NAIC Model Insurers Supervision, Rehabilitation, and Liquidation Act is divided into four sections designed to facilitate actions of insolvency. **General Provisions** establishes the Act’s absolute authority for the rehabilitation or liquidation of insolvent insurers. **Supervision Proceedings** offers alternative plans for use prior to the need for the Department’s full intervention. **Formal Proceedings** outlines methods for transferring authority from the insurer to the Department. **Interstate Relations** provides for the transfer of an insurer’s assets and records to the state of domicile.
Rehabilitation proceedings can occur for the following reasons:

- The company's continued operation would not serve the best interests of policyowners, creditors, or the general public.
- The company's officers and directors have violated the law by committing certain acts or omissions.
- The company's officers, directors, or owners have attempted to transfer a significant amount of assets, or have attempted a merger without the Department's approval.

**Guaranty Associations**

State Guaranty Associations are organized to protect claimants, policyholders, annuitants and creditors of financially impaired or insolvent insurers by providing funds for the payment of claims and other related policy benefits. The Association is composed of insurers authorized to transact insurance business within the state. Association membership exceptions include fraternal organizations and non-profit companies. Member insurers are assessed certain sums of money to cover the Association's operating expenses. If an insurer insolvency should occur, each member insurer will be assessed additional fees to cover the insolvency.

Guaranty associations are often compared to the Federal Deposit Insurance Corporation (FDIC), which protects bank depositors from bank failures. Like the FDIC, coverage by the guaranty association is subject to limitations, usually something like $300,000 for death benefits, $100,000 for life insurance cash surrender/withdrawal values, $100,000 for health benefits, and an overall cap for individuals.

Some of the characteristics of the Association include the following:

- It establishes accounts to collect funds for the administration and assessment of the association
- It is supervised by the Commissioner, and a board of directors (usually nine members)
- The duties of the board and the Commissioner are specified by law
- An insurer's authorization to transact business in the state is contingent upon membership in the association
- Member insurers are assessed on the percentage of premiums each insurer has individually earned in the state

The NAIC has helped to establish a National Organization of Life and Health Insurance Guaranty Associations (NOLHGA) which helps facilitate cooperation and communication among the state guaranty associations.

**Marketing And Advertising Life And Health Insurance**

States often regulate the marketing and advertising of life and health insurance policies to assure truthful and full disclosure of pertinent information when selling these policies. As a rule, the insurer is held responsible for the content of advertisements of its policies. Advertisements cannot be misleading
or obscure, or use deceptive illustrations, and must clearly outline all policy coverages as well as exclusions or limitations on coverage (such as preexisting condition limitations).

Most states require insurers to keep a permanent advertising file of all advertisements used in the state until the next regular examination of the insurer by the Insurance Department, or for a specified minimum number of years, such as two or three.

Also, many states require the delivery of a Buyers Guide and Policy Summary or Outline of Coverage at the time of policy delivery. The Buyers Guide is a document providing basic information about the insurance policies, and the Policy Summary (life insurance) or Outline of Coverage (health insurance) is a written statement describing the elements of the policy being sold. Generally, it must include the agent’s name and address, the name and office address of the insurer, and the generic name of the policy and each rider.

Exercise

A. Insurance laws are generally written by

( ) 1. the federal government.
( ) 2. the state legislature.
( ) 3. the state Department of Insurance.
( ) 4. the Commissioner.

B. The head of the State Department of Insurance (usually called the Commissioner) is responsible for all of the following except

( ) 1. examining individual insurance policies before issuance.
( ) 2. administering and carrying out state insurance laws.
( ) 3. imposing penalties for violations of the Insurance Code.
( ) 4. issuing insurance licenses and Certificates of Authority.

C. The non-financial regulatory activities of an insurance department fall under the broad heading of

( ) 1. company conduct.
( ) 2. regulatory conduct.
( ) 3. market conduct.
( ) 4. producer conduct.

Answer: A. 2. the state legislature; B. 1. examining individual policies before issuance; C. 3. market conduct.

**PRODUCER REGULATION**

Producers may function as either an agent or a broker. Agents represent their companies; brokers represent their clients. While both agents and brokers seek to serve both their clients and companies by matching coverage with need, it is important to know the difference between the two roles. Regardless of their role, producers are governed by the Insurance Code with respect to licensing and unfair trade practices.
Licensing Regulation

GLBA, passed in 1999, contained a small but important section on the regulation of insurance producers, stating that 29 states must have uniform or reciprocal licensing regulations in place by November 12, 2002, or the federal government would begin licensing agents and brokers. Ideas about uniformity and reciprocity of state licenses had already been in the works for years, and the National Association of Commissioners had even drafted a Producer Licensing Model Act (PLMA) that satisfied GLBA. In addition, the PLMA had the advantages of creating some standard statutory language, maintaining individual state authority over licensing and maintaining important consumer protections.

As of mid-2002, more than 40 states have passed the PLMA, and more than 45 states have met the GLBA minimum requirements. This text will discuss the general provisions of the PLMA. However, no two states enacted the PLMA exactly the same way. Refer to your State Law Digest for more information on licensing regulations in your state.

License Required

Under the statutes of most states, no person is permitted to act as an insurance producer unless currently licensed as a producer for the class or classes or insurance involved. Acting as a producer includes selling, soliciting, or negotiating insurance. In many states, adjusters, consultants, and service representatives must also be licensed.

PLMA streamlined the qualifications for insurance producers. Some states still require additional qualifications. The qualifications listed in the Model Act are:

- Be at least 18 years of age
- Have not committed any act that is a ground for denial, suspension or revocation of an insurance license
- Where required by the Commissioner, complete a prelicensing course of study for the lines of authority for which the person has applied
- Where required, pay the appropriate fees
- Where required, successfully pass the examinations for the lines of authority for which the person has applied.

A business entity acting as an insurance producer is required to obtain an insurance producer license. Before approving the application, the Commissioner must find that

- The business entity has paid the appropriate fees
- The business entity has designated a licensed producer responsible for the business entity's compliance with the insurance laws, rules and regulations of the state.

The Commissioner may require any documents reasonably necessary to verify the information contained in an application.
Exceptions To License Requirements

PLMA also defines a standard set of exemptions from the licensing requirements. Generally speaking, people who do not get paid commissions for selling insurance do not need a license. The list of exemptions according to PLMA includes:

- insurers
- officers, directors or employees of an insurer or a producer who do not receive commission on policies written or sold in the state if the individual’s activities are executive, administrative, managerial, clerical or a combination of these, and are only indirectly related to selling, soliciting or negotiating insurance
- officers, directors or employees of an insurer or a producer who do not receive commission on policies written or sold in the state if the individual’s function relates to underwriting, loss control, inspection or the processing, adjusting, investigating or settling of a claim on a contract of insurance
- officers, directors or employees of an insurer or a producer who do not receive commission on policies written or sold in the state if the individual is acting in the capacity of a special agent or agency supervisor assisting insurance producers where the person’s activities are limited to providing technical advice and assistance to licensed insurance producers and do not include the sale, solicitation or negotiation of insurance.
- A person who secures and furnishes information for the purpose of group life insurance, group property and casualty insurance, group annuities, group or blanket accident and health insurance, or for the purpose of enrolling people under plans, issuing certificates under plans or otherwise assisting in administering plans, or performs administrative services related to mass marketed property and casualty insurance; where no commission is paid for the service.
- An employer or association or its officers, directors, employees, or the trustees of an employee trust plan, to the extent that the individuals are involved in the administration or operation of a program of employee benefits for the employer’s or association’s own employees or the employees of its subsidiaries or affiliates, when the program involves the use of insurance issued by an insurer, as long as the individuals are not compensated in any manner by the insurer issuing the contracts.
- Employees of insurers or organizations employed by insurers who are engaging in the inspection, rating or classification of risks, or in the supervision of the training of insurance producers and who are not individually engaged in the sale, solicitation or negotiation of insurance.
- A person whose activities are limited to advertising without the intent to solicit insurance through communications in printed publication or other forms of electronic mass media whose distribution is not limited to residents of the state, provided that the person does not sell, solicit or negotiate insurance that would insure risks residing, located or to be performed in this state
- A person who is not a resident of a state who sells, solicits or negotiates a contract of insurance for commercial property and casualty risks to an insured with risks located in more than one state insured under that contract, provided that the person is licensed as an insurance producer in the state where the insured maintains its principal place of business and the contract of insurance insurers risks located in that state
• A salaried full-time employee who counsels or advises his or her employer relative to the insurance interest of the employer or of the subsidiaries or business affiliates of the employer provided that the employee does not sell or solicit insurance or receive a commission

Other exemptions may be allowed in individual states. Check the Law Digest text for variations or additions applicable in your state.

**Nonresident Producer Licensing**

The majority of states allow for reciprocity in nonresident licensing as required in GLBA. Reciprocity means a mutual exchange of privileges. In the case of producer licensing, it means the recognition of two states of the validity of licenses or privileges granted by the other.

The NAIC has encouraged states to eliminate any licensing and appointment retaliatory fees that might get in the way of reciprocity, suggesting that states avoid charging nonresident fees that are higher than resident and create a barrier to entry. Check your State Law Digest to see what the rules are in your state.

The PLMA suggests the following requirements for an individual who wants to receive a nonresident producer license:

• Is currently licensed as a resident and in good standing in his or her home state
• Has submitted the proper request for licensure and has paid the fees required by the state in which he or she wants to be licensed as a nonresident producer
• Has submitted or transmitted to the Commissioner the application for licensure that he or she submitted to his or her home state, or a completed Uniform Application
• Is from a state that awards non-resident producer licenses to residents of this state on the same basis

States generally will not require any additional attachments to the Uniform Application or impose any other conditions on applicants that exceed the information requested within the Uniform Application.

The Commissioner may verify the producer’s licensing status through the Producer Database maintained by the National Association of Commissioners, its affiliates or subsidiaries.

A nonresident producer who moves from one state to another state or a resident producer who moves to another state must file a change of address and provide certification from the new resident state within 30 days of the change of legal residence. No fee or license application is required.
Obtaining a License

Application For Examination

A resident individual applying for an insurance producer license has to pass a written examination unless exempt as discussed above. The exam is developed by the Commissioner to test the knowledge of the individual concerning the lines of authority for which the application is made, the duties and responsibilities of an insurance producer and the insurance laws and regulations of the state.

The Commissioner may, and generally does, make arrangements to contract with an outside testing service for administering examinations and collecting the nonrefundable fee as described by state law. Each individual applying for an examination must pay a nonrefundable fee. If the individual fails to appear for the exam as scheduled or fails to pass the exam, he or she must reapply for the exam and remit all the required fees and forms before being rescheduled for another examination. States may limit the frequency of application for examination.

Exemptions From Examination

A person licensed as an insurance producer in another state who moves to this state has 90 days after establishing legal residence to become a resident licensee. Prelicensing education is generally not required to obtain any line of authority previously held in another state. This exemption is only available if the person is currently licensed in another state, or if the application is received within 90 days of the cancellation of the applicant’s previous license. The Commissioner may require certification that, at the time of cancellation, the applicant was in good standing in that state, or that the state’s Producer Database records indicate that the producer is or was licensed in good standing for the line of authority requested.

Issuance Of License

Licenses contain the licensee’s name, address, personal identification number, and the date of issuance, the lines of authority, the expiration date and any other information the Commissioner deems necessary.

Temporary Agent Licenses

In most states, temporary agent licenses may be issued for up to 180 days without requiring an examination if the Commissioner considers the temporary license necessary for maintaining an insurance business in the following cases:

• To the surviving spouse or court-appointed personal representative of a licensed producer who dies or becomes disabled to allow adequate time for the sale of the insurance business, or for the recovery or return of the producer to the business, or to provide for the training and licensing of new personnel to operate the producer’s business
• To a member of a business entity licensed as an insurance producer, upon the death or disability of an individual designated in the business entity application or the license
• To the designee of a licensed insurance producer entering active service in the armed forces of the United States of America
• In any other circumstance where the Commissioner considers the temporary license necessary to ensure the public interest will be served.

The authority of any temporary license can be limited in any way the Commissioner considers necessary to protect insureds and the public. The temporary licensee may be required to have a suitable sponsor who is a licensed producer or insurer and who assumes responsibility for all acts of the temporary licensee, and may impose similar requirements designed to protect insureds and the public. Temporary licenses may be revoked if the interests of insureds or the public are endangered. A temporary license may not continue after the licensee disposes of the business.

MAINTAINING A LICENSE

Change Of Address
Every licensee must promptly give to the head of the Insurance Department written notice of any change of business address. Most states require this notice be made within 30 days.

Assumed Names
An insurance producer doing business under any other than the producer's legal name is required to notify the Commissioner before using the assumed name.

Office And Records
Every resident producer must have and maintain in the state issuing the license a place of business accessible to the public. The designated place of business must be where the licensee principally conducts transactions under the license. The licenses of the licensee and solicitors appointed by the licensee shall be conspicuously displayed in a part of the place of business which is customarily open to the public. The producer must keep at the place of business the usual and customary records pertaining to insurance transactions.

Continuation/Expiration/Renewal Of License
Producer licenses generally remain in effect unless revoked or suspended as long as the appropriate fee is paid and the continuing education requirements are met by the due date.

An individual insurance producer who allows his or her license to lapse may, within 12 months from the due date of the renewal fee, reinstate the same license without passing a written examination. However, a penalty of double the unpaid renewal fee will be required for any renewal fee received after the due date.
An insurance producer who is not able to comply with the license renewal procedures due to military service or some other extenuating circumstance (for example, medical disability) may request a waiver of those procedures. The producer may also request a waiver of any examination requirement or any other fine or sanction imposed for failure to comply with renewal procedures.

**Appointment**

If a producer is going to function as an agent of an insurer, the producer generally needs to be appointed by that insurer. To appoint a producer as its agent, the appointing insurer needs to file a notice of appointment within **15 days** from the date the agency contract is executed or the first insurance application is submitted. If an appointment fee is required, it will be paid by the appointing insurer. Any appointment renewal fees required in subsequent years are also paid by the appointing insurer.

In many states, the Commissioner verifies the eligibility of each producer appointed within the first **30 days** after being notified of the appointment. If the producer is found to be ineligible, the insurer is notified within **five days**.

Like the insurance license, as long as the appropriate forms are filed and the appropriate fees are paid by the appointing insurer, appointments remain in effect until terminated, or until the producer’s license is revoked or terminated. If the filing of an appointment is late, additional fees may be charged.

Notice that producers are licensed by the state, and appointed by an insurer. Loss of an appointment does not necessarily mean that the producer has lost his or her license. It simply means that the producer may no longer represent that particular company although he or she is still licensed within the state.

**Termination Of Appointment**

Subject to a producer’s contract rights, if any, an insurer may terminate any of its appointed producers at any time. The insurer must give prompt written notice of the termination and the date to the Insurance Department (and to the producer when reasonably possible), and must file a statement of facts related to the termination and reasons for it.

If the appointment was terminated because the producer was found to have done something that would be grounds for revocation, denial or suspension of his or her license, the insurer is obligated to notify the Commissioner, generally within **30 days**. If the insurer finds out after terminating the appointment that the producer did something while appointed that would have been grounds for revocation, denial or suspension of an insurance license, the insurer has to notify the Commissioner when it makes the discovery. As long as this notification is made without malicious intent, whoever makes such notifications is immune from civil liability, and no civil cause of action may be brought against such person.
License Denial, Nonrenewal Or Revocation

The Commissioner may place on probation, suspend, revoke or refuse to issue an insurance producer’s license or may levy a civil penalty for any combination of the following causes, listed in the PLMA.

- Providing incorrect, misleading, incomplete or materially untrue information in the license application
- Violating any insurance laws, or violating any regulation, subpoena or order of the Commissioner or of another state’s Commissioner
- Obtaining or attempting to obtain a license through misrepresentation or fraud
- Improperly withholding, misappropriating or converting any money or property received in the course of doing insurance business
- Intentionally misrepresenting the terms of an actual or proposed insurance contract or application for insurance
- Having been convicted of a felony
- Having admitted or been found to have omitted any insurance unfair trade practices or fraud
- Using fraudulent, coercive, or dishonest practices, or demonstrating incompetence, untrustworthiness or financial irresponsibility in the conduct of business in this state or elsewhere
- Having an insurance producer license, or its equivalent, denied, suspended or revoked in any other state, province, district or territory
- Forging another’s name to an application for insurance or to any document related to an insurance transaction
- Improperly using notes or any other reference material to complete an examination for an insurance license
- Knowingly accepting insurance business from an individual who is not licensed
- Failing to comply with an administrative or court order imposing child support obligations
- Failing to pay state income tax or comply with any administrative or court order directing payment of state income tax

If the Commissioner nonrenews or denies an application for a license, the applicant or licensee must be notified and advised, in writing, of the reason for the denial or nonrenewal of the license. The applicant or licensee may make a written demand for a hearing within a reasonable time as specified in state law.

A business entity’s license may be suspended if the Commissioner finds that an individual licensee’s violations were known or should have been known by one or more of the partners, officers or managers acting on behalf of the business entity and the violation was not reported nor corrective action taken.

A civil fine may be imposed in addition to or instead of license denial, suspension or revocation. Depending on the violation, fines can range from $100 to several thousand dollars. If a producer is in violation of civil law, the Commissioner can refer the matter to the State Attorney General for criminal prosecution and possible imprisonment.
Exercise

A. Producers may act as

( ) 1. agents, representing the insurance company.
( ) 2. brokers, representing the individual seeking insurance.
( ) 3. either agents, representing the insurance company, or brokers, representing the individual seeking insurance.
( ) 4. neither agents, representing the insurance company, or brokers, representing the individual seeking insurance.

B. To become licensed as an insurance producer, an individual must be at least

( ) 1. 16 years of age.
( ) 2. 18 years of age.
( ) 3. 21 years of age.
( ) 4. 25 years of age.

C. Which of the following individuals would NOT be exempt from a producer licensing requirement?

( ) 1. Alicia works in an insurance office conferring directly with or offering advice to prospective purchasers about the benefits, terms and conditions of insurance policies, and urges a person to apply for policies Alicia thinks would be a good match.
( ) 2. Brenda works for an insurer acting in the capacity of a special agent or agency supervisor assisting insurance producers by providing technical advice and assistance to licensed insurance producers on non-sales related areas.
( ) 3. Cannie gathers information for the purpose of enrolling individuals under a group life insurance plan at her company. Cannie also issues certificates and assists in administering the plan.
( ) 4. Del inspects, rates and classifies risks. At times, Del also supervises the training of insurance producers.

D. An insurance producer who permits his or her license to lapse may generally reinstate the policy within

( ) 1. 3 months from the due date of the renewal fee.
( ) 2. 6 months from the due date of the renewal fee.
( ) 3. 9 months from the due date of the renewal fee.
( ) 4. 12 months from the due date of the renewal fee.

Answer: A. 3. either agents, representing the insurance company, or brokers, representing the individual seeking insurance; B. 2. 18 years of age; C. 1. Alicia works in an insurance office conferring directly with or offering advice to prospective purchasers about the benefits, terms and conditions of insurance policies, and urges a person to apply for policies Alicia thinks would be a good match; D. 4. 12 months from the due date of the renewal fee.
REGULATED PRACTICES

License For Controlled Business Prohibited

Coverage written on a producer’s own life or health, and on the lives or health of such persons as the producer’s relatives or business associates, is called controlled business. Because of the effect that controlled business could have on the insurance industry if people began becoming licensed solely to sell insurance to family and friends, the Commissioner limits such activities.

There is nothing wrong with a producer writing insurance for himself or herself, or on family members and close business associates such as partners. Generally, a licensee is not permitted to earn commission or compensation from controlled business in excess of a stated amount (35% to 50% of total compensation, depending upon the state) during a stated time period (usually a calendar-year). If a greater proportion does come from controlled business, the practice is in violation of law and the license may be revoked or suspended.

Unfair Trade Practices

The Unfair Trade Practices Act is divided into two parts—Unfair Marketing Practices and Unfair Claims Practices. In each state, statutes define and prohibit certain trade and claims practices which are unfair, misleading and deceptive.

Misrepresentations

A misrepresentation is simply a lie. It is a violation of Unfair Marketing Practices for any person to make, issue, or circulate any illustration, sales material, or to make any statement which is false, misleading or deceptive. Misrepresentations include (but are not limited to):

- Misrepresenting the benefits, advantages or terms of any policy
- Misrepresenting policy dividends by implying or stating that they are guaranteed
- Misrepresenting the financial condition of an insurer by means of an inaccurate or incomplete financial comparison

Misrepresenting an insurance policy by using any name or title which is untrue or misleading or by indicating that an insurance policy represents shares of stock

In some cases, misrepresentation can occur unintentionally. To prevent this, the producer must know the products he or she is selling and accurately explain these products to a population largely ignorant about insurance. To assist in explaining the products being sold, many states require that Life Insurance Buyer’s Guides be distributed by an insurance company to its prospects to explain basic insurance plans and identify the types of insurance available.
**False Or Deceptive Advertising**

It is illegal for any person to formulate or use an advertisement or make a statement which is untrue, deceptive or misleading regarding any insurer or person associated with an insurer.

**Twisting**

Twisting occurs when a producer convinces a policyowner to lapse or surrender a present policy in order to sell him or her another one, usually from a different company. This is not to say all policy replacements are wrong. If a producer proves to the policyowner that the protection he or she has is not the best available, and the policyowner decides to replace the old policy with a better one, that policyowner has been well served. However, the producer must be careful that the arguments used on the policyowner can stand the scrutiny of the Commissioner. Any attempt by the producer to misrepresent another insurer by falsely making statements about the financial condition of the company or by giving an incomplete comparison of policies can create legal liability.

**Churning**

Closely allied with twisting is churning, a term describing the practice of using misrepresentation to induce replacement of a policy issued by the insurer the producer is representing, rather than the policy of a competitor. The impetus behind churning is to allow the producer to collect a large first-year commission on a new policy. Churning is the result of a producer putting his or her interests above those of the client.

**False Financial Statements**

It is a violation of Unfair Marketing Practices for any person to deliberately make a false financial statement regarding the solvency of an insurer with the intent to deceive others.

**Defamation**

It is illegal for any person or company to make any oral or written statements or to circulate any literature which is false, maliciously critical, or derogatory to the financial condition of any insurer, or which is calculated to injure anyone engaged in the insurance business.

**Discrimination**

It is illegal to permit discrimination between individuals of the same class or insurance risk in terms of rates, premiums, fees and policy benefits, due to their place of residence, race, creed or national origin.

**Rebating**

Splitting a commission with a prospect is prohibited in almost every state (California and Florida are exceptions). Rebating is any inducement in the sale of insurance which is not specified in the insurance contract. The offer of sharing commissions with the insurance applicant is an inducement in the sale of insurance which is not part of the insurance policy and thus, rebating. Rebates include not only cash but also personal services and items of value.
Illegal Premiums And Charges

It is unlawful for any person or insurer to collect premiums or make charges which are not specified in the insurance contract.

Boycott, Coercion Or Intimidation

It is a violation of the Act for any person or organization to commit or be involved in any act of boycott, coercion or intimidation which is intended to create a monopoly or restrict fair trade in the transaction of insurance. For example, it is unlawful for a bank to force a person to purchase insurance from a particular company or agent as a condition for receiving a loan from the bank. The bank may require that adequate insurance be purchased or be in force to back such a loan but the bank cannot force or intimidate a person into purchasing coverage from a specific insurer as a condition for the granting of a loan.

Unfair Claims Practices

Claims settlement practices are regulated, in the public interest, for two main reasons: (1) it is for the purpose of settling claims that insurance companies have collected policyowners’ money, and (2) when insureds are denied claims, or claim payments are delayed or altered, the consequences go beyond the policy benefits, and can drastically affect other areas of the insured’s financial situation. The Unfair Claims Practices provisions of the Unfair Trade Practices Act are designed to protect the insureds and claimants from any claims settlement practices which are unfair, deceptive or misleading. The following are considered unfair claims practices:

- Misrepresenting pertinent facts or insurance policy provisions relating to coverage at issue
- Failure to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies
- Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies
- Refusing to pay claims without conducting a reasonable investigation based upon all available information
- Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed
- Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear
- Compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by such insureds
- Attempting to settle a claim for less than the amount to which a reasonable person would have believed he or she was entitled by reference to written or principal advertising material accompanying or made part of an application
- Attempting to settle claims on the basis of an application which was altered without notice, knowledge or consent of the insured
- Making claims payments to insureds or beneficiaries not accompanied by statements setting forth the coverage under which the payments are being made
NOTES

- Making known to insureds or claimants a policy of appealing arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration
- Delaying the investigation or payment of claim by requiring an insured, claimant, or the physician of either, to submit a preliminary claim report and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information
- Failing to promptly settle claims where liability has become reasonably clear under one portion of the insurance policy coverage in order to influence settlement under other portions of the insurance policy coverage
- Failing to promptly provide a reasonable explanation of the basis relied on in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement

Some states have added another provision which makes it an unfair claim practice to offer a settlement or payment in any manner prohibited by law.

**Penalties**

Following an investigation and a hearing, if the Insurance Department finds that any person or insurer is engaged in any unfair trade or unfair claims practice, the Commissioner may issue a **cease and desist order** prohibiting the individual or company from continuing the practice. Failure to comply with the cease and desist order can result in a substantial fine (usually $10,000). In addition, fines and loss of license may also be imposed for any company or person guilty of violating the Unfair Trade Practices Act.

The Insurance Department may also issue a consent order, which is a disciplinary action in which the party at fault (the insurance company or agent) agrees to discontinue a particular practice (usually an unfair trade or claims practice) through a written agreement with the Insurance Department. Usually the individual denies the allegations but consents to the action taken by the Insurance Department. Consent orders (also known as consent decrees) may or may not involve a fine.

**Exercise**

Match the following descriptions with the concepts listed below by selecting the correct letter for each concept and writing it next to the description.

_____ A. Making a statement that is derogatory to the financial condition of an insurer, and which is intended to cause injury
_____ B. Making incomplete comparisons of policies, for the purpose of inducing a policyholder to change or replace an existing policy
_____ C. Using any name or title of any insurance policy that does not reflect the true nature of the policy

1. Misrepresentation
2. Twisting
3. Defamation

Answer:  A. 3. Defamation; B. 2. Twisting; C. 1. Misrepresentation
SELF-REGULATION

The last channel of regulation of the business is self-regulation, that is those restraints from within the industry either by individual company conscience or by group pressure of insurance associations. This was the first type of regulation of the business and is still the predominant type in Great Britain.

There are several inter-company organizations or associations that impose “codes” on their members. These include the National Association of Life Underwriters (producers) through its state and local associations, the International Association of Health Underwriters (producers), and the American Society of Chartered Life Underwriters (producers). In recent years, these industry associations have had a major impact on prelicensing and continuing education laws. For example, often the state Association of Life Underwriters will be the organization which is the major force in obtaining passage of these laws through the state legislature. Continuing education laws are designed to protect the consumer by mandating certain continuing educational requirements if a producer is to maintain his or her license. These educational requirements usually focus on product knowledge, insurance regulations and ethics. The majority of states have continuing education requirements.

The NAIC

The National Association of Insurance Commissioners (NAIC), an association of state Commissioners, although without legal authority as a group, also imposes a strong influence in the area of the industry’s self-regulation. The NAIC is the organization that has done the most to standardize law between the states. Although the wording, and sometimes the provisions themselves differ from state to state, for the most part the differences are only slight as each state attempts to follow, in essence, the wording of the “model laws” established by the NAIC.


REVIEW

1. Most insurance regulation takes place at the
   ( ) A. international level.
   ( ) B. national level.
   ( ) C. state level.
   ( ) D. local level.

2. Applicants for insurance must be given advance notice including all of the following types of information **except**
   ( ) A. the persons who are collecting information.
   ( ) B. the kind of information to be collected.
   ( ) C. the sources of information.
   ( ) D. the persons with access to personal information.
3. Which of the following does not contain provisions protecting individual privacy?
   ( ) A. Gramm-Leach-Bliley Act
   ( ) B. Privacy Act of 1974
   ( ) C. McCarran-Ferguson Act
   ( ) D. Fair Credit Reporting Act

4. Consumer reporting agencies are prevented from putting information in their reports about all of the following except:
   ( ) A. bankruptcies over 10 years old.
   ( ) B. suits and judgments over 7 years old if the statute of limitations has not expired.
   ( ) C. arrests, indictments or conviction of crime reports.
   ( ) D. paid tax liens or accounts placed for collection more than seven years previous.

5. Under the Financial Modernization Act, an individual about whom a financial institution collects any information is a
   ( ) A. customer.
   ( ) B. consumer.
   ( ) C. client.
   ( ) D. patron.

6. Under the Financial Modernization Act, an individual with whom a financial institution has an ongoing relationship is a
   ( ) A. customer.
   ( ) B. consumer.
   ( ) C. client.
   ( ) D. patron.

7. The Commissioner of Insurance has all of the following powers except:
   ( ) A. conducting investigations and examinations.
   ( ) B. making reasonable rules and regulations.
   ( ) C. promulgating insurance law.
   ( ) D. approving insurance policy forms sold within the state.

8. Nonfinancial regulatory activities of an insurance department fall under the broad heading of
   ( ) A. market regulation.
   ( ) B. conduct regulation.
   ( ) C. market conduct.
   ( ) D. insurance conduct.

9. Associations organized to protect claimants, policyholders, annuitants and creditors of financially impaired insurers are known as
   ( ) A. Insurance Associations.
   ( ) B. Department Associations.
   ( ) C. Liability Associations.
   ( ) D. Guaranty Associations.
10. Which of the following is not a requirement for obtaining a producer’s license in most states?

( ) A. Have not committed any act that is grounds for denial or suspension of an insurance license.
( ) B. Be at least 19 years of age.
( ) C. Pay the required fees.
( ) D. Complete any required prelicensing course.

11. Which of the following people would be required in most states to obtain an insurance license?

( ) A. Rachel, a salaried employee of a large department store chain, who counsels her employer on insurance-related matters.
( ) B. Ross, who works in an advertising agency, supervising the advertising business of a major insurer.
( ) C. Phoebe, who works as an underwriter for a small insurer.
( ) D. Chandler, who sells insurance to businesses only.

12. A person licensed as an insurance producer in another state who moves to this state has how long after establishing legal residence to become a resident licensee without taking prelicensing education or an examination?

( ) A. 30 days
( ) B. 60 days
( ) C. 90 days
( ) D. 120 days

13. Which of the following individuals is least likely to be granted a temporary license?

( ) A. Georgia, whose insurance producer-husband passed away unexpectedly, leaving her with a business to either learn or sell.
( ) B. Kim, who wants to try selling insurance on a temporary basis before investing the time and money into being licensed.
( ) C. Dave, an employee of a business entity, when the individual designated as the licensee in the business entity is disabled in an auto accident and unable to return to work for several months.
( ) D. Lee, whose insurance producer-fiancée was recalled to active duty by the Navy and appointed Lee her designee.

14. Business written on the producer’s own life or interests is known as

( ) A. controlled business.
( ) B. personal business.
( ) C. conflicted business.
( ) D. producer business.

15. Which of the following is considered an unfair claims practice?

( ) A. Splitting a commission with a prospect.
( ) B. Failing to affirm or deny coverage within a reasonable time after proof of loss.
( ) C. Convincing a policyowner to lapse or surrender an existing policy in order to sell another policy.
( ) D. Making any oral or written statement which is false, maliciously critical, or calculated to injure a competing producer.
16. An organization that establishes model laws which are often adopted by states with only slight differences is the
   ( ) A. National Association of Insurance Companies.
   ( ) B. National Association of Independent Commissioners.
   ( ) C. National Association of Insurance Consultants.
   ( ) D. National Association of Insurance Commissioners.

**Answers:**

1. C. state level.
2. A. the persons who are collecting information.
3. C. McCarran-Ferguson Act
4. C. arrests, indictments or conviction of crime reports.
5. B. consumer.
7. C. promulgating insurance law.
8. C. market conduct.
10. B. Be at least 19 years of age.
11. D. Chandler, who sells insurance to businesses only.
12. C. 90 days
13. B. Kim, who wants to try selling insurance on a temporary basis before investing the time and money into being licensed.
15. B. Failing to affirm or deny coverage within a reasonable time after proof of loss.
UNIT 3

INSURANCE LAW

LEARNING OBJECTIVES

After completing Unit 3—Insurance Law, you will be able to:

1. Explain the role of agency in insurance sales.
2. List and define the three types of authority granted in an agency relationship.
3. Define fiduciary and explain what it means for an insurance producer to be a fiduciary.
4. Explain the legal doctrines of waiver and estoppel.
5. Describe the responsibilities an agent has toward the insured and toward the insurance company.
6. Describe the responsibilities an insurer has to its agents.
7. Explain what Errors and Omissions policies cover, and why they are important.
8. Define contract, and list and describe the elements necessary for the formation of a valid contract.
9. Describe the four basic parts contained in all life and health insurance contracts.
10. List and describe the five major areas reviewed by the courts when interpreting contracts.
11. Explain the following characteristics unique to insurance contracts: utmost good faith, aleatory, adhesion, unilateral, executory, conditional, personal.
12. Explain the difference between warranties and representations.
13. Explain the difference between misrepresentation, concealment and fraud.
14. Define parol evidence and describe how it impacts insurance contracts.
Agency Law Principles

An understanding of the law of agency is important as an insurance company, like other companies, must act through agents.

Agency is a relationship in which one person is authorized to represent and act for another person or for a corporation. Although a corporation is a legal “person,” it cannot act for itself, so it must act through agents. An agent is a person authorized to act on behalf of another person, who is called the principal. In the field of insurance, the principal is the insurance company and the sales representative or producer is the agent. When one is empowered to act as an agent for a principal, he or she is legally assumed to be the principal in matters covered by the grant of agency. Contracts made by the agent are the contracts of the principal. Payment to the agent, within the scope of his or her authority, is payment to the principal. The knowledge of the agent is assumed to be the knowledge of the principal.

Presumption Of Agency

If a company supplies an individual with forms and other materials (signs and evidences of authority) that make it appear that he or she is an agent of the company, a court will likely hold that a presumption of agency exists. The company is then bound by the acts of this individual whether or not he or she has been given this authority.

Authority

The authority of an agent is of three types: express, implied or apparent.

Express authority is an explicit, definite agreement. It is the authority the principal gives the agent as set forth in his or her contract. It is very important for an agent to know the limitations of the contract and to operate within its limits. To do otherwise could place him or her in a position of personal liability. His or her actions and knowledge are binding on the insurance company, so he or she must be alert to the consequences of his or her actions and words.
Implied authority is not expressly granted under an agency contract, but it is actual authority which the agent has to transact the principal's business in accordance with general business practices. For example, if an agent's contract does not give him or her the express authority of collecting and submitting monthly premiums, but the agent does so on a regular basis, and the company accepts the premium, then the agent is said to have implied authority. That is, it is a general business practice to collect premium, and by accepting the premium from the agent, the company has implied that the agent has the authority to conduct this practice.

Lingering implied authority means that the agent carries “signs or evidences of authority.” By having these evidences of authority an agent who is no longer under contract to an insurer could mislead applicants or insureds. When the agency relationship between agent and company has been terminated, the company will try, or should try, to get back all the materials it supplied to the former agent, including sales materials.

On the other hand, the public cannot assume that an individual is an agent merely because he or she says so. The agent must carry the credentials (for example the agent’s license and appointment) and company documents (such as applications and rate books) that represent him or her as being an agent for an insurance company.

Apparent authority is the authority the agent seems to have because of certain actions undertaken on his or her part. This action may mislead applicants or insureds, causing them to believe the agent has authority which he or she does not, in fact, have. The principal adds to this impression by acting in a manner that reinforces the impression of authority. For instance, an agent’s contract usually does not grant him the authority to reinstate a lapsed policy by accepting past due premiums. If, in the past, the company has allowed the agent to accept late premiums for that purpose, a court would probably hold that the policyowner had the right to assume that the agent’s acceptance of premium was within the scope of his or her authority.

Collection Of Premium

All premiums received by an agent are funds received and held in trust. The agent must account for and pay the correct amount to the insured, insurer, or other agent entitled to the money.

Any agent who takes funds held in trust for his or her own use is guilty of theft and will be punished as provided by law.

An agent may establish an account separate from a personal account to deposit the trust funds. All trust funds may be deposited into the single separate account, however, the agent’s records must clearly distinguish the funds held for each individual.

Agent’s Responsibility To Insured/Applicant

An agent has a fiduciary responsibility to the insured, the insurer, the applicant for insurance, current clients, etc. The agent has a fiduciary duty to just about any person or organization which he or she comes into contact with as
part of the day-to-day business of transacting insurance. By definition, a **fiduciary** is a person in a position of financial trust. Thus, attorneys, accountants, trust officers and insurance agents are all considered fiduciaries.

As a fiduciary, the agent has an obligation to act in the best interest of the insured. The agent must be knowledgeable about the features and provisions of various insurance policies as well as knowing the use of these insurance contracts. The agent must be able to explain the important features of these policies to the insured. The agent must recognize the importance of dealing with the general public’s financial needs and problems and offering solutions to these problems through the purchase of insurance products.

As a fiduciary, the agent must know and comply with the state’s insurance laws. Many of these laws are for consumer protection. It is the agent’s duty to comply with these laws and thus protect the interests of the insured at all times.

As a fiduciary, the agent must collect and account for any premiums collected as part of the insurance transaction. It is the agent’s duty to make certain that these premiums are submitted to the insurer promptly. Failure to submit premiums to the insurer, or putting these funds to one’s own personal use, is a violation of the agent’s fiduciary duties and possibly an act of embezzlement. The insured’s premiums must be kept separate from the agent’s personal funds. Failure to do this can result in **commingling**—mixing personal funds with the insured or insurer’s funds.

**Waiver And Estoppel**

The legal doctrines of waiver and estoppel are directly related to the responsibilities of insurance agents. An insurer may, by waiver, lose the right of making certain defenses that it might otherwise have available. **Waiver** is defined as the intentional and voluntary giving up of a known right. An insurance company may waive its right to cancel a policy for nonpayment by accepting late payments.

Waiver and estoppel often occur together, but they are separate and distinct doctrines. **Estoppel** means that a party may be precluded by his or her acts of conduct from asserting a right that would act to the detriment of the other party, when the other party has relied upon the conduct of the first party and has acted upon it. An insurer may waive a right, and then after the policyowner has relied upon the waiver and acted upon it, the insurer will be estopped from asserting the right.

The agent must be alert in his or her words, actions, and advice to avoid mistakenly waiving the rights of the insurance company. As a representative of the company the agent’s knowledge and actions may be deemed to be knowledge and actions of the company.

**Agent’s Responsibilities To Company**

The agent’s contract or agency agreement with the insurer will specify the agent’s duties and responsibilities to the principal. As previously mentioned, the agent has a fiduciary duty to the insurer. In all insurance transactions, the
agent’s responsibility is to act in accordance with the agency contract and thus for the benefit of the insurer. If the agent is in violation of the agency agreement, then he or she may be held personally liable to the insurer for breach of contract.

An agent has a duty to act with a degree of care that a reasonable person would exercise under similar circumstances. This prudent person rule is to protect the insurer and the insured from unreasonable insurance transactions on the part of the agent.

In accordance with the agent’s fiduciary obligation to the insurer and his or her agency agreement, the agent has a responsibility of accounting for all property including money which comes into his or her possession. The agent must not embezzle or commingle these funds.

As part of the agent’s working relationship with the insurer, it is important that pertinent information be disclosed to the insurer, particularly with regard to underwriting and risk selection. If the agent knows of anything adverse concerning the risk to be insured, it is his or her responsibility to provide this information to the insurer. To withhold important underwriting information could adversely affect the insurer’s risk selection process. In accordance with agency law, information given to the agent is the same as providing the information to the insurer.

It is the agent’s responsibility to obtain necessary information from the insurance applicant and to accurately complete the application for insurance. A signed and witnessed copy of the application becomes part of the legal contract of insurance between the insured and the insurer and thus it is critical that the application be accurate.

Finally, the agent has a responsibility to deliver the insurance policy to the insured and collect any premium which may be due at the time of delivery. The agent must be prepared to provide the insured with an explanation of some of the policy’s principal benefits and provisions. If the policy is issued with any changes or amendments, the agent will also be required to explain these changes and obtain the insured’s signature acknowledging receipt of these amendments.

**Company’s Responsibility To The Agent**

The company likewise has a responsibility to the agent. It is required to permit the agent to act in accordance with the terms of the agent’s employment contract, and the company must recognize all of the provisions of that contract.

In addition, the company must pay the agent the compensation agreed upon in the contract, must reimburse the agent for proper expenditures made on behalf of the principal, and must indemnify the agent for any losses or damages suffered without fault on the part of the agent but occurring on account of the agency relationship.
Potential Liabilities Of Agent/Errors and Omissions (E&O) Exposure

Errors and omissions insurance is needed by professionals who give advice to their clients. It covers negligence, error, or omission by the insurer, or producer who is the insurer's representative. E&O policies protect producers from financial losses they may suffer if insureds sue to recover for their financial loss due to a producer giving them incorrect advice (error) or not informing them of an important issue (omission). Since a producer's office is very busy, he or she must take special care to follow strict procedures (and train all employees to do the same) in regard to taking applications, explaining coverages, collecting premiums, submitting changes to policies upon an insured's request, and preparing claim forms. Any error or omission could result in losing a client and could lead to a lawsuit. All E&O policies have certain basic characteristics in common:

- The policy covers only losses due to negligence, error, or omission. For example, the producer who fails to tell a client that his or her purchase of a new policy means that waiting periods have to be met again, can be sued for this omission if the event previously covered occurs and the insured finds that he or she is not currently covered.
- The policy usually has a high deductible, such as $500 or $1,000. The high deductible provides an added incentive for a producer to reduce his or her errors.
- The coverage may be written with both a limit per claim, and a limit for all claims during the policy period.
- Except for obvious exclusions, like a producer committing unfair trade practices or intentional fraud, the policy has few other exclusions.

Exercise

A. Insurance agents are appointed by

( ) 1. the federal government.
( ) 2. the State Department of Insurance.
( ) 3. the Insurance Commissioner.
( ) 4. insurance companies.

B. Name the three types of agent authority.

1. ________________________________
2. ________________________________
3. ________________________________

C. Life and health insurance producers _________ the authority to bind an insurance company to a contract agreement.

( ) 1. have
( ) 2. do not have

Answer: A. insurance companies; B. Express, implied, and apparent; C. 2. do not have
The formation of a life or health insurance contract differs from the formation of other insurance contracts in that the life or health producer usually does not have the authority to bind the insurer.

The life or health insurance producer has no authority to put a policy into effect. The producer can only solicit offers from prospective insureds, securing their applications and initial premium payments. The application and premium must be sent to the insurance company underwriter, who determines whether or not the company wishes to accept the risk.

The restricted underwriting authority of the life insurance producer is related to the nature of life insurance contracts. Life insurance policies are generally non-cancellable, long-term contracts. A life insurance policy is contestable for a one or two-year period. Property and casualty insurance, however, involves a short-term contract often for one year or less and the insurance company usually reserves the right to cancel the policy if the risk appears to be undesirable. In addition, life and health insurance underwriting decisions frequently rest on medical questions. The life or health insurer employs medical experts and has at its disposal various investigative reports that shed light on the desirability of a risk. The insurance company is in a much better position than the producer to evaluate the applicant’s insurability.

**Contract Elements**

Insurance policies are legal contracts and are subject to the general law of contracts. This is a distinct body of law which is separate from criminal law (crimes against society) and tort law (legal liability issues usually involving damages for negligence). Contract law dictates the formation and enforcement of legal contract rights.

A contract is a legal agreement between two or more parties promising a certain performance in exchange for a valuable consideration. Under the law, the following elements are necessary for the formation of a valid contract:

- Agreement (offer and acceptance)
- Consideration
- Competent parties
- Legal purpose

**Agreement (Offer And Acceptance)**

There can be no contract without the agreement or mutual assent of the parties. A common intention on all terms of the contract is essential to an agreement and no essential terms of the contract may be left unsettled. Further, the intention of the parties to a contract must be communicated to one another.

The parties to an insurance contract are the insurance company and the applicant, who may become the insured or may name another person to be insured. Unless otherwise indicated, it is assumed that the applicant is the prospective insured.
Offer

An offer is a proposal that creates a contract if accepted by another party according to its terms. A contract arises only if the acceptance indicates clear assent to the exact terms and conditions of the offer. Generally, any words or actions by the person receiving the offer which imply agreement will be interpreted as acceptance of the offer.

The offer may come from the insurer (company) or the applicant. In either case the offer must be definite and clear in its terms. If an applicant gives the insurer a completed application and pays the first premium, the application is an offer. If the policy is issued as applied for, the insurer accepts the offer.

There is no offer if the applicant sends the application to the insurance company without payment of the premium. Such an application is merely an invitation to the company to make an offer. The insurance company makes an offer by issuing the policy. The applicant accepts it by paying the first premium.

Acceptance

An acceptance must be unconditional and unqualified. A qualified or conditional acceptance rejects the offer and may constitute a counter offer. If an insurance company, after receiving an application and premium payment, issues a policy with more restrictive coverage than that applied for, the company has made a counter offer.

For example, a counter offer occurs if an applicant applies for a standard health insurance policy, pays the premium, and receives a policy containing an exclusionary endorsement for specified physical conditions. The applicant must decide whether or not to accept the policy as modified. If he or she accepts the policy, there is a contract. If he or she rejects the modified policy, there is no contract, and the applicant is entitled to a return of his or her premium.

Consideration

Each party to the contract must give valuable consideration. In the insurance contract, the value given by the insurer consists of the promises contained in the policy contract. The consideration given by the insured consists of the statements made in the application and the payment of the initial premium.

The consideration may consist of any of the following:

- A monetary payment
- An act
- A forbearance from action
- The creation, modification or destruction of a legal right
- A return promise

In other words, each of the parties to the contract gives up something of value or forbears from exercising a right.
It is important to know that part of the applicant’s consideration consists of the statements in the application. A great deal of importance is placed on the representations in the application, since the insurance company’s entire decision of whether to contract is based on its evaluation of the information in the application.

The application should be complete and accurate. The producer must take the time to ask each and every question and to record the answers fully and legibly. The producer must be careful to avoid haphazard or cursory completion of application forms on behalf of applicants since incomplete or inaccurate application information hurts both the insurance company and the applicant. Further, the producer must not assist the applicant in deliberately deceiving the company regarding material facts in the application. Later discovery of false information in the application may be cause for denying coverage.

Failure to complete all required information on the application in a thorough, honest, and detailed manner could subject the producer to the embarrassment of having to explain to his or her client why the insurance policy is invalid. This failure could also lead to disciplinary action by his or her insurance company and by the state.

**Competent Parties**

For a contract to be binding, both parties must have the legal capacity to make a contract.

To have the legal capacity to make insurance contracts, an insurance company must have authority under its charter to issue contracts and be authorized by the state to issue contracts. The company’s representative must also be licensed by the state. The legal effect of a contract made by an unlicensed insurer depends on state law.

The insured or applicant must be of legal age and be mentally competent to make an insurance contract. Applications of minors must usually be signed by an adult parent or guardian to comply with the legal age requirement for making contracts.

**Legal Purpose**

To be valid, a contract must be for a legal purpose and not contrary to public policy. Wagering or gambling contracts are contrary to public policy. An insurance contract, however, is not against public policy where an insurable interest exists.

**Parts Of The Insurance Contract**

While it is not a legal requirement that all contracts be in writing, insurance contracts always are, because of their complex nature. The number of pages which make up an insurance contract varies because of the types of insurance and the individual risks being insured, but all life/health insurance contracts contain four basic parts:

- Policy face (Title page)
- Insuring clause
- Conditions
- Exclusions
Policy Face (Title Page)

The policy face is usually the first page of the insurance policy. It includes the policy number, name of the insured, policy issue date, the amount of premium and dates the premium is due, and the limits of the policy. The policy face also includes the signatures of the secretary and president of the issuing insurance company. In addition, there are generally clauses required by law to give the insured information on his or her right to cancel, and a warning to the insured to read the policy carefully.

Insuring Clause

The insuring clause generally also appears on the policy face. It is a statement by the insurance company which sets out the essential element of insurance—the promise to pay for losses covered by the policy, in exchange for the insured's premium and compliance with policy terms.

Conditions

This section spells out in detail the rights and duties of both parties. Conditions are provisions which apply to the insured and insurer. For example, the conditions include the reinstatement provision, suicide clause, payment of claim provision, and similar standard policy provisions.

Exclusions

In this section, the company states what it will not do. The exclusions are a basic part of the contract and a complete knowledge of them is essential to a thorough understanding of the agreement. Certain risks must be excluded from insurance contracts because they are not insurable. Such risks would include, war and acts of war, self inflicted injuries, certain exclusions for hazardous occupations or avocations, such as sky diving, scuba diving, auto racing, etc. In reality, it is likely that coverage for persons who engage in hazardous activities would be available for an additional premium.

Exercise

Match the following descriptions with the concepts listed below by selecting the correct letter for each concept and writing it next to the description.

___ A. A promise to pay for losses in exchange for the insured's premium.
___ B. The company states what it will not do.
___ C. Includes information such as the name of the policyowner, name of the insured, and premium required.
___ D. Details the duties and rights of both parties.

1. Policy Face
2. Insuring Clause
3. Conditions
4. Exclusions

Answer: A. 2. Insuring Clause; B. 4. Exclusions; C. 1. Policy Face; D. 3. Conditions
Contract Construction

When the courts have a case involving contracts it looks at the “rules of construction” to interpret the contract. The rules of construction help to identify and establish the intent of the parties to the contract. There are five major areas which the courts review in order to interpret the contract, establish the intent of the parties, and hand down a ruling.

Plain Language And Word Definitions

If the language of the contract is clear the courts do not have to interpret the meaning of the contract. The courts give the words in the contract their “ordinary meaning.” In cases where ordinary words have been used in a technical capacity, then the technical meaning of the word is accepted.

The Entire Contract

The courts look at the entire contract to determine the intent of the parties. It does not consider material added to the basic contract, nor does it take only parts of the contract to make a determination. Once the intent of the contract has been established, individual clauses which might tend to contradict the general intent of the contract will not take precedence over the intent of the entire contract.

Interpretation In Favor Of Valid Contract

Because the courts assume that when people make a contract they intend for it to be valid, the courts will, if possible, render an interpretation of the contract which makes it valid rather than invalid. Even if a party to the contract did not have the intention of making a valid contract, the courts will if possible, interpret the contract as being valid, and the dishonest party then becomes involved with charges dealing with fraud.

Unclear Contract Of Adhesion Interpreted Against The Insurer

If a contract contains wording which is unclear the courts will interpret the language used against the writer of the contract, unless the wording used is required by law to be stated in a specific manner. Insurance contracts are contracts of adhesion, which mean the insured had no part in determining the wording of the contract, therefore the courts will interpret the contract in favor of the policyholder, insured, or beneficiary.

Written Contracts

If a contract contains unclear or inconsistent material between printed, typed, or handwritten material in the contract, the typed, or handwritten material will determine intent. Where there is a discrepancy between typed material and handwritten material, the handwritten material will determine the intent. This procedure is used because printed material is standard and for general use, but typed or handwritten material is added to the existing printed material and is a better indication of the parties' intent.
More and more states are developing regulations dealing with these areas of contract construction. Regulations now govern areas of contract construction, which include the following:

- Commonly accepted definitions of words
- The use of “plain language” in the contract
- The kind of type or print used in contracts

**Contract Characteristics**

The insurance contract has certain characteristics not typically found in other types of contracts.

**Utmost Good Faith**

The insurance contract requires utmost good faith between the parties. This means that each party is entitled to rely upon the representations of the other and each party should have a reasonable expectation that the other is acting in good faith without attempts to conceal or deceive. In a contract of utmost good faith, the parties have an affirmative duty to each other to disclose all material facts relating to the contract. That is not just a duty not to lie, but also a duty to “speak up.” Failure to do so usually gives the other party ground to void the contract.

**Aleatory**

An insurance contract is said to be “aleatory,” or dependent upon chance or uncertain outcome, because one party may receive much more in value than he or she gives in value under the contract. For example, an insured who has a loss may receive a greater payment from an insurer for the loss than he or she has paid in premiums. On the other hand, an insured may pay his or her premiums and have no loss, so the insurer pays nothing.

**Adhesion**

In insurance, the insurer writes the contract and the insured “adheres” to it. Although the insured may request special provisions or coverages, it is the insurance company that ultimately draws up and issues the policy. This concept is important because when a contract of adhesion is ambiguous in its terms, the courts will interpret the contract against the party who prepared it. The courts will usually grant any reasonable expectation on the part of the policyowner or the beneficiaries from a contract that was drawn up by the insurance company.

**Unilateral**

Contracts may be bilateral or unilateral. An exchange of a promise for a promise is bilateral, whereas an exchange of an act for a promise is unilateral. Generally, insurance contracts are unilateral. This means that after the insured has completed the act of paying the premium, only the insurer promises to do anything further. The insurer has promised performance and is legally responsible. The insured has made no legally enforceable promises and cannot be held for breach of contract. For example, the insured may stop paying premium because he is not legally responsible to continue paying premium.
Executory

An insurance contract is an **executory contract** in that the promises described in the insurance contract are to be *executed in the future, and only after certain events (losses) occur.*

Conditional

Insurance contracts are also **conditional** contracts because when the loss occurs certain conditions must be met to make the contract legally enforceable. For example, a policyholder might have to satisfy the test of having an insurable interest, and satisfy the condition of submitting proof of loss.

A condition is a contract provision which limits the rights contained in the contract. A **condition precedent** means that an act must be performed, or an event must take place before the right is met. For example, an insured must become injured to collect the medical benefit; or the insured must die before a spouse can collect the death benefit. A **condition subsequent** exists when an act or event is of such nature as to cancel a right. For example, if the contract contains a provision that denies payment of the death benefit in the case of suicide, within a two-year period of the policy effective date, the insured who commits suicide within one year cancels the existing right of payment of the death benefit.

Personal Contract

Generally, insurance policies are personal contracts between the insured and insurer. Except for life insurance and some marine coverages involving transportation and cargo, insurance is not transferable to another person without the consent of the insurer. Fire insurance, for example, does not follow the property. If an owner sells an insured building and no arrangements are made for transferring coverage to the new owner, no insurance exists—the previous owner no longer has insurable interest, and the new owner has no personal coverage.

Warranties And Representations

A **warranty** is something that becomes part of the contract itself and is a statement which is considered to be **guaranteed** to be true. Under a strict interpretation, any breach of warranty provides grounds for voiding the contract.

A **representation** is a statement **believed** to be true to the best of one’s knowledge. An insurer seeking to void coverage on the basis of a misrepresentation usually has to prove that the misrepresentation is material to the risk.

Under most state laws, an applicant’s statements or responses to questions on an application for insurance (in the absence of fraud) are considered to be representations, and not warranties.

An example would be a question on the application asking for your sex or date of birth. You represent yourself to the insurance company as being male or female, and a certain age. The accuracy of these items is very important to the insurance company issuing the policy. If they are incorrect, they may be considered misrepresentations, and the policy may be voided as a result.
There is a difference between representation of a fact and an expression of opinion. A good example is a question on many applications: “Are you now to the best of your knowledge and belief in good health?” If the applicant answers “yes” while knowing in fact that he or she is not, there is a misrepresentation of actual fact. If, on the other hand, he or she has had no medical opinion and suffers from no symptoms recognizable to a layman, his or her answer is an opinion and thus not a misrepresentation.

**Impersonation**

Impersonation means assuming the name and identity of another person for the purpose of committing a fraud. The offense is also known as false pretenses. In the case of life insurance, an uninsurable individual applying for insurance may ask another person to substitute for him to take the physical examination.

**Misrepresentation And Concealment**

A misrepresentation is a written or oral statement which is false. Generally, in order for a misrepresentation to be grounds for voiding an insurance policy, it has to be material to the risk.

Concealment is the failure to disclose known facts. Generally, an insurer may be able to void the insurance if it can prove that the insured intentionally concealed a material fact.

Material information or a material fact is something which is crucial to acceptance of the risk. For example, if the correct information about something would have caused the insurance company to deny a risk or issue a policy on a different basis, the information is material.

**Fraud**

Fraud is an intentional act designed to deceive and induce another party to part with something of value.

Fraud may involve misrepresentation and/or concealment, but not all acts of misrepresentation or concealment are acts of fraud. If someone intentionally lies in order to obtain coverage or to collect on a false claim, that would be a matter of fraud. If someone misrepresents something on an application (perhaps a medical treatment the person is embarrassed to talk about) without any intent to obtain something of value, no fraud has occurred.

**Parol (Oral) Evidence Rule**

The parol evidence rule limits the impact of waiver and estoppel on contract terms by disallowing oral evidence based on statements made before the contract was created. It is assumed that any oral agreements made before contract formation were incorporated into the written contract. Once formed, earlier oral evidence will not be admitted in court to change or contradict the contract. An oral statement may waive contract provisions only when the statement occurs after the contract exists.
1. Ralph is a producer for Hoosier Insurance Company. His contract states that he is allowed to put the company’s logo on his business cards and the door to his office. This is an example of

(  ) A. express authority.
(  ) B. implied authority.
(  ) C. lingering implied authority.
(  ) D. apparent authority.

2. Tom has always made a practice of having his policyholders mail their premium checks directly to him, and forwarding them on to the insurer, so that he is aware of anyone missing a payment and can contact policyowners directly if that should happen. His contract does not allow this, but the insurer is aware of the practice and has not asked him to stop. This practice is an example of

(  ) A. express authority.
(  ) B. implied authority.
(  ) C. lingering implied authority.
(  ) D. apparent authority.

3. Gina accepts the initial premium when she sells an insurance policy, and sends it to the company with the application. Nothing in her contract mentions handling of initial premiums. This is an example of

(  ) A. express authority.
(  ) B. implied authority.
(  ) C. lingering implied authority.
(  ) D. apparent authority.

4. Albert’s life insurance premium is due on the 10th of the month. Because he gets paid at the end of the month, he has always sent the premium in late. The insurer has been accepting his premium this way for 3 years when a new CEO comes in and decides to crack down on late premiums, canceling Albert’s policy for nonpayment of premium. Albert contests this decision legally and gets the policy reinstated. The decision to reinstate the policy is an example of

(  ) A. estoppel.
(  ) B. waiver.
(  ) C. contract of adhesion.
(  ) D. express authority.

5. When representing an insurer, a producer acting as an agent has a responsibility to act with the degree of care that

(  ) A. a licensed insurance producer would apply under similar circumstances.
(  ) B. a reasonable person would apply under similar circumstances.
(  ) C. a lawyer would apply under similar circumstances.
(  ) D. any person would apply under similar circumstances.
6. Which element is not necessary for the formation of a valid contract?
   ( ) A. Consideration
   ( ) B. Competent parties
   ( ) C. Written document
   ( ) D. Legal purpose

7. The initial premium payment sent with an application constitutes which part of the insurance contract?
   ( ) A. Consideration
   ( ) B. Acceptance
   ( ) C. Offer
   ( ) D. Legal purpose

8. Life insurance contracts contain all of the following except:
   ( ) A. policy folder.
   ( ) B. insuring clause.
   ( ) C. conditions.
   ( ) D. exclusions.

9. Ken has paid only four premiums on his health insurance policy when he is hit by a car. The insurance company pays out nearly half a million dollars to cover his treatment and a lengthy stay in intensive care. This is an example of
   ( ) A. contract of adhesion.
   ( ) B. aleatory contract.
   ( ) C. unilateral contract.
   ( ) D. utmost good faith.

10. Carol applies for a life insurance policy and pays the initial premium. Carol has
    ( ) A. accepted an offer from the insurer.
    ( ) B. made an offer to the insurer.
    ( ) C. accepted a counter offer from the insurer
    ( ) D. made a counter offer to the insurer.

11. The insurer looks at Carol’s application and decides to offer Carol a modified policy, including an exclusion Carol did not request. The insurer has
    ( ) A. accepted an offer from Carol.
    ( ) B. made an offer to Carol.
    ( ) C. accepted a counter offer from Carol.
    ( ) D. made a counter offer to Carol.

12. The failure to disclose known facts is
    ( ) A. misrepresentation.
    ( ) B. concealment.
    ( ) C. fraud.
    ( ) D. impersonation.
13. The promises described in the insurance contract are to be executed in the future after certain events occur.

( ) A. Utmost good faith
( ) B. Executory
( ) C. Aleatory

14. One party may receive much more from the contract than he or she gives in exchange.

( ) A. Utmost good faith
( ) B. Executory
( ) C. Aleatory

15. Both parties to the contract have an affirmative duty to disclose all information relevant to the contract, whether it is requested or not.

( ) A. Utmost good faith
( ) B. Executory
( ) C. Aleatory

Answers:
1. A. express authority.
2. D. apparent authority.
3. B. implied authority.
4. A. estoppel.
5. B. a reasonable person would apply under similar circumstances.
6. C. Written document
7. A. Consideration
8. A. policy folder.
9. B. aleatory contract.
10. B. made an offer to the insurer.
11. D. made a counter offer to Carol.
12. B. concealment.
13. B. Executory
14. C. Aleatory
15. A. Utmost good faith
UNIT 4
UNDERWRITING BASICS

LEARNING OBJECTIVES

After completing Unit 4—Underwriting Basics, you will be able to:

1. Describe the role played by each of the following: applicant, policyowner, insured, and beneficiary.
2. Define third-party ownership, and list some situations where it might be appropriate.
3. Explain the importance of the underwriting process in regards to policy issuance.
4. Define adverse selection, and explain why it is relevant to policy issuance.
5. List five sources of underwriting information, and briefly describe the type of information available from each.
6. List the four parts of the typical life or health insurance application and describe the type of information requested on each.
7. Briefly describe the safeguards that must be used if a company wants to use a blood test for the AIDS virus prior to policy issue.
8. List and define the three types of insurance risk.
9. List and describe the factors used in determining life or health insurance rates.
10. List the possible premium modes, and explain the effect that varying premium modes have on the total cost of the policy.
11. Describe how loss ratios and expense ratios work, and what they indicate.
12. Explain reserves as they are required in the insurance industry.
UNDERWRITING BASICS

Policy Issuance

Once the prospect has agreed to purchase the insurance contract, three important functions must take place:

- The underwriting process will begin
- The application will be approved and the policy issued (or declined)
- The producer will deliver the policy to the policyowner

Each of these activities is important—not only to provide the best possible service to the policyowners—but to comply with state laws regulating the writing of life insurance policies.

It is important to clearly understand all of the individuals who might be involved and the parts they play in the insurance process. These might include the applicant, the insured, the policyowner, and the beneficiary. Although these are four separate roles, they may all be played by one person, or by two, three, four, or more persons. Let us define them individually.

Applicant—the individual who fills out the application and applies for the insurance.

Policyowner—the individual who pays the premium, accepts the policy when it is delivered by the agent, has the special owner’s rights, such as designating beneficiaries. The policyowner is usually, but not necessarily, also the applicant.

Insured—the individual whose life is covered by the policy.

Beneficiary—the individual or individuals who the policyowner has named to receive the benefits of the policy.

Most of the time, the applicant, policyowner and the insured are the same person. For example, a husband who applies for insurance on his own life will be the insured and most often will also be the policyowner.

The term third-party ownership refers to a situation where the policy is owned by someone other than the insured. For example, in a business situation, a corporation may apply for insurance on the life of a key employee. In this case, the corporation is the applicant and the policyowner, and the key employee is the insured. The corporation would also be the beneficiary.
THE UNDERWRITING PROCESS

By definition, underwriting is the process of selection, classification and rating of risks. Simply put, underwriting is a risk selection process. The selection process consists of evaluating information and resources to determine how an individual will be classified (standard or substandard). Once this part of the underwriting procedure is complete, the policy will be rated in terms of the premium which the applicant will pay. The policy will then be issued and subsequently delivered by the producer.

Selection Criteria

An underwriter’s job is to use all the information gathered from many sources to determine whether or not to accept a particular applicant. Individuals applying for individually owned life and health insurance receive more underwriting scrutiny than members of a group. The following concepts apply primarily to individual underwriting. Group underwriting considerations are discussed in the next unit. The underwriter must exercise judgment based on his or her years of experience to read beyond the facts and get a true picture of the applicant’s lifestyle. Are there any factors (occupation, hobbies, lifestyle) which make this individual likely to die before his or her natural life expectancy? Is there any reason to anticipate that this individual will be ill or involved in an accident that will cause high medical expenses? An underwriter cannot, and is not expected to, foresee all circumstances. However, the underwriter’s purpose is to protect the insurance company insofar as he or she can against adverse selection—very poor risks, and those parties with fraudulent intent.

Adverse selection exists when the group of risks insured is more likely than the average group to experience loss. For instance, in a randomly-selected group of 1,000 25-year-old individuals, only two might be expected to die in a given year. However, human nature is such that many healthy 25-year-olds do not see the need to buy life insurance and prefer to spend their money elsewhere. It is only those 25-year-olds who are ill or perhaps employed in dangerous occupations who are likely to buy insurance. An underwriter must take care not to accept too many of these poorer-than-average risks or the insurance company will lose money.

Exercise

Match the following descriptions with the terms below:

_____A. The individual who pays the premium.
_____B. The individual whose life is covered by the policy
_____C. The individual who fills out the application.
_____D. The individual named in the policy to receive benefits.

1. Applicant
2. Policyowner
3. Insured
4. Beneficiary
E. The tendency for poor risks to seek and be covered by insurance more often than average risks is

( ) 1. inappropriate selection.
( ) 2. adverse selection.
( ) 3. inappropriate risk.
( ) 4. adverse risk.

Answer: A. 2. Policyowner; B. 3. Insured; C. 1. Applicant;
D. 4. Beneficiary; E. 2. adverse selection

Sources Of Underwriting Information

The underwriter has various sources of information to provide the necessary information for the risk selection process. These sources include:

- The application
- Medical exams and history
- Inspection reports
- The Medical Information Bureau (MIB)
- The agent

The Application. The application is a vital document because it is usually attached to and made a part of the contract. The producer must take special care with the accuracy of the application in the interest of both the company and the insured.

Application forms vary as to the type and amount of information required to complete the form. Insurers may use different forms for different insurance coverages, or they may use a multipurpose form.

The application is divided into sections or parts. Each section is designed to obtain specific types of information. The form of the application may differ from one company to another. However, most applications provide the following information:

- Part I—General Information
- Part II—Medical Information
- The Agent’s Statement or Report
- Proper signatures of all parties to the contract

Part I

Part I of the application asks for general or personal data regarding the insured. This would include such information as: name and address, date of birth, business address and occupation, Social Security number, marital status, and other insurance owned. In addition, if the applicant and the insured are not the same person, then the applicant’s name and address would be included in Part I.
Part II

Part II of the application is generally designed to provide information regarding the insured’s past medical history, current physical condition and personal morals. If the insurance applied for qualifies as “non-medical”, then the producer and the insured will complete Part II of the information. In some cases, the proposed insured is required to take a medical examination and Part II of the application is completed as part of the physical exam.

Part II of the application provides information regarding the past medical history of the insured by asking questions related to the types of illnesses and accidents experienced by the insured; periods of hospitalization and any surgery and reasons for visits to any physician.

In addition, Part II requires information regarding the current health of the insured by asking for current medical treatment for any sickness or condition and types of medication taken. The name and address of the insured’s physician is also required.

Usually Part II of the application will also include questions regarding alcohol and any drug use by the insured. Avocations and high risk hobbies are also usually reported on Part II. Generally, any plans for a prolonged trip or stay in a foreign country are also reported in Part II. Naturally, questions regarding alcohol and drug use are designed to help determine the morale attitude of the insured.

Attending Physician’s Statement

Another source of medical information available to the underwriter is an Attending Physician’s Statement (APS). After a review of the medical information contained on the application or the medical exam, the underwriter may request an APS from the proposed insured’s doctor. Usually, the APS is designed to obtain more specific information about a particular medical problem.

Medical Examinations And Testing

Medical examinations, when required by the insurance company, are conducted by physicians or paramedics at the company’s expense. Usually such exams are not required with regard to health insurance, thus the importance of the agent in recording medical information on the application. The medical exam requirement is much more common with life insurance underwriting than with health insurance underwriting.

Simplified issue life insurance requires no medical exam and only asks very basic health-related questions on the application. Usually this type of insurance is only available in low face amounts, to reduce the risk of adverse selection against the company.
AIDS Considerations

Beginning in the decade of the 1980s, a new concern for life and health insurers came to the forefront: the risk to life and health from acquired immune deficiency syndrome or AIDS. Individual health insurance buyers and the providers of health coverages have been greatly impacted by the enormous threat of this problem for which no cure now exists.

State legislatures and the insurance industry began developing responses to AIDS as well as to two related conditions:

- AIDS-related complex (ARC), which is caused by the same virus as AIDS—HIV-III—but may have less severe symptoms, and
- Positive test results for antibodies of human T-cell lymphotropic virus type III (HTLV-III)

Together, AIDS, ARC and HTLV-III are the subject of AIDS legislation covering a broad range of considerations including testing, discrimination, reporting, jobs, and confidentiality. We are concerned here primarily with how these diseases and related laws affect health insurance.

That these are diseases, just like any other disease, is a key point of insurance legislation. Many states instruct insurers to treat AIDS, ARC and HTLV-III infection exactly like other disease or illness in these ways:

- Underwriting decisions must be applied in the same manner as for other diseases.
- Provisions regarding coverage limitations, deductibles, exclusions, coinsurance, and similar clauses must be applied in the same way as for other diseases.
- Claim settlement considerations (such as when an illness begins or when a new claim should be submitted, rather than being considered a continuation of an old claim), must be on the same basis as other diseases.

In general, it is accurate to say that legislation requires insurers to make no basic distinctions in the way insurers handle insureds or applicants with AIDS-related conditions and the way they handle insureds or applicants with other diseases.

State legislatures that have adopted specific AIDS insurance regulations often pointedly prevent insurers from attempting to identify in the applicant population those who appear likely to develop an AIDS-related condition. For example, insurers may be specifically prohibited from looking at certain characteristics of individuals in order to attempt to predict these health conditions, especially characteristics such as sexual orientation, marital status, and geographical area of residence. Instead, insurers are expected to develop sound statistical bases (just as they do for conditions such as heart disease or cancer) to draw upon in making decisions to do the following:

- Accept or reject an applicant
- Rate an applicant as a standard or substandard risk
- Renew, nonrenew or cancel a policy
Basically, most state legislation concerning AIDS and AIDS-related conditions and insurance is designed to ensure that insurers do not unfairly discriminate when making underwriting decisions against persons who have certain characteristics.

Even as efforts are being made to ensure nondiscrimination in providing coverage for AIDS-related conditions, some interest groups are attempting to prevent insurers from using screening tests to detect AIDS antibodies. The argument generally addresses the issues of privacy, confidentiality and unfair discrimination. Insurers, on the other hand, claim that prohibitions against using such tests set AIDS conditions apart from other diseases—exactly the opposite intent of insurance legislation—since insurers have routinely been able to order medical testing for other conditions such as diabetes, high cholesterol levels or high blood pressure.

While issues regarding privacy and underwriting may still be in a state of flux, one thing is certain: the costs for treating HIV and AIDS are going up. With the introduction of powerful drugs like protease inhibitors, many of those infected with HIV or even full-blown AIDS are now able to lead normal or near-normal lives, living far longer than could have been expected just a few years ago. Unfortunately, these drugs can be very expensive—up to $24,000 per year or more. For those with health insurance, either group or individual, that covers prescription drugs, the cost of their treatment can have an impact on the overall cost of health insurance.

Currently, state laws vary widely in regard to using certain tests to detect AIDS antibodies and using the results to make underwriting decisions. Blood tests for the AIDS virus prior to policy issuance are a common underwriting requirement. Typically, the proposed insured must sign a consent form before the blood test is performed. AIDS testing is almost always required whenever a large amount of insurance is applied for. Each insurance company sets thresholds for the ages and amounts of insurance for when medical underwriting (including blood tests for the AIDS virus) will be required.

Test results are confidential and certain procedures must be followed to inform the applicant of any positive results. A signed release form is required whenever test results will be disclosed to any party who is not otherwise entitled to the information.

**Agent’s Statement**

The Agent’s Statement is part of the application and requires that the agent provide certain information regarding the proposed insured. Generally, this includes information regarding the producer’s relationship to the insured, data about the proposed insured’s financial status, habits, general character and any other information which may be pertinent to the risk being assumed by the insurer.

The application will also record information regarding the policyowner/insured’s choices with regard to the mode of premium (monthly, annually, etc.), the use of dividends and the designation of a beneficiary.
Finally, the signatures of the insured (and the policyowner if different from
the insured) are required in the appropriate places on the application. Usu-
ally, the producer also signs the application as a witness to the applicant’s
signatures.

**Inspection Reports**

To supplement the information on the application, the underwriter orders an
inspection report on the applicant from an independent investigating firm or
credit agency, which covers financial and moral information. This information
is used to determine the insurability of the applicant. If the amount of insur-
ance applied for is average, the inspector will write a general report in regard
to the applicant’s finances, health, character, work, hobbies, and other habits.
The inspector will make a more detailed report when larger amounts of insur-
ance are requested. This information is based on interviews with the appli-
cant’s associates at home (neighbors, friends), at work, and elsewhere.

**Investigative Consumer Reports**

An “investigative consumer report” includes information on a consumer’s
character, general reputation, personal habits, and mode of living that is
obtained through investigation, i.e., interviews with associates and friends
and neighbors of the consumer. Such reports may not be made unless the
consumer is clearly and accurately told about the report in writing.

This consumer report notification is usually part of the application. At the
time the application is completed, the producer will separate the notification
and give it to the applicant.

**Medical Information Bureau**

Another source of information which may aid the underwriter in determining
whether or not to underwrite a risk is the Medical Information Bureau (MIB),
based in Westwood, Massachusetts. This is a nonprofit trade association which
maintains medical information on applicants for life and health insurance.
The MIB has over 600 member companies that write 80% of the health insur-
ance and 99% of the life insurance policies in the U.S. and Canada.

The MIB maintains a database of medical information and avocation risks on
applicants for life and health insurance. For every 10 applicants, the MIB will
have a file on one or two. MIB information is reported in code form to member
companies in order to preserve the confidentiality of the contents. The data-
based does not contain any details about the risk. The codes simply alert com-
panies to the fact that there was information obtained and reported by a
member company on this particular impairment or avocation risk. The report
does not indicate any action taken by other insurers, nor the amount of life
insurance requested.

Underwriters compare the MIB file against the information contained in the
application. If the MIB file contains a code for a condition that should be listed
on the application but isn’t, the underwriter would then inquire more specifi-
cally about that area. For example, an MIB file might contain a code indicat-
ing high cholesterol levels, while the application indicates that the applicant
had no ongoing medical conditions. This would prompt the underwriter to investigate whether the applicant had misrepresented his or her health status, or perhaps had been able to reverse the condition.

In addition to tracking medical and avocation information, the MIB also reports the number of times information has been requested on an individual in the previous two years. There are two reasons for this report, which is called the Insurance Activity Index (IAI). The first reason is to allow insurance companies to identify people who frequently replace their insurance policies. Since most of the costs associated with issuing a policy occur in the first one or two years, insurance companies are interested in identifying individuals who are likely to cancel their policy after only a year.

The IAI may also identify situations where an individual is loading up on insurance policies by applying for a series of smaller policies that might fall below the radar screen for other underwriting requirements. By purchasing several small to mid-size policies, an individual may be trying to avoid drawing attention to the accumulation of an extremely generous death benefit. There have been situations where this has occurred as part of criminal “murder for profit” schemes.

An insurer may not refuse to accept a risk based solely on the information contained in an MIB report. There must be other substantiating factors which lead an insurer to decide to deny coverage. The MIB must provide explanations to applicants who are denied coverage, allowing consumers to challenge possibly inaccurate information about their medical history.

**Field Underwriting**

A key element in the underwriting process is the role of the insurance producer. It can be argued that the producer is the most important part of the risk selection process. The producer is in a position to see and talk to the proposed insured, to ask the questions contained on the application and to accurately and completely record the answers to those questions.

Thus, one of the most important functions of the producer is the completion of the application. Much of the information reported on the application becomes the basis upon which to accept or reject the proposed insured. In addition, a signed and witnessed copy of the application becomes part of the policy, the legal contract between the insured and the insurer.

As a field underwriter, the producer can help expedite the underwriting process by the prompt submission of the application, by scheduling the applicant for a physical exam (if necessary) and by assisting the home office underwriter with other requirements such as obtaining an APS.

The most important element of this process for the producer is the accuracy, thoroughness and honesty displayed when completing the application. Answers to questions must be recorded accurately, and completely by the producer. In addition, honest reporting is required. The producer may not omit pertinent information or report it inaccurately in order to get the policy issued. The ethical conduct of the producer with regard to the underwriting process must be above reproach.
Finally, if the proposed insured is rated or declined for the insurance, it is the producer’s role as a field underwriter to explain the reasons for the underwriting action. Seldom is an individual declined for life insurance but it does happen that they may be classified as substandard and thus a rated or substandard policy may be issued in lieu of the one applied for. When this occurs, the producer must be prepared to not only explain the reasons for the substandard rating but also to explain the rated policy which the company has issued. In addition, there are usually some underwriting forms (amendments or revisions) which must be signed by the applicant when the policy is delivered and it is the producer’s responsibility to return these signed forms to the home office.

**Exercise**

Match the following descriptions with the terms below:

___ A. A source that may provide additional information based on risks listed in previously applied-for insurance policies.

___ B. The part of the application designed to obtain more specific information about a particular medical problem.

___ C. The part of the application that asks for general or personal data on the proposed insured.

___ D. The part of the application that requires the producer to provide information about the proposed insured.

___ E. The part of the application designed to provide information regarding the insured’s medical history.

___ F. A source that may provide additional information based on interviews with the proposed insured’s associates.

1. Part I  
2. Part II  
3. Attending Physician’s Statement  
4. Agent’s Statement  
5. Medical Information Bureau  
6. Inspection Reports

**Answer:** A. 5. Medical Information Bureau; B. 3. Attending Physician’s Statement; C. 1. Part I; D. 4. Agent’s Statement; E. 2. Part II; F. 6. Inspection Reports

**CLASSIFICATION OF RISKS**

As was previously stated, underwriting is the process of selection, classification and rating of risks. Risk classification refers to the determination of whether a risk is standard or substandard based on the underwriting or risk evaluation process. Basically, a standard risk is simply an average risk.

**Standard risks** are those who bear the same health, habit, and occupational characteristics as the persons on whose lives the mortality table used was compiled. Most insurers offer special but higher rates to persons who are not acceptable at standard rates because of health, habits or occupation. This is
sometimes called “extra risk” insurance. Some companies have coined euphemistic names for it in order to avoid the rather insulting implication that persons offered this type of coverage are substandard. About 90% of individuals covered are standard risks. Less than 2% of individuals applying are turned down for coverage completely.

There are several methods of determining the extra rate for the substandard class of risk:

- **Rated-Up Age:** This plan assumes that the insured is older than his or her actual age, which is a way of saying that he or she will not live as long or remain as healthy as a “standard” risk. Thus an impaired risk of age 35 may be issued a policy as applied for but with the rate of age 40. While having the merit of simplicity of handling, this method is no longer widely used.
- **Flat Additional Premium:** A constant (that is, not varying with age) additional premium is added to the “standard” rate.
- **Tabular Rating:** Applicants are classified on the basis of the extent to which mortality of risks with their impairment or degree of impairment exceeds that of the “standard” risk. Percentage tables are developed and used to calculate the amount of extra premium to be charged for any class of impaired risks. Extra percentage tables are usually designated as “Table A,” “Table B,” etc. Each usually reflects about a 25% increase above 100%, or “standard.” Insurers vary in the number of tables on which they will accept risks. One may not accept anything lower (or “higher,” depending on viewpoint) than, say, Table C (175%). Another may write through Table F (250%). Companies can be found that will write up to 1,000%—or perhaps even higher. More and more high risk cases are becoming acceptable (and, also, many conditions once considered “high risk” are now, on the basis of more experience, being accepted as “standard”). Today it is a rare case when coverage cannot be found anywhere for almost any risk.
- **Graded Death Benefits:** The insured pays the standard premium for, say, $20,000 of insurance but receives a policy with a face amount of perhaps $15,000. After some time has elapsed the company may increase the amount of insurance periodically and when the company considers the substandard condition to no longer exist, the full $20,000 of coverage would be granted.

**Preferred Risks.** If a substandard risk presents an above average risk of loss, a preferred risk presents a below average risk of loss. In an effort to encourage the public to practice better health, the insurance industry has developed preferred risk policies with lower (or preferred) premium rates. Those applicants who may be eligible for preferred risk classification are those who:

- Work in low risk occupations and do not participate in high risk hobbies (scuba diving, sky diving, etc.)
- Have a very favorable medical history
- Presently are in good physical condition without any serious medical problems
- Do not smoke
- Meet certain weight limitations
DETERMINATION OF PREMIUMS
(RATING CONSIDERATIONS)

The final step in the underwriting process is the rating of the risk or the
determination of the premium. There are three factors used in determining
insurance rates:

- Mortality (life insurance rates) or Morbidity (health insurance rates)
- Interest
- Expenses

Mortality Or Morbidity

If an underwriter could predict exactly how long each insured would live, he
could charge a premium for each risk that was precisely correct for covering
the policy face amount, and expenses, while taking into account the interest to
be earned on the premium paid. Of course an underwriter cannot do this on an
individual policy, but he can predict the probability of numbers of deaths for a
large group of people. The larger the number of people and deaths recorded,
the more reliably actuaries can predict how many will die at a specific age in
the entire population of insureds of that age. If the records are kept for many
millions of people over a long period of time, the predictability becomes very
reliable. This is an example of the Law of Large Numbers in action.

Insurance companies have kept the kind of records required to produce pre-
cise predictions, and the result is called a mortality table. The table is based
on statistics kept by insurance companies over the years on mortality by age,
sex, and other characteristics.

The deaths per 1,000 (mortality rate) is taken from the mortality table and
converted into a dollar and cents rate. For instance, if the mortality rate for a
particular age group is 3.00, it means, on the average, three out of every 1,000
can be expected to die at that age.

An insurance company would need to collect $3 from each of 1,000 policyown-
ers in order to have sufficient premium to pay out $1,000 in benefits for those
who die in that age group.

To illustrate:  
\[
1,000 \times 3 = 3,000 \\
3 \text{ deaths} \times 1,000 = 3,000 
\]

Health insurance policies use related but much more complex statistics to
determine morbidity rates. Morbidity is the likelihood that a person will
suffer an accident, contract a disease, or otherwise require medical care. For
many years, insurance companies have kept records that document the out-
come of insuring various types of risks. For instance, they know that older
people are more likely to become ill than younger people, so health insurance
premiums tend to be higher for older people. Similarly, insurers know that
people employed in certain occupations are more likely to be injured than
those in other occupations. These determinations are based on what has hap-
pened in the past, the company’s and the industry’s experience.
In order to set rates for health insurance, however, insurers need to consider not only how often people will become ill or injured, but at how much it will cost when they do. Insurers look at how frequently claims happen among a particular population, or the claim frequency rate, as well as the average dollar amount per claim. These two figures are multiplied to create the aggregate claim amount, which is a primary element in calculating health insurance rates.

**Interest**

Because premiums are paid in advance of claims, insurance companies have money to invest to earn interest. This interest helps to lower the premium rate.

As explained, the basic cost of life or health insurance is the cost of mortality or morbidity, however, in constructing a rate, interest enters in. It is assumed that all premiums are paid at the beginning of the year and all claims paid at the end. Therefore, it becomes necessary to determine how much should be charged at the beginning of the year, assuming a given rate of interest, to have enough money at the end of the year to pay all claims.

**Expenses**

Using the cost of mortality and discounting for interest, there is enough money to pay claims, but we have no money to pay operation expenses. The premium without expense loading is a “net” premium. (Do not confuse “net” as it is used here with the same term sometimes used to indicate a participating premium minus dividends paid.)

An expense loading is added to the net premium in order to: (1) cover all expenses and contingencies, (2) have funds for expenses when needed, and (3) spread cost equitably among insureds.

Loading consists of four main items:

- **Acquisition Costs**—All costs in connection with putting the policy on the books are charged as incurred in the insurance accounting. In most cases, these costs will be so proportionately high in comparison to ensuing years that they must be amortized over a period of years. One of the highest acquisition costs is the producer’s first year commission. This is the reason a policy that lapses in the first two or three years creates a loss for the insurer. It has not yet recovered acquisition costs.

- **General Overhead Loading**—Clerical salaries, furniture, fixtures, rent, management salaries, etc., must be considered when determining expenses. The allocation of these costs is unaffected by the size of the premium, probably little affected by the face amount, but is most likely affected by the number of policies.

- **Loading for Contingency Funds**—Once a level premium policy has been issued, the premium can never be increased. However, unforeseen contingencies could make the rate inadequate. Assessment companies reserve the right to charge additional premiums in such a case. Legal reserve companies establish contingency reserves to draw on in such cases.
• **Immediate Payment of Claims**—In rate-making, it is assumed that all claims are paid at the end of the year. This is not literally true, of course. Relying on the law of large numbers, it is safe to assume that claims will be spread throughout the year. Therefore, theoretically, all claims will be paid six months before the end of the year. Allowance must be made for this loss in the expense loading.

The **gross annual premium**, the amount the policyowner actually pays for the policy, equals the mortality risk discounted for interest, plus expenses. By definition, the **net premium** is the mortality risk discounted for interest, without any expense adjustment.

By formula:

\[
Gross\ \text{Premium} = Mortality - Interest + Expenses
\]

\[
Net\ \text{Premium} = Mortality - Interest
\]

The risk factor increases with age. This is the reason that some life insurance policy premiums increase periodically. For example, the premium for a one-year renewable and convertible term insurance policy increases each year because each year the insured is one year older and thus the mortality risk is greater. This can result in very expensive premiums as the insured becomes older.

The **level premium** concept was devised to solve this problem of increasing premiums. Mathematically, the level premiums paid by the policyowner are equal to the increasing sum of the premiums caused by the increased risk of mortality. Accordingly, in the early years of the policy, the level premiums paid are actually more than the amount necessary to cover the cost of mortality. Conversely, in the later years of the policy, the premiums paid are less than the amount necessary to cover the increased cost of mortality. This “shortage” in the later years of the policy is accounted for by the overcharges (plus interest earned) in the early policy years.

**Premium Mode.** Once the single premium amount has been determined, the company will break this amount into smaller amounts (annual, semi-annual, quarterly, or monthly) which will be more convenient for the insured to pay. This frequency of payment is called the premium mode. This is important because the insurance company invests the premium amounts it receives and uses the income as part of the eventual settlement. The more payments the insured wishes to break his premium into, the higher the total premium. This is because of the interest lost by not receiving money for coverage in advance and because of increased administrative expenses.

**LOSS RATIOS**

Loss and expense ratios are basic guidelines as to the quality of company underwriting. A **loss ratio** is determined by dividing losses by total premiums received. Loss ratios are often calculated by account, by line of insurance, by “book of business” (all accounts placed by each producer or agency), and for all business written by an insurer. Loss ratio information may be used to make decisions about whether to renew accounts, whether to continue agency...
contracts, and whether to tighten underwriting standards on a given line of insurance. An **expense ratio** is determined by dividing an insurer's operating expenses (including commissions paid) by total premiums. When the combined loss and expense ratio is 100%, the insurer breaks even. If the combined ratio exceeds 100%, an underwriting loss has occurred. If the combined ratio is less than 100%, an underwriting profit, or gain, has been realized.

For example, let’s assume that the ABC Insurance Company realizes $3 million in underwriting losses for all term insurance policies. This same block of business also generates $10 million in premium. The loss ratio would be calculated as follows:

\[
\text{Loss Ratio} = \frac{\text{Losses}}{\text{Premiums}}
\]

\[
\text{Loss Ratio} = \frac{$3 \text{ million}}{$10 \text{ million}} = 30\%
\]

Further, let’s assume that the ABC Insurance Company has operating expenses totaling $2 million for this same block of term insurance. The expense ratio would be:

\[
\text{Expense Ratio} = \frac{\text{Operating Expenses}}{\text{Premiums}}
\]

\[
\text{Expense Ratio} = \frac{$2 \text{ million}}{$10 \text{ million}} = 20\%
\]

The combined loss and expense ratio equals 50%. Thus, the ABC Insurance Company has an underwriting gain or profit on this block of term insurance.

**RESERVES**

Insurers are required to follow certain regulations and laws to be certain they will have the money needed to pay claims as they arise. Funds set aside to pay future, existing and ongoing claims are known as **reserves**. Reserves are accounting measurements of an insurer's liabilities to its policyholders. Theoretically, the reserve is the amount together with interest to be earned and premiums to be paid that will exactly equal all of the company’s contractual obligations.

Companies must also keep enough on hand to pay claims that might arise should some major catastrophe occur on a local, regional or national basis. For instance, if a nationwide epidemic were to occur, causing widespread disability among insureds, insurance companies would need very large reserves to handle claims. Any reserves set aside to cover current or future claims are called unpaid claim reserves.

Since insurance premiums are paid in advance, an insurance company always has a certain amount of money which it has not yet earned by providing protection. This amount, too, is considered a reserve, called an **unpaid premium reserve**. When a policy is cancelled before its term ends, unpaid premium is ordinarily returned to the former policyowner.
A life insurance reserve is a fixed liability of the insurer. This liability represents the insurer’s promise to pay the face amount of the policy at some future time. By law, a portion of every premium must be set aside as a reserve against the future claim from the policy as well as other contractual obligations such as cash surrender and nonforfeiture values. Accordingly, the policy reserve is equal to the premiums paid plus the interest earned on those premiums and other policy obligations.

Insurance companies demonstrate their solvency to the state Insurance Departments by showing their assets as well as adequate funds to cover their reserve obligations. In addition to its assets, the insurer must show that it will continue to receive future premiums plus interest in order to cover its reserve obligation.

By law, the Insurance Commissioner requires that a specific reserve be maintained if a company is to be solvent. The reserve must be calculated using a mortality table and an interest specified by the Commissioner. Most states require that premiums be calculated using the Commissioner’s Standard Ordinary table. In addition, the estimated investment return or interest rate paid on the premiums will also be determined by the Insurance Commissioner. Usually, a very conservative interest rate is specified.

**REVIEW**

1. John fills out an application for a life insurance policy to insure his own life, and for which he plans to pay the premiums. John is playing all of the following roles **except**

   ( ) A. applicant.
   ( ) B. policyowner.
   ( ) C. insured.
   ( ) D. beneficiary.

2. Life insurance that requires no medical exam and asks only basic medical questions is known as

   ( ) A. simplified policy.
   ( ) B. simplified issue.
   ( ) C. simplified risk.
   ( ) D. preferred risk.

3. In many jurisdictions, testing for the presence of HIV infection requires all of the following **except**

   ( ) A. a signed consent form before the blood test is performed.
   ( ) B. a signed release form whenever test results will be disclosed to any party who is not otherwise entitled to the information.
   ( ) C. medical oversight of any testing by a specialist in HIV research.
   ( ) D. confidentiality of results in the absence of a signed release form.
4. Which of the following is not likely to be contained in a MIB report?
   ( ) A. Mr. Jones reported a heart condition on an insurance application two years ago.
   ( ) B. Mr. Smith was turned down for insurance by two companies in the past year.
   ( ) C. Mr. Green’s information has been requested 14 times in the previous two years.
   ( ) D. Mr. Brown reported a hobby as a flight instructor a year ago.

5. If an applicant is rated or declined an insurance policy, the reasons for this decision will be explained to the applicant by
   ( ) A. the producer.
   ( ) B. the underwriter.
   ( ) C. the insurer.
   ( ) D. the Insurance Commissioner.

6. A is a 25 year old who drinks occasionally, does not smoke or have any known health problems. A would probably be classified by an insurer as
   ( ) A. a standard risk.
   ( ) B. a substandard risk.
   ( ) C. a superstandard risk.
   ( ) D. a preferred risk.

7. Which of the following does NOT have an impact on insurance premium rates?
   ( ) A. Mortality or morbidity
   ( ) B. Interest rates.
   ( ) C. Producer certification
   ( ) D. Expenses

8. To be certain the insurer has the money available to pay claims as they arise, they are required to maintain
   ( ) A. a risk based capital ratio.
   ( ) B. reserves.
   ( ) C. expense ratios.
   ( ) D. reinsurance.

Answers:
1. D. beneficiary.
2. B. simplified issue.
3. C. medical oversight of any testing by a specialist in HIV research.
4. B. Mr. Smith was turned down for insurance by two companies in the past year.
5. A. the producer.
6. A. a standard risk.
7. C. Producer certification
8. B. reserves.
UNIT 5

GROUP INSURANCE

LEARNING OBJECTIVES

After completing Unit 5—Group Insurance, you will be able to:

1. Explain certificates of insurance.
2. List and describe five common types of groups that are eligible for insurance.
3. List three characteristics of groups authorized for group insurance.
4. Explain the difference between contributory and noncontributory policies, and list the minimum participation percentage for each.
5. Explain the difference between underwriting for group insurance policies and underwriting for individual insurance policies.
6. Define adverse selection and explain its importance to insurance underwriting.
7. Explain the probationary and eligibility periods.
8. List and describe one statutory, and seven optional underwriting requirements for group policies.
9. List and describe three mechanisms for funding group insurance.
10. List five types of groups eligible to purchase insurance, and describe each.
11. Explain the difference between contributory and noncontributory group insurance plans, and how participation limits affect each type of plan.
GROUP INSURANCE

Group insurance provides coverage to many people under one policy. It gets its name from the requirement that several people must first be members of a group before they become eligible to purchase the insurance.

A person who is covered by group insurance does not receive a policy as proof of insurance. As the master policyowner, the group receives and holds the insurance policy. The insured group members receive a certificate of insurance that certifies the coverage, the benefits under the policy, the name of the covered individual or individuals, and the name of the beneficiary if applicable.

TYPES OF GROUPS

The first type of group would be the employees of an eligible employer. This is called an employee group or an individual employer group. The employer is the policyowner, and establishes the eligible class of employees to be covered under the group policy.

Usually, this classification will include all full-time employees (including the employer). Further, the classification can also specify full-time, salaried, non-union employees. By classifying the employee group in this manner, the employer is legally able to exclude certain groups of employees (part-time, union, etc.) from the eligible class of covered employees. The eligible class of employees may also include retired employees.

A second type of group could be composed of several employers forming a trust fund to combine their workers for life insurance eligibility. This is known as a multiple employer group. The trusts are called multiple employer trusts or METs.

A policy may be issued to the trustees of a trust group if the fund has been

- Established by two or more employers in the same or related field
- Established by one or more labor unions or associations (this is known as a “Taft-Hartley Trust”)

The trustees are the policyholders of the plan which covers eligible employees. This type of plan must not be for the benefit of the employer, union or association. The individuals who may be considered “employees” as defined by this section are the same as those previously listed under employee group.
A third type of organization eligible for group insurance includes members of labor organizations, such as the United Auto Workers. An association or labor group must have the following characteristics to be considered an authorized group:

- Have a constitution and bylaws
- Be organized and maintained in good faith for purposes other than obtaining insurance
- Have insurance for the purpose of covering members, employees, or the employees of members for the benefit of persons other than the association or its officers or trustees

Credit insurance is written to provide payment of the insured's debt when he or she dies prematurely or is disabled due to accident or sickness. The creditor is the policyowner and the debtor the insured. Benefits under credit insurance are not permitted to exceed the amount of indebtedness.

**PREMIUMS**

Group insurance policies are often able to provide coverage at a lower premium than individual policies. One reason for this is that the administrative costs to cover a group of fifty people are much lower than the administrative costs involved in writing fifty separate policies.

Group insurance premiums are based on the experience of the group as a whole. Premium may be paid entirely by the policyowner, or it may be paid jointly by the policyowner and the insured. If the insured contributes money toward the premium, the plan is considered contributory. In most states, at least 75% of the eligible employees must participate under a contributory plan. If the premium is paid entirely by the policyowner, the plan is considered noncontributory. All of the eligible members must participate in noncontributory plans.

**Exercise**

A. To be eligible to purchase insurance, an association group must

   ( ) 1. have a constitution and bylaws.
   ( ) 2. be organized and maintained strictly for the purpose of obtaining insurance.
   ( ) 3. Have insurance for the purpose of covering the association or its officers or trustees only.

B. For group insurance policies, the covered individual receives proof of coverage in the form of

   ( ) 1. an insurance policy.
   ( ) 2. an insurance contract.
   ( ) 3. a certificate of coverage.
   ( ) 4. a certificate of policy.
C. If a group insurance policy is contributory, what percentage of eligible employees must participate?

( ) 1. no set percentage
( ) 2. 50%
( ) 3. 75%
( ) 4. 100%

Answer: A. 1. have a constitution and bylaws; B. 3. a certificate of coverage; C. 3. 75%

**GROUP UNDERWRITING CONSIDERATIONS**

Group life insurance is usually written on a group basis as opposed to an individual basis. In other words, the underwriter focuses on the group as a whole, rather than individual members. Each group participant completes a very short application form which usually consists of the individual's name, address, Social Security number, dependent information and beneficiary designation. There are no medical questions. Thus, no medical underwriting takes place. (However, evidence of insurability must be furnished by an employee who wants to join a contributory group after the period of eligibility has ended.)

It is therefore possible for individuals in poor health to receive group insurance benefits because there is no medical underwriting. All eligible participants obtain coverage. But underwriting, the risk selection process, does occur, to help protect insurers from adverse selection.

**Adverse Selection**

Adverse selection is the tendency for poor risks to seek and be covered for insurance more often than average risks. Thus in a group situation, the underwriter must consider such things as the type of work done, the ages of the participants, and the probability of this particular group being an adverse risk to the company. For example, a group of coal miners presents a much different risk than a group of bank employees.

The larger the group to be insured, the more predictable will be the expected losses from the group. Thus, it is more difficult for the underwriter to anticipate expected losses from relatively small groups (10, 20 or 25 participants).

Once a group is written, the underwriter wants the business to stay on the books and thus is concerned about the financial stability of the company. If the company has a history of financial problems, i.e., bankruptcy, layoffs due to no work, seasonal employment, then possibly the group may be declined for these financial reasons.

The group underwriter is concerned with the number of new group entrants. The insurer does not necessarily want a group in which there is no turnover. If the loss experience is to be favorable, employees must leave the group due to retirement or terminations and new (younger) employees must take their place. This turnover of employees helps bring some stability in terms of loss experience and possible adverse selection.
Adverse Underwriting Decisions

A risk will be rejected when the insurer believes the applicant cannot be profitable at a reasonable premium or with reasonable coverage modifications. If a risk is rejected based on information in an investigative report, the applicant must be notified and given the name and address of the reporting company. In health insurance, when renewal is denied, the insured must be given a written explanation for nonrenewal or be notified that the explanation is available upon written request.

Probationary Period

Often, individuals coming into a covered group will be required to serve a probationary period before becoming eligible for group coverage. It costs the insurer money to enroll an individual in a group plan. Some groups experience high turnover among membership. It would be prohibitively expensive, for example, to cover all workers in a business as of the first day of employment in businesses with high turnover.

To avoid this expense, the insurer usually requires that employees be on the job a specified period of time before the insurance is put into force. This period of time is often 90 days, though it can be longer or shorter.

Eligibility Period

If the group plan is noncontributory, all individuals become immediately covered after the probationary period. If the plan is contributory, the employees must first fulfill the probationary period, and then must enroll within the eligibility period to avoid medical underwriting. This is one way insurers protect against adverse selection.

The eligibility period typically runs for 30 or 31 days after the probationary period expires. If the group member does not apply during the eligibility period, he or she is generally required to take a medical exam before being eligible for coverage.

If an individual does not enroll during the eligibility period, but wants to enroll later, he or she will generally be required to take a physical examination, and will be selected on an individual basis, just as if the policy were an individual policy.

Exercise

A. Albert works as a window washer at the top of city skyscrapers. Bernie works as a window washer on the ground floor. The fact that Albert is more likely to seek insurance coverage than Bernie is an example of

   ( ) 1. risk selection.
   ( ) 2. adverse underwriting.
   ( ) 3. adverse selection.
   ( ) 4. risk underwriting.
B. Gianna starts work at a new job on March 1. She is not eligible for insurance coverage until July 1. The period of time between her start date and her eligibility date is

( ) 1. the probationary period.
( ) 2. the eligibility period.
( ) 3. the selection period.
( ) 4. the waiting period.

C. Gianna is eligible for coverage on July 1. She enrolls on July 15. She does not need to take a medical exam because she has enrolled within

( ) 1. the probationary period.
( ) 2. the eligibility period.
( ) 3. the selection period.
( ) 4. the waiting period.

D. Tom started work the same day Gianna did, at the same company. Tom doesn’t try to enroll in the company insurance plan until August 15. What will Tom probably need to do?

( ) 1. pay an extra premium
( ) 2. fulfill the probationary period again before coverage is available
( ) 3. look for insurance somewhere else
( ) 4. submit to a medical exam and full individual underwriting

Answer: A. 3. adverse selection; B. 1. the probationary period; C. 2. the eligibility period; D. 4. submit to a medical exam and full individual underwriting

STATUTORY REQUIREMENTS IN GROUP UNDERWRITING

The following factors and requirements represent the underwriting criteria for group health insurance.

Statutory Requirements

Nondiscriminatory Classifications

An eligible group must not discriminate in favor of individuals in a manner that increases the opportunity for adverse selection against the insurance company. For instance, if an employer has five typists in the same job classification (job title and salary range) the employer cannot single out one typist to receive benefits greater than the other four typists. Therefore, employees will be grouped under “classifications,” such as, “all eligible full-time employees,” “all clerical workers,” “all hourly employees,” “all salaried employees,” “all executives,” “employees working one year or more,” or “employees earning not less than $10,000 but not more than $15,000.”
Optional Requirements

Employer Control

The employer should be in charge of enrollment, premium payment, benefit selection and all other areas of administration that are not an insurance company function. Because the contract is between the insurer and the policyowner, it is the employer's duty to see that plan administration is conducted in a confidential, legal and objective manner that precludes the individual insured's active participation in the business end of the insurance administration.

Group Size

Most insurers require a minimum number of employees or plan participants before a group health insurance plan may be written. This requirement may vary depending on state laws. Typically, the minimum group size for health insurance is 10 but it could be as low as five or some other number. The larger the group, the more predictable will be the loss experience.

Relatively small groups (25 employees or less) may require some form of individual underwriting whereby each plan participant may be required to prove insurability. Generally, larger groups do not need to prove insurability.

Predetermined Coverage Amount

The underwriter should determine that individual coverage is based on some plan other than individual selection. Individual members of the group cannot select the level of benefits for their own coverage. Coverage can be based on such things as the number of years with the company, occupation, or salary. Coverage must be uniform for plan participants.

Enrollment Percentage

The underwriter should determine that individual participation meets his or her company's guidelines in order to prevent adverse selection. The insurance company requires that a majority of eligible individuals be members of the group of insureds. For example, under a plan of insurance where an employer pays the entire premium, and the employee does not contribute to the premium payment (noncontributory plan) 100% of all eligible employees must be covered. Under a plan where both the employer and the employee contribute toward the premium payment (contributory plan) 75% of all eligible employees must be covered.

Insurance Incidental To Group

The underwriter should determine that the group has not been formed only for the purpose of purchasing insurance. If individuals could form a group for the purpose of obtaining insurance the chance of adverse selection would increase dramatically.
Eligibility

The underwriter should first determine that the business is one that the insurer will cover. There was a period of time when certain occupations were of such a high risk or instable nature that employees could not get insurance. Today, virtually all occupations can get insurance coverage. However, the higher the risk or instability of the occupation the higher the premium.

Since death and illness rates differ in different parts of the country, underwriters may take geographic location into account. Also, certain parts of the country are more prone to catastrophic loss from natural disasters.

Composition Of Group

The underwriter should determine that the group is of such nature that there is a reasonably steady flow of new members into the group. Many states have regulations that specify the number of members that must join the group in order for the group to remain eligible. If a group were to keep the same individuals in the group the chance of accident, illness, or death would increase as the group became older. Because of this increase in risk, rates would also increase.

The group underwriter must also be concerned about currently disabled employees or their dependents. A new insurer may decide to decline the entire group because of a large number of current claims unless the existing insurer agrees by contract to continue to honor these claims.

Also a new insurer may establish a preexisting condition provision in the group contract which excludes coverage for any condition which exists before the effective date of coverage. This provision will normally exclude these conditions for a period of 6 or 12 months after the effective date of coverage.

Generally, there will also be a requirement that only employees currently working at least 25 hours per week are eligible for coverage. Employees not actively at work are usually eliminated from coverage.

Although there have been changes to underwriting standards due to the passing of unisex laws, there are still instances where a group composed largely of women in general, young women, or older employees pay higher premiums.

FUNDING OF GROUP INSURANCE

Several mechanisms for funding group insurance have been developed. Alternative funding allows employers to absorb some of the risk and save premium dollars (and increase cash flow).

For example, a shared funding arrangement allows the employer to self-fund health care expenses up to a certain limit. The employer can select a deductible and pay covered expenses for any individual incurring claims up to that maximum, at which point the insurer assumes the risk.
Under a **retrospective premium** arrangement, the insurer agrees to collect a provisional premium but may collect additional premium or make a premium refund at the end of the year based on the actual incurred losses.

A **minimum premium** plan is where the employer agrees to fund expected claims and the insurer funds excess claims. The employer and insurer agree to a “trigger” beyond which the insurer is liable. The employer is responsible for a minimum premium consisting of administrative expenses, reserves, and a premium for stop-loss to fund claims over the “trigger”.

A large employer may elect to fully self-fund, or may self-fund a plan but contract for **administrative services only (ASO)**.

**REVIEW**

1. The baker’s union and the butcher’s union worked together to form a trust to provide insurance to their employees. This type of group is called
   ( ) A. an employee group.
   ( ) B. a multiple employer trust.
   ( ) C. a Taft-Hartley trust.
   ( ) D. a labor group.

2. Jimmy’s Print Shop and Bryan’s Boutique join together to form a trust to provide insurance to their employees. This type of group is called a
   ( ) A. an employee group.
   ( ) B. a multiple employer trust.
   ( ) C. a Taft-Hartley trust.
   ( ) D. a labor group.

3. The candlestick maker offers insurance to its employees. This type of group is called a
   ( ) A. an employee group.
   ( ) B. a multiple employer trust.
   ( ) C. a Taft-Hartley trust.
   ( ) D. a labor group.

4. The United Auto Workers union provides insurance to their employees. This type of group is called
   ( ) A. an employee group.
   ( ) B. a multiple employer trust.
   ( ) C. a Taft-Hartley trust.
   ( ) D. a labor group.

5. General Electricians offers insurance to their employees. About 80% of the eligible employees are currently covered under the plan. The plan is most likely
   ( ) A. contributory.
   ( ) B. noncontributory.
   ( ) C. inclusive.
   ( ) D. noninclusive.
6. Group insurance generally does **not** require
   ( ) A. stringent medical underwriting.
   ( ) B. a short application form.
   ( ) C. a minimum level of participation among the eligible insureds.
   ( ) D. a master policyowner to hold the policy.

7. Sara is hired on to work at a restaurant. She is not eligible to join the
   group insurance plan for 30 days. This is an example of
   ( ) A. the introductory period.
   ( ) B. the weeding out period.
   ( ) C. the probationary period.
   ( ) D. the eligibility period.

8. Marie has worked at the restaurant for more than a year, but never partici-
   pated in the insurance program. She decides that it is now time to sign up.
   She is required to undergo a medical exam, because she is signing up after
   ( ) A. the probationary period has expired.
   ( ) B. the weeding out period has expired.
   ( ) C. the introductory period has expired.
   ( ) D. the eligibility period has expired.

9. Which of the following group underwriting characteristics is generally
   required by law?
   ( ) A. Employer control
   ( ) B. Predetermined coverage amount
   ( ) C. Nondiscriminatory classifications
   ( ) D. Insurance incidental to group

10. Kelsy's Printing funds all the claims in a year, regardless of the amount of
    the claim. Kelsy's insurer just manages the paperwork for the claims.
    What option is Kelsy's Printing using?
    ( ) A. Retrospective premium
    ( ) B. Minimum premium
    ( ) C. Variable premium
    ( ) D. Administrative services only

11. Al's Print Shop pays a provisional premium at the beginning of the year.
    At the end of the year, Al's insurer has the right to change that premium
    by charging more or issuing a refund. Al's policy is funded using which
    premium option?
    ( ) A. Retrospective premium
    ( ) B. Minimum premium
    ( ) C. Variable premium
    ( ) D. Administrative services only

12. PDQ Printing pays for all the routine claims. PDQ's insurer pays for
    excess or unexpected claims beyond a specified trigger point. PDQ's policy
    is funded using which premium option?
    ( ) A. Retrospective premium
    ( ) B. Minimum premium
    ( ) C. Variable premium
    ( ) D. Administrative services only
Unit 5—Group Insurance

Answers:

1. C. a Taft-Hartley trust.
2. B. a multiple employer trust.
3. A. an employee group.
4. D. a labor group.
5. A. contributory.
6. A. stringent medical underwriting.
7. C. the probationary period.
8. D. the eligibility period has expired.
10. D. Administrative services only.
11. A. Retrospective premium.
12. B. Minimum premium.
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IMPORTANT

This book is designed as a learning program. BISYS Education Services is not engaged in rendering legal or other professional advice, and the reader should consult legal counsel as appropriate.

We have tried to provide you with the most accurate and useful information possible. However, the content of this publication may be affected by changes in law or industry practice, and, as a result, information contained in this publication may become outdated. This material should in no way be used as an original source of authority on legal matters.

Any laws and regulations cited in this publication have been edited and summarized for the sake of clarity.

Any names used in this publication are fictional and have no relationship to any person living or dead.
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SUGGESTED STUDY GUIDE: HEALTH INSURANCE FOR SELF-STUDY OR CLASSROOM PREPARATION

INTRODUCTION

To assist you in adequately preparing for your producer licensing exam, the following study schedule has been specifically developed to provide you with a step-by-step approach that guides you through the entire program. Each section of your text contains a separate study schedule. The study program for this section of the text is based on an eight day schedule. It is appropriate for both self-study and preparation for classroom instruction. It is important that you follow these steps as closely as possible to maximize your comprehension, retention and ability to apply the information to specific circumstances.

Due to the need to cover a significant amount of information in the time frame provided, it is important that you remain on schedule. If you fall behind, you will need to extend your study time, rather than planning to simply “make up” the time in the later units. As you proceed through the program, you should monitor your progress by checking off each item as you complete it.

STUDY COMPONENTS

This study guide pertains only to the Health Insurance section of the course. However, it assumes that you have purchased a Total Package, containing all of the following components:

- Textbook (Health Concepts or Life & Health Concepts)*
- State-specific insurance law digest*
- Exam Workbook
- Explanation Of Answers—Exam Workbook
- Exam Review audiotape
- Exam Review (diskette or online—both versions not required)

*Required Component
If the package you ordered does not contain one of the components referred to in the Study Guide, go to the next step. If you would like to order one of these components, contact BISYS Education Services’ Customer Service Department at 1.800.428.4215.

**STUDY SCHEDULE: HEALTH INSURANCE**

**Day 1**

**Unit 1—Health Insurance Basics**

1. Review the Learning Objectives for this unit.
2. Read the entire unit.
3. Complete the Review Questions at the end of the unit; reread the appropriate material for any questions that you missed.
4. Listen to the Unit 1 segment on the Exam Review audiotape.
5. Complete the Unit 1 review exam on the Exam Review diskette/Online Review.

**Unit 2—Policy Underwriting, Issuance And Delivery**

1. Review the Learning Objectives for this unit.
2. Read the entire unit.
3. Complete the Review Questions at the end of the unit; reread the appropriate material for any questions that you missed.
4. Listen to the Unit 2 segment on the Exam Review audiotape.
5. Complete the Unit 2 review exam on the Exam Review diskette/Online Review.

**Day 2**

**Unit 3—Policy Provisions**

1. Review the Learning Objectives for this unit.
2. Read the entire unit.
3. Complete the Review Questions at the end of the unit; reread the appropriate material for any questions that you missed.
4. Listen to the Unit 3 segment on the Exam Review audiotape.
5. Complete the Unit 3 review exam on the Exam Review diskette/Online Review.
Day 3

Unit 4—Disability Income Insurance
1. Review the Learning Objectives for this unit.
2. Read the entire unit.
3. Complete the Review Questions at the end of the unit; reread the appropriate material for any questions that you missed.
4. Listen to the Unit 4 segment on the Exam Review audiotape.
5. Complete the Unit 4 review exam on the Exam Review diskette/Online Review.

Day 4

Unit 5—Medical Expense Insurance
1. Review the Learning Objectives for this unit.
2. Read the entire unit.
3. Complete the Review Questions at the end of the unit; reread the appropriate material for any questions that you missed.
4. Listen to the Unit 5 segment on the Exam Review audiotape.
5. Complete the Unit 5 review exam on the Exam Review diskette/Online Review.

Day 5

Unit 6—Special Types Of Health Policies
1. Review the Learning Objectives for this unit.
2. Read the entire unit.
3. Complete the Review Questions at the end of the unit; reread the appropriate material for any questions that you missed.
4. Listen to the Unit 6 segment on the Exam Review audiotape.
5. Complete the Unit 6 review exam on the Exam Review diskette/Online Review.

Unit 7—Group Health Insurance
1. Review the Learning Objectives for this unit.
2. Read the entire unit.
3. Complete the Review Questions at the end of the unit; reread the appropriate material for any questions that you missed.
4. Listen to the Unit 7 segment on the Exam Review audiotape.
5. Complete the Unit 7 review exam on the Exam Review diskette/Online Review.
Day 6

Unit 8—Social Health Insurance

1. Review the Learning Objectives for this unit.
2. Read the entire unit.
3. Complete the Review Questions at the end of the unit; reread the appropriate material for any questions that you missed.
4. Listen to the Unit 8 segment on the Exam Review audiotape.
5. Complete the Unit 8 review exam on the Exam Review diskette/Online Review.

Day 7

Unit 9—Long-Term Care

1. Review the Learning Objectives for this unit.
2. Read the entire unit.
3. Complete the Review Questions at the end of the unit; reread the appropriate material for any questions that you missed.
4. Listen to the Unit 9 segment on the Exam Review audiotape.
5. Complete the Unit 9 review exam on the Exam Review diskette/Online Review.

Unit 10—Health Insurance And Taxation

1. Review the Learning Objectives for this unit.
2. Read the entire unit.
3. Complete the Review Questions at the end of the unit; reread the appropriate material for any questions that you missed.
4. Listen to the Unit 10 segment on the Exam Review audiotape.
5. Complete the Unit 10 review exam on the Exam Review diskette/Online Review.

Day 8

State-Specific Insurance Law Digest

1. Find all units that deal with Health Insurance (Units 2 and 4 in some states, Unit 3 in others).
2. Read the entire unit(s).
Exam Review Diskette/Online Review

1. Begin taking the practice final exams for the Health Insurance section in sequential order as was done with the unit review exams.

2. Continue this exam sequence until you have scored 70% or higher on each individual exam. As you score 70% or higher on an exam, skip that exam in subsequent rounds.
LEARNING OBJECTIVES

After completing Unit 1—Health Insurance Basics, you will be able to:

1. Explain the risk that health insurance is designed to protect against.
2. List 12 different types of loss health insurance may be purchased to guard against.
3. Explain the difference between a limited policy and other health policies, and list 6 types of limited policies.
4. List 6 environments where physicians might see patients.
5. Explain the difference between reimbursement, fee-for-service, and capitation payment.
6. Explain the role of Blue Cross/Blue Shield organizations, how they differ from commercial insurers, the corporate structure they usually employ, and the types of coverage and benefits they offer.
7. Explain how HMOs are different from traditional insurers, and the role government had in promoting the development of HMOs.
8. List and describe four typical HMO structures.
9. Explain the difference between open and closed panel HMOs.
10. Explain the difference between basic and supplemental HMO services, and list what is generally included as basic, and what may be included as supplemental.
11. Define the following HMO-related terms: copayment, exclusion, limitation, gatekeeper, open-enrollment, quality assurance, open-ended HMO, open access HMO.

(continued)
12. Explain what an HMO's grievance system is designed to do, and how it must function.

13. List practices that HMOs are commonly prohibited from engaging in.

14. Describe the basic characteristics of Preferred Provider Organizations, Point-of Service Plans, Exclusive Provider Organizations, and Multiple Option Plans.

15. Explain how self-funding works, what a stop-loss contract is, and list the advantages and disadvantages of self-insurance.

16. Explain what a 501(c)(9) trust is, and when it is used.

17. Describe the basic characteristics of cafeteria plans, Medical Savings Accounts, Multiple Employer Trusts, Multiple Employer Welfare Arrangements, Blanket policies, and Franchise policies.

18. List the major statutory health insurance programs offered by the federal and state government.

19. List the types of benefits provided by Social Security.

20. Explain who is eligible for Workers Compensation, and list the types of benefits provided under Workers Compensation.

21. Explain the limits that apply to income benefits under Workers Compensation.

22. Briefly explain who qualifies for Medicaid, the intent of the program, and how it functions.

23. Briefly explain who qualifies for TRICARE, the intent of the program, and how it functions.
Why it is not often recognized, the financial impact of total disability may be greater than the financial impact of death. A person may live for many years totally disabled and, therefore, be unable to generate an income to pay for the higher medical and living expenses caused by the disability.

Health insurance provides payment of benefits for the loss of income and/or the medical expenses arising from illness or injury. Health insurance is often called accident and sickness insurance or accident and health insurance. Many different kinds of health insurance coverages are available. Health insurance varies according to the methods of underwriting, the injury or illness covered, the types of insurers, the types of benefits and services provided, the types of losses covered, and the amount of benefits available.

Health insurance originated in the United States in the mid-1800s. It was first provided by casualty insurance companies and then by riders to life insurance products. The earliest policies were to provide benefits for losses due to accidental injuries and to protect railroad travelers. Later coverage provided benefits due to illness as well as accidents.

**Types of Losses and Benefits**

**Loss of Income From Disability**

Disability income insurance, also referred to as loss of time insurance, pays a weekly or monthly benefit for disabilities due to accident or sickness. The primary purpose of disability income coverage is to replace loss of personal income due to a disability.

Disability income policies are issued on an individual basis or on a group basis through an employer-sponsored plan, labor union or association. Benefits paid are in accordance with the policy’s provisions and to a degree, the insured’s loss of income.
Accidental Death And Dismemberment (AD&D)

AD&D policies (or riders) pay the policy’s principal sum for accidental death in accordance with the policy’s provisions and definition of accidental death. The principal sum is similar in meaning to a policy’s face amount. This same amount is paid if the insured suffers the actual severance of two arms, two legs, or the loss of vision in two eyes due to an accident. This amount is usually identified as the capital sum if the policy is paying an accidental dismemberment benefit.

AD&D benefits may be included as riders on life insurance policies, as part of disability income insurance, as part of health insurance, or as a separate policy (a type of limited coverage).

Medical Expense Benefits

Medical expense insurance, commonly referred to as hospitalization insurance, provides benefits for expenses incurred due to in-hospital medical treatment and surgery as well as certain outpatient expenses such as doctor’s visits, lab tests and diagnostic services. Hospitalization insurance may be issued as an individual policy covering all family members or as a group insurance policy provided through an employer-sponsored program.

When medical expense coverage provided for proprietors and partners is paid for by the business, the premiums have traditionally been considered tax deductible to the business but includable as income to the individual. There is no limit to the amount of tax free medical expense benefits the individual can receive.

Dental Expense Benefits

Dental expense benefits are generally sold as part of group health insurance coverage. Most insurers do not provide individual dental policies. Dental benefits are offered for preventive maintenance (cleanings and x-rays), repair (fillings, root canals, etc.) and replacement of teeth.

Long-Term Care Insurance

Long-term care (LTC) insurance pays for the care of persons with chronic diseases or disabilities, and may include a wide range of health and social services provided under the supervision of medical professionals. LTC often covers nursing home care, home-based care, and respite care.

Limited Health Exposures And Insurance Contracts

There are a variety of special health insurance policies providing limited coverage. To ensure that the insured has sufficient notice that the coverage is limited, every policy that provides limited coverage must, by law, state plainly on the first page of the policy: “THIS IS A LIMITED POLICY.”
Travel accident insurance provides coverage for death or injury resulting from accidents occurring while the insured is a fare-paying passenger on a common carrier.

Specified disease or dread disease insurance provides a variety of benefits for only certain diseases, usually cancer or heart disease.

Hospital income insurance pays a specified sum on a daily, weekly or monthly basis while the insured is confined to a hospital. The amount of the benefit is not related to expenses incurred or to wages lost while the insured is hospitalized.

Accident only insurance provides coverage for injury from accident, and excludes sickness. Benefits may be paid for all or any of the following: death, disability, dismemberment, or hospital and medical expenses.

Credit insurance is listed here because of the limited nature of its coverage. This policy is issued only to those who are in debt to a creditor. The coverage is limited to the total amount of the debtor's indebtedness.

Blanket insurance is a form of group insurance. Often the individual's name is not known because the individuals come and go. Such groups include students, campers, passengers of a common carrier, volunteer groups, and sports teams. Unlike group insurance the individuals are automatically covered under the blanket policy, and they do not receive certificates of insurance.

Prescription Coverage

Prescription medication coverage is normally provided as an optional benefit under a group medical expense policy. The insured and eligible dependents are provided with a stated cost for any prescription medication required. This specific cost is usually, two, three, or five dollars per prescription. Thus, regardless of the cost of the medication, the insured only pays the stated amount and the balance of the prescription cost is paid by the insurance company.

**DETERMINING INSURANCE NEEDS**

Life insurance is designed to protect the individual and his or her family from the risk of premature death by providing specific amounts of money exactly when needed to cover necessary expenses. Health insurance is designed to protect the insured from the risk of medical and disability expenses.

Similar to life insurance, health insurance benefits provide benefits exactly when needed. Disability income insurance can enable the insured to pay a mortgage and other necessary family expenses when total disability due to an accident or sickness cuts off the insured's income.

Medical expense insurance provides the insured with necessary funds to cover hospital and physician expenses associated with a serious illness, thus preserving the family's savings and other assets.
Basically, the process of determining health insurance needs is similar to identifying an individual's life insurance requirements. The principal difference is the risk being insured—premature death or health insurance expenses.

The individual's and family's health insurance needs must be identified. These needs are then prioritized in terms of their importance to the family. Other forms of health insurance should be reviewed with regard to this needs analysis. These benefits include:

- Workers compensation benefits for job-related disabilities
- Social Security disability benefits
- Medicare, if the individual is eligible
- Work-related benefits through employer-sponsored plans
- Health coverage under any statutory plans

Once the individual's total health insurance needs analysis has been completed, then meaningful recommendations can be made as to the type and amounts of health insurance required.

**Exercise**

A. Julia has a policy that will pay any expenses that she incurs due to in-hospital medical treatment, as well as some of the expenses she incurs on an outpatient basis. Julia probably has a

   ( ) 1. disability income policy.
   ( ) 2. medical expense insurance policy.
   ( ) 3. long-term care policy.
   ( ) 4. hospital income insurance policy.

B. George has a policy that will provide him an income if he is disabled from illness or injury and recuperating at home. George probably has a

   ( ) 1. disability income policy.
   ( ) 2. medical expense insurance policy.
   ( ) 3. long-term care policy.
   ( ) 4. hospital income insurance policy.

C. George's brother, Jerry, has a policy that will provide him an income if he is disabled from illness or injury, but only if he is confined to a hospital. George's brother probably has a

   ( ) 1. disability income policy.
   ( ) 2. medical expense insurance policy.
   ( ) 3. long-term care policy.
   ( ) 4. hospital income insurance policy.

D. Between George and his brother Jerry, who has the more limited policy

   ( ) 1. George
   ( ) 2. Jerry.
   ( ) 3. neither, both policies probably have the same limitations.
   ( ) 4. it is not possible to tell from the information provided.

Answer: A. 2. medical expense insurance policy; B. 1. disability income policy; C. 4. hospital income insurance policy; D. 2. Jerry
HEALTH CARE PROVIDERS

Patients have traditionally been seen by physicians in office or hospital environments. Today physicians also see patients in surgicenters, urgent care centers, and at skilled nursing facilities. Surgicenters provide a site for outpatient surgery where general anesthesia must be used, but a patient does not need to stay overnight. Urgent care centers see patients often without an appointment during the daytime, as well as evening and weekend hours. Skilled nursing facilities provide medical care for patients who no longer require hospitalization, but cannot yet care for themselves at home. Home health care is also provided by nurses and others for patients ready to be at home, but who cannot yet fully provide for all of their own needs.

The traditional broad health coverage provided by insurance plans provides little incentive for efficient, cost-effective health care delivery. In the past decade it has become clear that too much money is being spent on health care. One response from insurers and providers has been to reorganize the health care delivery system into a form of managed care. Managed care imposes controls on the use of health care services, the providers of health care services, and the amount charged for these services, usually through health maintenance organizations or preferred provider arrangements, all discussed below. Of all workers covered by employer-sponsored health plans in 1994, 63% were enrolled in managed care plans.

HEALTH CARE PLANS

The insurers of health care are not only the traditional stock and mutual companies, and Blue Cross and Blue Shield, but also the health maintenance organizations and preferred provider organizations formed by hospitals and physicians to deliver health care directly to enrollees in their plans.

Commercial Insurers

Commercial insurers are stock and mutual life insurers, and sometimes casualty companies. Commercial insurers have traditionally provided coverage on a reimbursement basis but have also begun to embrace alternative approaches. Reimbursement plans pay benefits directly to the insured, who is responsible for paying the providers of medical services.

Commercial insurers offer both individual and group health insurance products. These products include, basic medical expense coverage, major medical plans, comprehensive medical plans, disability income policies and other types of health products.

Recent developments from commercial insurers in response to the need for cost control include the Preferred Provider Organizations (PPOs) and Health Maintenance Organizations (HMOs).
Blue Cross And Blue Shield

The 65 Blue Cross and Blue Shield plans nationwide provide coverage to 64 million people. When considered in combination, they are the dominant health insurer of the United States. The nation’s Blue Cross and Blue Shield Plans are loosely affiliated through the national Blue Cross & Blue Shield Association but are independently managed.

Differences From Commercial Insurers

Blue Cross and Blue Shield (the Blues) are different from traditional commercial insurers in the following important areas:

- The Blues provide the majority of their benefits on a service basis rather than on a reimbursement basis. This means that the insurer pays the provider directly for the medical treatment given the insured, instead of reimbursing the insured.
- The Blues have contractual relationships with the hospitals and doctors. As participating providers, the doctors and hospitals contractually agree to specific costs for the medical services provided to subscribers. Thus, there is no contractual arrangement between the Blues and the subscribers as there would be between the insurer and the insured.

Corporate Structure

Blue Cross/Blue Shield organizations, which are often referred to as service organizations, are examples of producers’ cooperatives. Physicians and hospitals that sponsor Blue Cross/Blue Shield plans provide the insurance, so are considered to be the “producers” in the cooperative.

Traditionally, the Blues have operated as nonprofit organizations, which means any net gain realized from company operations is eventually returned to the subscribers in the form of reduced premiums or increased benefits. A few plans have been allowed to become for-profit companies, or form for-profit subsidiaries, to allow them to raise money for expansion and compete in the health care marketplace.

Blue Cross traditionally has been a hospital service plan and Blue Shield a physicians service plan but these distinctions are becoming blurred. In most states, Blue Cross and Blue Shield have merged, but each group still covers the expenses for which it was first developed: Blue Cross covers hospital expenses and Blue Shield covers medical and surgical expenses. In some states both Blue Cross and Blue Shield serve as hospital and physician service plans. Under the hospital plan the contract is between Blue Cross and the hospital providing the hospital care. Under the medical plan the contract is between Blue Shield and the physicians providing the service. The contract is evidence of their joint cooperation in providing health care to the public. One purpose of these plans was to make certain health care providers—hospitals and practitioners—received payment for their services. Thus, with occasional exceptions, reimbursements for incurred expenses are made directly to the providers, not to the subscribers.
The favorable tax environment for Blues organizations has eroded over the years and some states have withdrawn the favored status Blue Cross/Blue Shield previously enjoyed. In addition, the federal Tax Reform Act of 1986 made the Blues taxable as insurance companies.

**Enrollment And Premium Rates**

Members of Blue Cross and Blue Shield are known as **subscribers**. Subscribers in either plan can transfer their membership from one Blues organization to another in other areas of town, or to other cities or states. Subscribers may also change their coverage from individual to family, from family to group, or any combination of change they need to make. When transfers or changes are made, the subscriber's coverage continues without interruption.

Blue Cross and Blue Shield plans are called **prepaid** plans because the plan subscribers pay a set fee, usually each month, for medical services covered under the plan.

**Types Of Coverage And Benefits**

Blue Cross offers broad coverages and pays claims on a service basis. The plan covers hospital daily room and board, outpatient services for minor surgery, or accidental injury, medical emergencies, diagnostic testing, physical therapy, kidney dialysis, chemotherapy, and in some cases preadmission testing. Family plans may also include coverage for dependent handicapped children. Maternity benefits are also made available the “same as for any other disability.”

Blue Cross also has a supplemental coverage, for catastrophic loss, which is similar to commercial major medical plans. This supplement has a deductible and an 80%-20% coinsurance feature.

Blue Shield offers prepaid medical coverage for physician services received by plan subscribers. Again, through the contractual arrangement with the providers, Blue Shield will normally pay the participating physician a predetermined amount for the specific service provided. Usually, this amount will be based on the usual, customary and reasonable (UCR) fees charged by other physicians in the same geographical area for the same or similar medical procedures.

It is also possible to obtain dental coverage through Blue Cross/Blue Shield, which contracts with dental providers and pays fees on a service basis. An estimated 15% of people with dental insurance have their coverage through Blue Cross/Blue Shield plans.

**Blues And Managed Care**

The Blues have also been strongly influenced by managed care. Many Blues subscribers are now covered by a Blues-affiliated HMO or PPO, or point-of-service (POS) plan.
Special Requirements For Consolidated Plans

Jointly-operated (consolidated) Blue Cross/Blue Shield plans are often so comprehensive that supplementing them with major medical coverage is not necessary. Plan provisions applying to consolidated Blue Cross/Blue Shield plans are similar to plan provisions applying to comprehensive major medical plans.

Health Maintenance Organizations

History And Development

The number of Health Maintenance Organizations (HMOs) has grown rapidly in response to increasing health care costs. The purpose of HMOs is to manage health care and its costs through a program of prepaid care that emphasizes prevention and early treatment. This prepayment, which entitles the health care consumer to a wide range of services, is referred to as a service-incurred basis. In contrast, traditional health insurance coverage is handled on a reimbursement basis, with the insured or provider being reimbursed for all or part of medical expenses actually incurred.

The emphasis on prevention means HMOs cover preventive medicine, such as routine physical and well-child examinations and diagnostic screening paid for in advance. This is in sharp contrast to health insurance plans that traditionally did not cover preventive programs, paying only after the fact of disease or injury. Theoretically, the HMOs’ focus on prevention ultimately leads to reduced health care costs. At the same time, HMOs provide for hospital, surgical, and medical treatment when such services are needed.

One way HMOs differ from traditional health insurance providers is that HMOs have a dual function not shared by insurance companies. The illustration that follows, which is oversimplified for clarity, shows that under traditional arrangements, consumers receive the health care itself from one group, the medical profession—physicians, hospitals, therapists, and so forth—while the financial coverage comes from a separate entity—the insurance company.

Traditional Health Insurance Arrangement

In contrast, as shown in the following chart, an HMO provides both the health care services and the health care coverage.
These two functions are combined because the HMO is comprised of a group of medical practitioners who have contracted to provide specified services to HMO members at agreed-upon prices. In return, each consumer who is a member of the HMO agrees to pay the HMO a specified amount in advance to cover required hospital and medical services. Thus, the HMO both handles the financial arrangements and makes the health care services available.

**Federal Requirements**

While the emphasis on prevention and containing costs was a major factor in the development of HMOs, federal HMO laws further encouraged development by two primary means:

- Providing for government grants
- Requiring certain employers who provide health benefits to employees to offer enrollment in an HMO as an option

In order to receive government grants, HMOs must:

- Maintain certain minimum financial requirements in terms of the net worth of the HMO and/or reserves to pay health claims.
- Provide a defined package of health services that includes routine preventive care.
- Require no more than nominal “use charges” or copayments (in addition to the prepaid amounts) for services actually rendered to individuals.
- Establish premiums on a community rating basis without considering actual usage of services by individuals.

Once an HMO has met the minimum standards as well as other federal and state requirements, it is allowed to operate in a designated service area—often within a certain county or a specified distance surrounding the HMO facilities. Then, the federal law regarding employers comes into play.

The HMO Act of 1973 required employers with certain characteristics to offer HMO coverage by a federally qualified HMO as an alternative to an indemnity plan. Under this law, if the HMO operates in the service area of an employer that has 25 or more employees and that employer provides health care benefits, enrollment in the HMO must be offered as an alternative to traditional health insurance plans. This is often referred to as the dual choice option or dual choice law.
This requirement was repealed at the federal level in 1995, although some states still impose dual choice requirements. Federal law now simply requires that employers “not financially discriminate” in the amounts of employee contribution made towards HMO and indemnity plans. Employers are required to contribute equally to either type of health coverage for employees. However, the employer is never required to pay more for the HMO than it pays for any existing insurance plan already in place. If the HMO cost is greater, the employee choosing the HMO must make up the difference.

HMO Organization

Profit Vs. Nonprofit

There are a number of ways to analyze the organization of an HMO. The first concept we'll address is whether the HMO operates on a for-profit or a not-for-profit basis.

Usually, but not always, if the HMO is a producers’ cooperative owned and operated by a group of physicians, the HMO is for-profit. If it is a consumers’ cooperative where the doctors are salaried employees of the HMO, it is usually not-for-profit.

Typical Structures: Group Model

The basic structure of an HMO involves contractual agreements with a variety of health care providers and facilities to provide services to HMO subscribers. Within that structure, four models are used, one of which is the group model.

More than two-thirds of HMOs existing in the late 1980s were based on the group model, sometimes called the medical group model or the group practice model. Under this arrangement, the HMO contracts with an independent medical group that specializes in a variety of medical services to provide those services to HMO subscribers. Under the agreement, the HMO pays the medical group entity, not the individual service providers. The medical group itself chooses how to pay its individual physicians, all of whom remain independent of the HMO rather than becoming salaried employees.

Often, the HMO pays the group a capitation fee, which is a fixed amount paid monthly for each HMO member. Thus, the medical group can make a profit on those members for whom a fee is paid but who use few or no services. On the other hand, the medical group can lose money on frequent users. The medical group model thus entails some financial risk on the part of the practitioners.

Typical Structures: Staff Model

A second type of arrangement is the staff model, so named because the contracting physicians are paid employees working on the staff of the HMO. They generally operate in a clinic setting at the HMO's physical facilities. When hospital services are required, the staff doctors and HMO administration arrange for those services. In some cases, the HMO may even own and operate a hospital. Unlike the group model, practitioners in the staff model are under no financial risk; they are simply employed by the HMO, and it is the HMO corporation that takes the risk.
Typical Structures: Network Model

The network model operates much like the group model, except the HMO contracts with at least two, and more likely several, medical groups rather than just one. In addition, the HMO may make similar contractual arrangements with independent doctors to provide services in their individual offices. The purpose of a network is to increase accessibility to providers as a convenience for HMO subscribers who might otherwise be required to visit a facility far from their homes or workplaces. Under the network model, medical groups are generally paid a capitation fee, while individual physicians may be paid either a capitation fee or a discounted fee.

Typical Structures: Individual Practice Association Model

The fourth and final model is one that gives HMO members the maximum freedom of choice of physicians and locations. The Individual Practice Association (IPA) model allows the HMO to contract separately with any combination of individual physicians, medical groups, or physicians’ associations. Some HMOs, in fact, have been started by such groups.

In the IPA model, there is no separate HMO facility. Physicians operate out of their own private offices, and their HMO patients may be individuals the physicians were already attending. Many people prefer this arrangement since it allows them to continue with their personal doctors. Payment is usually on a fee-for-service basis where the fees have been negotiated in advance.

Open And Closed Panel Types

So-called open and closed panels are yet another way to characterize HMOs. Physicians, hospitals and other health care providers who have contracts with an HMO are referred to as the HMO’s panel. An open panel means any and all providers who want to provide services for the HMO may do so as long as they agree to the HMO’s requirements.

In contrast, a closed panel is a limited number of health care providers chosen by the HMO. HMO subscribers must receive their health care services from this closed panel of providers in order to have those services paid for on the prepaid plan. The theory is that, with a closed panel, the HMO is better able to manage costs with fewer providers.

Sponsorship And Eligibility

Throughout this section, we’ve mentioned several types of groups that may sponsor HMOs. Other sponsoring groups include:

- Medical schools or associations
- Physicians
- Hospitals
- Employers
- Service organizations (such as Blue Cross/Blue Shield)
- Labor unions
- Consumer groups
- Insurance companies
- Government entities

Most HMOs, no matter who sponsors them, restrict membership to a specifically defined group. For example, an HMO organized by a labor union might limit enrollment to members of specific unions. An HMO sponsored by a Blue...
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Cross/Blue Shield plan might accept only the employees of organizations within its service area that employ 500 or more individuals. Every rule has its exception, however, and some HMOs solicit individual enrollees from the entire population in the service area.

Basic And Supplemental Services

The emphasis of HMOs is prevention, as the benefits offered are broader than those provided by commercial insurers or the blues. HMO benefits are not limited to treatment resulting from illness or injury as they also include preventive health care measures like routine physical examinations.

HMOs are required to provide for certain basic health care services.

- **Inpatient hospital and physician services** for a period of at least 90 days per calendar year for treatment of illness or injury. If inpatient treatment is for mental, emotional or nervous disorders, including alcohol and drug rehabilitation and treatment, then services may be limited to 30 days per calendar year. Treatment for alcohol and drug rehabilitation and treatment may be restricted to a 90-day lifetime limit. A partial list of the hospital services provided include room and board; maternity care; general nursing care; use of operating room and facilities; use of intensive care unit; X-rays, laboratory, and other diagnostic tests; drugs, medications and anesthesia; physical, radiation and inhalation therapy.

- **Outpatient medical services** when prescribed or supervised by a physician and rendered in a nonhospital based health care facility (i.e., physician’s office, member’s home, etc.). Outpatient medical services include diagnostic services, treatment services, short term physical therapy and rehabilitation services, laboratory and X-ray services and outpatient surgery.

- **Preventive health services** with the goal of protection against and early detection and minimization of the ill effects and causes of disease or disability. Specifically, this will include well child care from birth, eye and ear examinations for children age 17 and under, periodic health evaluations and immunizations.

- **In and out of area emergency services**, including medically necessary ambulance services, available on an inpatient or an outpatient basis 24-hours per day, 7-days per week.

Many HMOs may but are not required to provide one or more of the following supplemental health care services:

- Prescription drugs
- Vision care
- Dental care
- Home health care
- Nursing services
- Long-term care
- Mental health care
- Substance abuse services

Consumers who want supplemental services may purchase them from the HMO only as an adjunct to the basic health care services the HMO offers. For example, an employer could not ask an HMO to provide coverage for prescription drugs only without purchasing the basic package of services.
Copayments

Members of an HMO may be charged only nominal amounts—copayments—for basic services in addition to the original monthly payment. In many cases, no additional payments are required for services. All of this is spelled out in a descriptive document, which is called either the certificate of coverage or the evidence of coverage.

On the other hand, HMOs are permitted to require copayments on supplemental services as well as charging an amount that is added to the monthly fee. For example, suppose an HMO makes dental coverage available to members who want to pay for it. The basic package of services might cost $200 per month and an additional $5 will buy the dental coverage. Then, the HMO might require that the consumer pay $3 for every routine dental checkup. (All figures are theoretical.)

Exclusions And Limitations

Exclusions and limitations are used to either limit a benefit provided or specifically exclude a type of coverage, benefit, medical procedure etc. HMOs may not exclude and limit benefits as readily as commercial insurers. This is because the rationale of an HMO is to provide comprehensive health care coverage. Some of the benefits an HMO may exclude from coverage, and often do, include: eye examinations and refractions for persons over age 17, eyeglasses or contact lenses resulting from an eye examination, dental services, prescription drugs (other than those administered in a hospital), long-term physical therapy (over 90 days) and out-of-area services (other than emergency services).

Important Features Of HMOs

Gatekeeper System

HMOs often have a gatekeeper system under which the member must select a primary care physician (PCP) who in turn provides or authorizes all care for the particular member. Any referrals, such as to specialists, must be made and authorized by the PCP. Think of this person as opening (or refusing to open) the gate between the member and the health care providers. In emergency situations, the member’s needs are covered, but generally the individual must notify the PCP as soon as possible if it wasn’t possible to do so when the emergency arose. Members are required to involve the PCP in all service decisions to ensure claims will be paid.

Suppose Ronald knows his PCP can’t perform the open-heart surgery he needs. Ronald may not simply select a surgeon of his choice and assume the claim will be paid by his HMO. He must first consult with the gatekeeper, his personal PCP, who will make the referral and authorize treatment.

Twenty-Four Hour Access

As a rule, members have 24-hour access to the HMO. Telephones are answered and referrals and authorizations are made 24 hours a day, seven days a week. Nursing and medical staff, including PCPs, must be willing to respond during nonbusiness hours as well. Therefore, an HMO member who needed to consult with a PCP late at night or on a weekend would likely be able to do so.
Open Enrollment

The term open enrollment can mean two different things:

1. In employer-sponsored group plans: a time period each year when employees may choose to enroll or remain enrolled in the HMO or to change health plans;

2. A time period each year when an HMO must advertise availability to the general public on an individual basis.

In the first case, open enrollment allows employees who have not yet joined the HMO to do so if they wish. Those who are already HMO subscribers may at this time also choose to continue in the HMO or to change plans if another health care plan is available.

In the second case, open enrollment may be required by state law, permitting all who apply to join. During this period, which usually lasts 30 days, the HMO generally may not reject any applicant for health reasons. However, some laws permit the HMO to refuse enrollment to people who are hospitalized during the enrollment period or who have chronic illnesses or permanent injuries. For the most part, the advantage of open enrollment lies completely with potential enrollees, who may have been rejected for traditional coverage because of their health, but who will now be accepted by the HMO. The HMO, on the other hand, is placed at risk since it is more likely to lose money on such subscribers.

As an example, consider Darren, who has been rejected for health insurance by several insurance companies because of a history of heart attacks. Darren’s state requires HMOs to have a period of open enrollment. If Darren applies for HMO coverage during the open enrollment period, chances are he will be accepted even though he might not be able to obtain coverage elsewhere because of his medical history.

Nondiscrimination

When HMO coverage is offered to a group, the HMO may not refuse to cover an individual member of the group because of adverse pre-existing health conditions, such as a history of heart trouble that predates enrollment in the HMO. This is different from traditional insurers, which generally have the option of refusing to cover certain group members and of excluding pre-existing health conditions.

HMOs are permitted to refuse coverage for individuals with pre-existing conditions, except during open enrollment as discussed previously.

Complaints

All HMOs are required to have a complaint system, often called a grievance procedure, to resolve written complaints by members. The HMO is required to provide forms for written complaints, including the address and telephone number of where complaints should be directed. Additionally, upon providing the necessary forms for a complaint to a member, the HMO must notify the member of any time limits applying to a complaint. Complaints must be
resolved within 180 days of being filed with the HMO (with a few exceptions). Complaints may be resolved through binding arbitration if so specified by the HMO and agreed to by the member.

HMOs must have mechanisms to handle complaints from subscribers for two categories:

- Coverage complaints
- Care complaints

The first category includes complaints about the coverage offered, payment or denial of health claims, and similar items. These complaints are reviewed internally and might eventually be referred to the state insurance department.

The second category refers to the quality of care received from an HMO provider. Medical personnel review this type of complaint. HMO subscribers must receive a document indicating how complaints can be registered. This information is usually included in the evidence or certificate of coverage.

**Prohibited Practices**

HMOs, like traditional commercial insurers, are not allowed to engage in certain types of business practices, policies, etc. Specifically, HMOs are prohibited from excluding a member’s preexisting conditions from coverage, from unfairly discriminating against a member based on age, sex, health status, race, color, creed, national origin, or marital status. HMOs are also prohibited from terminating a member’s coverage for reasons other than: nonpayment of premiums or copayments, fraud or deception in the member’s use of services, a violation of the terms of the contract, failure to meet or continue to meet eligibility requirements prescribed by the HMO, or a termination of the group contract under which the member was covered.

**Quality Assurance**

Because HMOs provide service benefits rather than reimbursement benefits, they are required to follow guidelines prescribed by the Insurance Department to assure quality service to members. These guidelines specify the requirements for reasonable hours of operation and after-hours emergency health care and standards to insure that sufficient personnel will be available to attend to members’ needs. The guidelines also require adequate arrangements to provide inpatient hospital services for basic health care and a requirement that the services of specialists be provided as a basic health care service.

**Open Ended Plans**

An open ended HMO (also known as a “leaky HMO” and “point of service HMO”) is a hybrid arrangement whereby participants may use non-HMO providers at any time and receive indemnity benefits which are subject to higher deductible and coinsurance amounts. The out-of-pocket cost to the participant (and probably the employer, too) is higher, but the arrangement allows participants to remain in control in choosing a health care provider.
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Open Access HMOs

Dissatisfaction with the “gatekeeper” mechanism, delays in receiving care, and problems in obtaining referrals have led many health plans to offer open access. An open access HMO allows members to receive care from network specialists without first going through a primary care physician (gatekeeper) and receiving a referral. Alternatively, a point of service (POS) plan allows members to seek the care of a specialist outside of the HMO provider network. Because the plan does not control the outside provider, POS plans tend to be more expensive than open access HMOs.

Exercise

A. The main difference between traditional health insurance arrangements and HMOs is that
   ( ) 1. traditional health insurance companies provide both the health care service and the health care financing, while HMOs provide only the health care financing.
   ( ) 2. traditional health care insurance companies provide both the health care service and the health care financing, while HMOs provide only the health care service.
   ( ) 3. HMOs provide both the health care service and the health care financing, while traditional health care insurance companies provide only the financing.
   ( ) 4. HMOs provide both the health care service and the health care financing, while traditional health care insurance companies provide only the service.

B. The following type of health care insurer is an example of a producer’s cooperative.
   ( ) 1. Urgent care center
   ( ) 2. Blue Cross/Blue Shield
   ( ) 3. Commercial insurer
   ( ) 4. Skilled nursing facility

C. The Hoosier HMO contracts with an independent medical group that specializes in a variety of medical services to provide those services to HMO subscribers. The Hoosier HMO is structured as a(n)
   ( ) 1. staff model HMO.
   ( ) 2. network model HMO.
   ( ) 3. group model HMO.
   ( ) 4. Individual Practice Association Model HMO.

Answer: A. 3. HMOs provide both the health care service and the health care financing, while traditional health care insurance companies provide only the financing; B. 2. Blue Cross/Blue Shield; C. 3. group model HMO

PREFERRED PROVIDER ORGANIZATIONS

Other efforts to reduce medical costs have resulted in Preferred Provider Organizations (PPOs). PPO refers to an arrangement under which a selected group of independent hospitals and medical practitioners in a certain area,
such as a state, agree to provide a range of services at a prearranged cost. The contracting agency or organizer of the PPO might be any one of a number of groups including:

- Traditional insurance companies
- Blue Cross/Blue Shield
- Local groups of hospitals
- Local groups of physicians

- An existing HMO
- Large employers
- Trade unions

The organizers and the providers agree upon medical service charges that are generally less than the providers would charge patients not associated with the PPO. Unlike most prepaid HMO arrangements, the providers are paid on a fee-for-service basis, rather than receiving a flat monthly amount for each user. Providers are willing to enter into this arrangement in return for guaranteed payment from the PPO and a potential increase in number of patients.

The people who will receive services choose a preferred provider from a list the PPO distributes. As a general rule, the users have more choices among doctors and hospitals under a PPO than under an HMO arrangement. However, some recent HMO structures offer similar arrangements. PPOs fall somewhere in between commercial insurers, where the user has unlimited choice of practitioners, and HMOs, where the user might be severely restricted. Even with the usually long list of PPO providers from which to choose, people may opt to go to another provider. However, the PPO agrees to pay its full benefits only when a preferred provider is used. If an individual uses a nonpreferred facility, the PPO usually pays a reduced amount and the individual must pay the balance.

While a PPO generally pays less for services performed by a nonpreferred provider, this rule is mitigated for emergency services under most PPO plans. Recognizing that emergencies may require treatment in other than preferred facilities or by providers who have not agreed to the PPO arrangement, PPO plans will generally pay in full for emergency treatment regardless of where and by whom it is performed.

Suppose Dorian is a member of a PPO in his hometown of Topeka, Kansas. While vacationing in Utah, he is injured in an auto accident and is rushed to the nearest hospital in Salt Lake City. Dorian's medical bills in Salt Lake City total $5,600 before he is returned to Topeka. The same treatment with his preferred providers in Topeka would have cost only $4,780. Under these circumstances, Dorian's PPO is likely to pay the Salt Lake providers the full amount due.

PPOs and HMOs are often lumped together and referred to as “managed health care systems.” While they do share the concept of saving costs by proper health care management and are similar in many ways, they are distinguishable by the fact that PPOs have no separate physical facility while HMOs generally do. But even this distinction has become blurred somewhat by continuing refinements and variations in the way HMOs operate. Currently, an HMO may operate through a PPO arrangement rather than have its own facility.
A distinguishing characteristic that still exists concerns regulation. While commercial insurance companies are regulated only by the states, HMOs have increasingly had to meet state requirements as well as the original standards established by the federal government. PPOs, on the other hand, are less stringently regulated, since any group that can agree upon the arrangements may call itself a PPO.

**POINT OF SERVICE PLANS**

Point of service plans (POS) are another form of managed care. With point of service plans, the insured is given a choice of receiving care in-network or out-of-network. In-network means receiving care through a particular network of doctors and hospitals participating in the plan and all care is coordinated by the insured primary care physician (PCP). This includes referrals to specialists and arrangements for hospitalization, which must all be approved by the PCP. In-network coverage is the highest level of coverage within the plan, which means the plan will pay more for medical services and the insured won’t have to submit claim forms. Out-of-network coverage applies when the insured receives care for a provider who does not participate in the plan’s network and the care is not coordinated by the primary care physician. When the insured receives out-of-network care, he or she will usually pay more of the cost than if it had been in-network care (emergencies excepted). Out-of-network care also means that the insured will have to submit claim forms in order to receive benefits.

For example, suppose Arnold is a member of a point of service plan. He develops a heart condition but decides not to follow his PCP’s recommendation of an in-network cardiologist. Instead, he becomes the patient of a famous cardiologist in another city who is out-of-network. Arnold can expect that his POS plan will pay less than it would pay had he become the patient of the in-network cardiologist.

**Exclusive Provider Organizations (EPOs)**

Exclusive provider organizations are a type of PPO in which individual members use particular preferred providers, instead of having a choice of a variety of preferred providers. Providers are not paid a salary, but are paid on a fee-for-service basis.

EPOs are characterized by a primary physician who monitors care and makes referrals to a network of providers (this is known as the gatekeeper concept), strong utilization management, experience rating, and simplified claims processing. EPOs can serve as an alternative to or companion to HMOs and PPOs.

**Emerging Variations**

Today there are many variations of managed health care providers, including physician hospital organizations (PHOs), practice management organizations (PMOs), and provider sponsored networks (PSNs).
The principal differences between these organizations are the parties to the contracts and their basic structure and organization. For example, with the physician hospital organization, the physicians and hospitals contract directly with employers to provide health care services. Most of these arrangements are funded through capitation fees much like HMOs.

**Multiple Option Plans**

A multiple option plan is an integrated health plan which may include services of an HMO, PPO, EPO, and/or indemnity plan, all of which are administered by a single vendor (usually an insurance company).

**EMPLOYER ADMINISTERED PLANS**

**Self-Funding**

If claim costs are fairly predictable, an employer may consider a self-funded health care plan. With a self-funded plan an employer, not an insurance company, provides the funds to make claim payments for company employees and their dependents. In the event that claims are higher than predicted, a self-funded health insurance plan can be backed-up by a “stop-loss” contract. A stop-loss contract is designed to limit the employer’s liability for claims. There are two variations of this coverage. Specific stop-loss coverage begins to apply after an individual’s medical expenses exceed a predetermined threshold such as $5,000. Aggregate stop-loss coverage applies when the employer’s liability for group insurance claims exceeds a specified amount. The insurer pays all claims once the specified amount is reached.

An employer self-funded plan may be an indemnity program which reimburses covered employees for medical care they have received. Or, the employer may provide benefits through the service plan offered under an HMO, or through an insurer’s PPO network.

An insurer may also be used for a self-funded employer under an “administrative services only” (ASO) contract. Under the ASO contractual agreement the insurer provides claim forms, administers claims, and makes payments to health care providers, but the employer still provides the funds to make claims payments.

**Advantages Of Self-Insurance**

Self-insurance has four major advantages:

- The company can save money if actual losses are less than those predicted.
- The expense of carrying insurance may be reduced because of the elimination of administrative costs, agent commissions, brokerage fees, and premium tax.
- Because the company has assumed the entire risk, there may be a greater effort on its part to seek ways to reduce claims, and encourage employees to actively participate in “wellness” programs and improved lifestyles.
- The company has use of the money that would normally be held by the insurance company.
Disadvantages Of Self-Insurance

The main disadvantages of self-insurance are the following:

- Actual losses may be more than predicted, causing the unexpected loss of funds that were to be used for other purposes.
- Expenses could be higher than expected if additional personnel have to be hired to administer claims, manage risk, or offer employee information.
- Income taxes could be higher because the company will not be able to take premiums paid as a deduction; only the claims paid, and operating expenses may be taken as a tax deduction.
- Contracts are usually not regulated by the Insurance Department, and therefore the Department cannot assist consumers with problems.
- Contracts are not subject to mandated benefits laws.

501(c)(9) Trusts

Section 501(c)(9) of the Internal Revenue Code provides for the establishment of voluntary employees’ beneficiary associations or 501(c)(9) trusts which are funding vehicles for the employee benefits that are offered to members. Liberalized tax treatment made 501(c)(9) trusts an attractive self-funding employee benefit plan alternative, but restrictive legislation in the Tax Reform Act of 1984 has caused their popularity to diminish.

Some employers may prefer to establish a 501(c)(9) trust for some of the tax advantages it provides. Under a regular self-funded plan, contributions to the plan cannot be deducted until benefits are distributed. But contributions to 501(c)(9) trusts are deducted immediately. Accumulated earnings on 501(c)(9) assets are also tax-deductible unlike earnings on funds in a regular self-insured plan.

Maintaining a 501(c)(9) trust can be quite costly though, and administration of the plan must be exceptional to make it worthwhile to the employer. High losses under the plan may negate any tax advantages a 501(c)(9) trust offers.

Small Employers

Small employers (usually defined as those with fewer than 25 or 50 employees) have been especially hard hit by increases in health care insurance premiums. Because many group plans are “experience rated,” small employers see an immediate premium increase whenever claims are particularly high. If the average age of the participants is particularly high, or if claims experience is high, or if there has been even one long or catastrophic illness in a small employer plan, it can have a devastating effect, making health insurance unaffordable for the whole group. Recent surveys by the Health Insurance Association of America (HIAA) indicate a substantial decline in the number of small firms that are able to offer health coverage to their employees.
Several states have acted to ensure that health insurance coverages are available at a reasonable cost and under reasonable conditions for small employers. Among the new requirements:

- Standard benefit plans that must be offered to small employers
- Maximum waiting periods for preexisting conditions
- The insurer may not exclude particular individuals or medical conditions from coverage
- Carriers may only cancel or nonrenew small employer plans for nonpayment of premium, fraud, misrepresentation, or noncompliance with plan provisions

**Cafeteria Plans**

A cafeteria plan could be defined as a plan in which employees select health benefits from a variety of coverage options, based on their individual and family needs. Cafeteria plans tend to be more complex (and more expensive) than traditional plans, especially with regard to plan administration, and usually make the most sense for larger employers. Benefits are elected in advance of the year in which they will be used (benefits to be used in 1999 will be elected at the end of 1998). Taxation of cafeteria plans is regulated by Section 125 of the Internal Revenue Code.

**Medical Savings Accounts (MSAs)**

A medical savings account (MSA) is an employer-funded account linked to a high deductible medical indemnity plan. Usually, the employer raises the existing plan deductible (usually by 300% to 400%) and in turn returns a portion of the premium savings to employees as contributions to the medical savings account. Employees can use the contributions to pay for health care expenses throughout the year, and at the end of the year may withdraw whatever remains in the account in cash (as taxable income).

Current law limits availability of MSAs to employers with 50 or fewer employees. The annual deductibles for individual coverage range from $1,500-$2,250, and for family coverage between $3,000-$4,500. The maximum amount that can be contributed to an MSA is 65% of the high-deductible plan for individuals, or 75% of the family deductible for those with family coverage. The pilot program authorizing MSAs is subject to Congressional reauthorization after December 31, 2000, but anyone enrolled in a current MSA is entitled to keep the plan for life.

**Multiple Employer Trusts (METs)**

Multiple employer trusts provide health insurance benefits to small businesses through a series of trusts usually established based on specific industries such as manufacturing, sales and service, real estate, etc.

Most states have group size eligibility requirements for employer groups to qualify for group insurance. Generally, states may require a minimum of five to ten participants for a group to be eligible for group benefits. METs typically have no such requirements and in reality a group of one could be eligible for group benefits.
METs are formed by insurers or third-party administrators who are called sponsors. The sponsor develops the plan, sets the underwriting rules, and administers the plan. To help prevent the possibility of adverse selection, the underwriter must make sure that the sponsor’s underwriting rules are adequate and that he or she adheres to them. This is necessary because an employer with only two, three or five employees could elect to join an MET because they know of the poor health condition of one of the employees. The underwriting standards must be able to prevent this from happening.

If state law allows, METs may be noninsured. A noninsured plan is a self-funded plan; that is, a plan that operates without the services and funds of an insurance company. The trustee has charge of the funds and the policies and all financial activities occur through the trust.

As with a traditional group insurance plan, a master policy is issued to a trustee who is operating under a trust agreement. The master contract has its own policy effective date and renewal dates which the insurer may use for changing rates on the MET’s entire block of business. Also, each individual employer under the MET has its own effective dates and anniversary dates. Rates are generally changed on the employer’s anniversary date, but usually not more than once in 12 months.

Multiple Employer Welfare Arrangements

Multiple Employer Welfare Arrangements (MEWAs) are employer funds and trusts providing health care benefits (among other benefits) to employees of two or more employers.

ERISA, the federal Employee Retirement Income Security Act which is designed to protect group health insurance plan participants, restricts states’ ability to regulate employee welfare benefit plans while preserving state insurance laws having to do with reserve requirements. A state may regulate insurance, but may or may not consider an employee welfare benefit plan an “insurance plan” for the purpose of regulation.

Some self-funded MEWAs claim they are not subject to Insurance Department regulation and operate under a supposed preemption under ERISA. As a result, many have gone unregulated, and have fraudulently collected premiums from small business only to fold and leave millions of dollars of unpaid claims.

State and federal regulators are attempting to resolve the question of jurisdiction. Meanwhile, in most states MEWAs need to obtain a Certificate of Authority in order to transact insurance business, and must be fully insured by a licensed insurer. Usually, agents and brokers are prohibited from assisting MEWAs to transact insurance until and unless the agent or broker files a report with the Department of Insurance outlining the MEWA’s organization, insurance contracts, benefit plan description, and the designated third party administrator.
OTHER FORMS OF GROUP INSURANCE

Blanket Policies

Many types of groups, such as the students of a single school or a group of campers, are indefinite in number and composition and are constantly changing. These characteristics prevent qualification for group insurance under the usual terms.

However, groups such as these can have health coverage at group rates under a blanket policy. Since no employer/employee relationship is involved, the members of such groups are not usually interested in covering themselves for loss of income resulting from their activities as a group. Instead, they usually want only hospital, medical and surgical coverages.

As an example, the dean of a college might make insurance available to all full-time students. The group members are constantly changing as students enroll, graduate, or drop out. By obtaining a blanket policy, the dean can secure student coverage at the same low premium rates as group coverage. However, the members of the group, the students, will not be identified by name. Instead, all who can prove they are enrolled full-time will be covered by the insurance “blanket.”

Or consider Gina, who owns a small business and is also the leader of a local Girl Scout troop. Through an insurance company, Gina has established insurance plans for both of these groups.

For her employees, Gina provides group health insurance. Under the group plan, Gina provides the insurance company with each group member’s name.

For the Scout troop, Gina provides a blanket policy, under which she does not give the insurance company a list of the group’s members, since they change frequently.

The members of a group insured under a blanket policy may or may not help to pay the premiums for their coverage. In the case of the college students, the school might require that they pay at least part of the premiums. In the case of the Scouts, perhaps Gina’s Scout council pays for the coverage, and the children are not required to pay anything. In any event, blanket policies may be either contributory or noncontributory.

Franchise Policies

Group policies require the number of insured persons to remain above a specified minimum. Many small businesses and other groups do not have enough members to qualify. An arrangement that allows very small groups to have some of the benefits of group insurance, especially the lower cost, is called franchise insurance.

Franchise insurance works much like group insurance, but it is established differently. There is no master policy. Instead, each member of the group receives an individual insurance policy. This allows group members to make some coverage choices, but they are required to provide health information on their applications, just as they would for individual policies.
Like true group coverage, franchise insurance offers hospital, surgical, medical and disability income coverage. Plans may be contributory or noncontributory. One premium is paid for the whole group.

One example of franchise insurance is coverage sold by mail to groups such as the members of a certain association or holders of certain credit cards. Purchasers receive individual policies at group rates, so this is a type of franchise insurance.

**GOVERNMENT HEALTH INSURANCE**

Both the federal and state government offer statutory health insurance programs. On the federal level, Social Security provides disability income benefits and administers the Medicare program. On the state level, all states have workers compensation laws and Medicaid or some similar form of state subsidized health care.

**SOCIAL SECURITY**

Social Security pays four types of benefits:

- Disability income benefits to workers
- Medicare benefits
- Retirement benefits to workers and their dependents
- Survivors benefits to a worker’s family

A special insured status is required if a worker is eligible for disability benefits under Social Security. This status requires that the worker be fully insured and to have earned at least 20 quarters of coverage in the 40 calendar quarter period ending with the calendar quarter in which the disability begins. This requirement is modified slightly if a covered worker is disabled prior to age 31.

A covered worker may be eligible for disability income benefits if the required insured status is achieved, the worker is under age 65, and can satisfy the Social Security definition of total disability.

Social Security defines total disability as the inability to engage in any substantial gainful activity due to physical or mental disability which is expected to last for at least 12 months or end in death. Substantial work activity means significant mental and/or physical duties for which a person is compensated.

This definition does not refer to the individual’s occupation prior to disability or to the level of predisability compensation. A surgeon earning $200,000 annually may be disabled to the degree that he or she could no longer perform surgery. However, if this person could perform other meaningful work duties (bank employee, school teacher, salesperson, etc.), he or she would probably not be eligible for disability benefits since they could not meet the Social Security definition of total disability.
The amount of the disability benefit is equal to the worker’s PIA (Primary Insurance Amount) which in essence is the same as the individual’s monthly retirement benefit. Disability benefits are only payable for total disabilities. Disability benefits begin with the sixth full month of disability. This waiting period begins with the first full month of disability. No benefit is paid for a partial disability.

Family members such as the following may also receive disability benefits as a result of the disabled person’s work record:

- An unmarried child under 18, or under 19, if in high school full time
- An unmarried child disabled before age 22
- A spouse caring for a child under 16 or disabled
- A spouse age 62 or older
- A disabled widow or widower age 50 or older
- A disabled surviving divorced spouse age 50 or older, if the marriage lasted at least 10 years

**WORKERS COMPENSATION**

Most states require employers to provide workers compensation benefits for their employees. Workers compensation is designed to help the person who suffers from loss of income due to injury or sickness which occurs as a result of his or her occupation.

**Eligibility**

In order to be **eligible** for workers compensation benefits the disabled worker must:

- Work in an occupation that is covered by workers compensation
- Have had an accident or sickness that is work-related

**Benefits**

Workers compensation laws provide for the payment of four types of benefits:

- Medical benefits
- Income benefits
- Death benefits
- Rehabilitation benefits

**Medical benefits** are provided without limit. An injured or diseased employee is entitled to receive all necessary medical and surgical treatment to cure or relieve the condition. Certain maximums or limits may apply to a type of care or a particular medical item, but overall benefits are unlimited.

**Income benefits** are paid to employees who suffer work-related disabilities. An **elimination period** applies before benefits for loss of wages begin. If the disability continues beyond a certain period, retroactive benefits will be paid for the initial waiting period. A disability may be total (making employment impossible) or partial (resulting in a reduced ability to work). Either type of disability may be temporary or permanent. For **permanent total disability**
or **temporary total disability**, the benefit is 66\(\frac{2}{3}\)% of weekly wages, subject to minimum and maximum weekly limits. However, for permanent total disability the dollar maximum and the benefit period are greater (benefits for permanent total disability often continue for life, while benefits for a temporary total disability are limited). People with **partial disabilities** are able to perform some work, so the laws provide a benefit equal to a percentage of the wage loss (difference between earnings before and after the accident). In addition to benefits for lost wages, the state provides scheduled benefits for specific **permanent partial disabilities**, such as loss of limbs, sight, or hearing. Usually these benefits are paid in addition to any other income benefits.

**Death benefits** provide two types of payments. Up to a certain dollar amount is provided as a burial allowance, and the state also provides weekly income payments for a surviving spouse and/or children. Weekly benefits are 66\(\frac{2}{3}\)% of the deceased worker’s wages, subject to minimum and maximum dollar amounts, and a maximum time limit, and an aggregate payment limit. Surviving children generally receive benefits until a certain age.

**Rehabilitation benefits** are now recognized as a valuable tool for reducing workers compensation costs and returning disabled employees to their jobs, as soon as possible. Rehabilitation may include therapy, vocational training, devices such as wheelchairs, and the costs of travel, lodging, and living expenses while being rehabilitated.

**MEDICAID**

Medicaid provides health care benefits for the financially needy. It is basically a state program with some federal financial support. Medicaid is designed to provide increased assistance to those who are unable to pay for their medical needs. For those persons aged 65 or over, Medicaid principally supplements Medicare for those who cannot pay the expenses not covered by Medicare. For those not eligible for Medicare, it provides medical assistance for certain categories of people who are medically needy—the blind, the disabled, families with dependent children, or medically needy children under age 21.

Medicaid is a federal-state program. The federal government encourages states to increase medical assistance to the indigent, regardless of age, by paying one-half of the administration cost of state medical assistance programs and 50% to 80% of the fees to the providers of services to the needy. The actual federal matching proposition varies inversely with the state average per capita income; therefore the poorer states receive the larger federal grants.

Generally, Medicaid helps to pay for medical services which the patient cannot pay for. Thus, Medicaid will cover such services as hospitalizations, physician’s services, diagnostic testing, pregnancies, etc.

In addition, Medicaid also serves as a “supplement” to Medicare in some situations. For example, Medicare currently offers extremely limited coverage for nursing home care. Often Medicaid will supplement these limited benefits by paying for nursing home expenses. Other health care expenses not completely covered by Medicare may be paid for by Medicaid.
TRICARE

The Department of Defense operates one of the largest health care systems in the United States, covering more than 8 million active duty and retired military personnel and their families. In response to increasing health care costs and the closing of many military hospitals, the Pentagon has revised and renamed its health care program. Formerly called CHAMPUS (Civilian Health and Medical Program of the Uniformed Services), the new TRICARE program provides care for all seven of the uniformed services, and incorporates many of the managed care options found in private health care plans. A choice of three health care plans is offered:

- TRICARE Prime offers HMO-style care provided through a primary care manager. All non-emergency care is received at military hospitals and clinics, or through the TRICARE network of contracted civilian care providers (TRICARE Prime is the least expensive to the enrollee)
- TRICARE Extra offers health care through a network of civilian hospitals and clinics who have agreed to charge an approved rate for medical treatments and procedures
- TRICARE Standard, which is essentially the same as the old CHAMPUS program, allows enrollees the flexibility of using civilian doctors for all outpatient care, with partial reimbursement by the government (TRICARE Standard is the most expensive to the enrollee)

Several military organizations also offer “TRICARE Supplements”, which, like Medicare supplements, are insurance plans that cover the deductibles and copayment charges imposed by the TRICARE health plan.

REVIEW

1. The Albuquerque HMO's contracting physicians are paid employees working on the staff of the HMO, operating in a clinic setting at the HMO's physical facilities. The Albuquerque HMO operates as a(n)

   ( ) A. staff model HMO.
   ( ) B. network model HMO.
   ( ) C. group model HMO.
   ( ) D. Individual Practice Association Model HMO.

2. Star HMO contracts with 14 medical groups to increase accessibility to providers as a convenience for subscribers. Each of the medical groups are paid on a capitation basis to provide services to Star's subscribers. The Star HMO operates as a(n)

   ( ) A. staff model HMO.
   ( ) B. network model HMO.
   ( ) C. group model HMO.
   ( ) D. Individual Practice Association Model HMO.
NOTES

3. The Provider's Choice HMO was started by a group of individual physicians who each operate out of their own offices. The physicians are paid on a fee-for-service basis with the fees negotiated in advance. Provider's Choice HMO operates as a(n)

( ) A. staff model HMO.
( ) B. network model HMO.
( ) C. group model HMO.
( ) D. Individual Practice Association Model HMO.

4. Gwyneth's HMO requires that she receive health care services from a specified, limited number of health care providers chosen by the HMO. Gwyneth's HMO is

( ) A. open-panel.
( ) B. closed-panel.
( ) C. choice-panel.
( ) D. guarded panel.

5. All of the following are examples of managed care plans except

( ) A. health maintenance organizations.
( ) B. preferred provider organizations.
( ) C. indemnity arrangements.
( ) D. point-of-service plans.

6. A method of payment in which a provider is paid a specific fee monthly for each subscriber is known as

( ) A. indemnity.
( ) B. fee-for-service.
( ) C. managed care.
( ) D. capitation.

7. Calvin is hit by a car while traveling out of state. When the bill for his emergency services arrives, Calvin's HMO will probably

( ) A. pay for the services, even though they were incurred out-of-network, because emergency coverage is a basic health care service.
( ) B. deny the claim, because the services were out of network.
( ) C. pay the claim only if the HMO had an affiliation agreement with the facility where the services were provided.
( ) D. pay the claim if the HMO had an affiliation agreement with the facility where the services were provided, or there if there is no affiliated facility within 50 miles.

8. Best Cleaners has a health plan that provides its employees with a high deductible medical indemnity plan and an account funded by the business that employees can use to pay for medical expenses throughout the year, or withdraw at the end of the year as taxable income. The plan is probably a

( ) A. cafeteria plan.
( ) B. Medical Savings Account.
( ) C. multiple employer trust.
( ) D. third-party administrator.
9. Bob’s Balloons has a plan in which its employees can select benefits from a variety of coverage options, based on individual and family needs. The plan is probably a

( ) A. cafeteria plan.
( ) B. Medical Savings Account.
( ) C. multiple employer trust.
( ) D. third-party administrator.

10. The Gargantuan Garage company funds its own claims, but uses another company to make sure the plan is run correctly, acting as a liaison between the insurer and the employer. This arrangement is probably a

( ) A. cafeteria plan.
( ) B. Medical Savings Account.
( ) C. multiple employer trust.
( ) D. third-party administrator.

11. Which of the following individuals would probably qualify for Social Security disability benefits?

( ) A. George, a ski instructor who breaks his leg.
( ) B. Carl, who becomes ill with a viral infection and is not expected to be able to work for the next 6 months.
( ) C. Mike, a mechanic who loses his dominant hand in an accident.
( ) D. John, who experiences serious early-onset Alzheimer’s and is unable to remember how to get to work.

12. Under Workers Compensation, the permanent total disability benefit, while subject to minimum and maximum dollar amounts, is generally

( ) A. 50% of weekly wages.
( ) B. 662/3% of weekly wages.
( ) C. 701/2% of weekly wages.
( ) D. 75% of weekly wages.

13. Under Workers Compensation, individuals with partial disabilities who are able to perform some work, are eligible to receive

( ) A. no benefits.
( ) B. 662/3% percent of weekly wages, subject to minimum and maximum dollar amounts.
( ) C. the entire wage loss, subject to minimum and maximum dollar amounts.
( ) D. a percentage of the wage loss, subject to minimum and maximum dollar amounts.

Answers:
1. A. staff model HMO.
2. B. network model HMO.
3. D. Individual Practice Association Model HMO.
4. B. closed-panel.
5. C. indemnity arrangements.
NOTES

7. A. pay for the services, even though they were incurred out-of-network, because emergency coverage is a basic health care service.

8. B. Medical Savings Account.


11. D. John, who experiences serious early-onset Alzheimer's and is unable to remember how to get to work.

12. B. 66⅔ of weekly wages.

13. D. a percentage of the wage loss, subject to minimum and maximum dollar amounts.
UNIT 2

POLICY UNDERWRITING, ISSUANCE AND DELIVERY

LEARNING OBJECTIVES

After completing Unit 2—Policy Underwriting, Issuance and Delivery, you will be able to:

1. Explain the underwriting objectives applicable to health insurance.
2. Define earned and unearned premium.
3. List possible payment modes for health insurance, and explain which is used most frequently, and which results in the highest overall cost to the insured.
4. Explain when health insurance policies go into effect.
5. Define the policy term for health insurance.
6. List and explain three reasons for delivering a policy in person.
7. Define replacement, and the advantages and disadvantages of replacing health insurance policies.
8. Define fiduciary, and explain how that applies to health insurance producers.
9. Summarize health insurance producers’ responsibilities.
POLICY UNDERWRITING, ISSUANCE AND DELIVERY

UNDERWRITING OBJECTIVES

Health insurance underwriting is the process of selection, classification, and rating of risks. Most companies offering health policies have a variety of policies available and underwriting standards for each policy are usually established. Low limit policies with limited coverages do not require the underwriting that broad coverage policies with high limits do; the greater the company’s exposure the more careful the underwriter has to be. Underwriting is generally more restrictive for individual than for group policies. The underwriter’s principal functions are to review applications to eliminate those that do not meet underwriting standards, thus reducing adverse selection, and to classify risks to establish benefits and corresponding premium.

Certain underwriting factors for health insurance may be more or less important than for the underwriting of life insurance. For example, an individual with a serious back ailment presents a major risk for the health insurance underwriter because of the danger of such a chronic condition creating several expensive claim situations. However, for the life insurance underwriter, this same condition may be of little significance as a bad back is not likely to affect the individual’s mortality.

PREMIUM PAYMENTS

Definition Of Premium

The premium is a sum of money the insured pays the insurer in exchange for or in consideration of the benefits or indemnities provided in the policy.

Since a premium is paid in consideration of the benefits provided in the policy, it is frequently called just that, a consideration. So, the premium is the consideration paid for the benefits provided by the policy.
**NOTES**

**Earned And Unearned Premium**

Premium payment frequency varies, but regardless of frequency, the insured is always paying for the upcoming period. That is, insurance premiums are paid in advance.

Suppose Kathryn’s health insurance premium is $500 per year, which she pays in full on January 1st. Since the $500 covers an entire year, the insurer earns the premium as the time passes, having both *earned* and *unearned* premium on hand during the policy term. The illustration below shows how it looks as the year passes.

**Unearned And Earned Premium**

![Illustration of Earned and Unearned Premium]

Referring to the illustration, you can see that as of March 31, the insurer has provided protection from January 1 through March 31. At this point, $125 represents the amount paid for the period for which protection has been provided, so $125 is the earned premium.

The remaining $375 of premium Kathryn has paid is, as of March 31, called the unearned premium.

**Payment Modes**

In the insurance industry, *mode* of premium payment refers to the *frequency* with which premiums are paid. Payments may be made:

- Annually—once a year
- Semi-annually—twice a year
- Quarterly—once every three months
- Monthly—once a month
- Weekly—once a week

Of these five modes, the least-used frequency for individual policies is weekly. You probably know that in group health plans employers often deduct the employees’ shares weekly, but it is likely that the employer actually sends the premium to the insurer less frequently.
Insurers generally calculate premiums on an annual basis. If the insured wants to pay by any of the other modes, the premium increases slightly as the frequency increases. The increases allow the insurer to recoup (1) the additional billing and handling costs and (2) the lost interest the insurer could have earned by having the full annual premium to invest all at once.

So, for example, a monthly premium mode results in a premium that is somewhat higher than a semi-annual mode. And, an annual premium mode results in a premium that is somewhat lower than a quarterly mode.

**Initial Premium**

The *initial premium*, as the name implies, is the first premium the applicant pays in order to place the policy into effect. A health insurance policy goes into force when:

- The initial premium has been paid and
- The policy is delivered to the insured

unless the initial premium was paid with the application and a conditional receipt was issued. When the initial premium is paid with the application and the applicant satisfies all of the conditions of the conditional receipt, coverage takes effect just as if the policy had already been issued.

A producer should always try to obtain the initial premium with an application and submit the entire package for underwriting. This affords faster protection to applicants, and applicants are less likely to change their minds about purchasing policies once they have money invested in them.

The important thing to remember is that coverage never applies until the insured has paid for it. If the initial premium does not accompany the application, the premium must be collected at policy delivery along with a signed statement that the insured continues to be in good health. The policy is then effective as of the date stated in the policy.

When the policy is delivered, the producer should explain the provisions, point out any exclusions and—very important—go over any significant rating that affects the insured's coverage and premium payments.

**Policy Effective Date**

Although it is generally true that a policy is effective when the initial premium has been paid and the policy delivered (or under the conditions of a conditional receipt), there is a better way for a producer to respond when asked when a particular policy takes effect.

The best approach is to state that the policy takes effect *on the date specified in the policy* as the effective date.

Remember that accident coverages usually take effect immediately when the policy is issued, while sickness coverages may require a probationary period. Therefore, different coverages under the same policy might have different effective dates.
Policy Term

Once a health insurance policy becomes effective, it will stay in force for the period for which the premium has been paid, unless the insurer or the insured cancels it. In other words, the policy will stay in force for a specified period or term.

The length of the term is governed by the length of time for which coverage is purchased by the premium payment. If a policy calls for annual premium payment, for example, one year is the term of the policy. If premiums are paid semi-annually, the term extends for each six-month period for which the premium is paid.

Policy Fee

When a policy is issued, some companies charge a policy fee, which is generally a flat amount that helps defray expenses such as acquisition costs, producer commissions, administration and maintenance of the policy. There are two different ways a policy fee might be handled.

Usually, the policy fee is added to the premium and is paid annually. For example, the company might charge an annual premium of $300 plus a $15 policy fee, for a total annual premium of $315, which the insured will pay every year.

Some companies, on the other hand, may charge a policy fee only once—at the time the policy is issued. For example, suppose the annual premium is $300 and the policy fee $25. The insured will pay an initial premium of $325, which includes the one-time policy fee, but for succeeding years, will pay only $300.

Exercise

A. The sum of money the insured pays the insurer in exchange for the benefits provided in the policy is the

( ) 1. co-payment.
( ) 2. premium.
( ) 3. indemnity.
( ) 4. capitation.

B. Ally pays for her health insurance monthly. Her identical twin Georgia has the same policy, but pays annually. Which of them probably pays more for the policy?

( ) 1. Ally probably pays more.
( ) 2. Georgia probably pays more.
( ) 3. They probably pay the same.
( ) 4. It is not possible to determine from the information provided.

C. Health insurance coverage never applies until

( ) 1. the policy is delivered.
( ) 2. an underwriting decision is made.
( ) 3. the application is reviewed by underwriting.
( ) 4. the insured has paid for the policy.

Answer:  
A. 2. premium; B. 1. Ally probably pays more; C. 4. the insured has paid for the policy
DELIVERING THE POLICY

The surest way to be certain the policy is delivered is to do it personally. In addition to knowing the policy has been delivered, the producer has the following opportunities:

- To explain the policy. It is important in health insurance for the policyowner to have basic understanding of what is and isn’t covered. With today’s high health costs, it is extremely important for the insured to know what the policy limitations are on the different types of medical expenses covered. Sometimes policy premiums are higher than standard (rated up) because the insured does not meet certain basic health requirements or is involved in extra hazardous hobbies or avocations. These facts should be explained to avoid future misunderstandings and/or dissatisfaction. Finally, if the premium was not collected with the application, the company may require the producer to obtain a statement of good health from the insured at the time the policy is delivered and the premium paid.
- To reinforce the relationship and goodwill which have been established with the client
- To explain the possible need for additional health or other coverages

Legally, the policy is considered “delivered” when it is mailed or turned over to the policyowner or someone acting on his or her behalf. Some companies do mail policies directly to policyowners. However, many prefer to have the producer make a personal delivery. In some cases, a constructive delivery is deemed to occur when the insurer mails a policy to its producer for actual delivery to the policyowner, because the insurer has issued the policy and released it for delivery. However, a legal delivery has not yet occurred if the insurer requires personal delivery for verification of good health at the time of delivery, or if the policy is being provided to the applicant merely to review and inspect at that time, and not necessarily to buy.

SERVICING THE POLICY

In many industries, closing the sale means the end of the producer/consumer transaction. However, this is not so in insurance. Insurance policies require ongoing customer service throughout the policy period. Competition in the industry is another incentive to provide good customer service, since it can make all the difference at renewal time. Good customer service makes insureds feel more comfortable doing business with you and makes them more likely to renew with your agency. Proper service of insurance policies also results in referrals, additional coverage, good public relations, and reduced E&O exposure.

REPLACEMENT

Producers attempting to replace the insured’s current policy with a new policy need to take special care not to mislead the insured or provide coverage which is to the insured’s detriment. Of particular concern is the fact that health conditions covered under an insured’s existing policy may not be covered under a replacement policy because of the exclusion of preexisting conditions, or new waiting periods may be established.
A producer recommending replacement should give special attention to the **exclusions** and **limitations** in the proposed policy as compared to the existing policy. Not all policies cover the same things. If the contracts are different, the replacement policy might not provide the same coverages or the same level of benefits as the existing policy.

A producer should consider the **underwriting requirements** of the replacing insurer. Will the insurer cover the insured on a basis as favorable to the applicant as the present insurer? Will the underwriter accept the risk at a similar rate, or will differences in the insured's health or the underwriter's requirements result in a higher premium rate?

Some states have passed "**no loss-no gain**" legislation which requires that when health insurance is replaced, ongoing claims under the former policy must continue to be paid under the new policy, thereby overriding any **preexisting conditions exclusion**. In replacing group health coverage, a **transfer of benefits** statement assures that benefits provided under the old policy continue under the new policy.

One would assume there is no benefit to the insured (and great benefit to the producer) when an insurance policy undergoes **intracompany replacement** (is replaced by a similar policy with the same insurer). Therefore, most general agency and producer contracts specify that the producer's commission will be limited to a percentage of the increase in premium only when a policy is replaced within the same company. This discourages the producer from replacing existing policies with new policies from the same insurer unless the amounts of coverage (and thus the premium) are substantially increased.

Because the elderly are extremely vulnerable and often victimized insurance prospects, and are most susceptible to being penalized by preexisting conditions limitations, producers should be aware that there are often more restrictive regulations for replacing Medicare supplement policies.

Certainly, there are legitimate circumstances when replacement of a policy makes sense and should be recommended—for example, when broader coverage or higher benefits can be obtained at a lower rate, and preexisting conditions and waiting periods are not issues.

However, a producer needs to be very careful in recommending a change in policies or carriers when any potential factors could lead to an uninsured loss which might otherwise have been covered. The producer needs to be aware of his or her own errors and omissions liability, particularly in the area of replacement. Replacement is not illegal, but it is heavily regulated.

**PROFESSIONALISM AND ETHICS**

All business transactions are based to a certain extent on trust. When it comes to insurance, the trust factor is especially significant. When asked what factors matter most in a financial advisor, consumers choose ethical performance more than twice as often as financial performance. Ethics and professionalism are critical components of a successful career as an insurance producer.
Ethics means setting a standard of conduct or behavior based on established values. Insurance producers and other industry employees have long sought to distinguish themselves as professionals. A professional is defined as a person in an occupation requiring an advanced level of training, knowledge or skill. Professionals enjoy privileges commensurate with their skills, but they also have higher responsibilities in caring for others because of the title of professional. Professionals relate to their clients in a way that reflects well on the entire industry. The highest standard of service is provided by preparing for a new client long before even meeting him or her.

**Fiduciary Responsibility**

Insurance producers have a fiduciary duty to just about any person or organization which he or she comes into contact with as a part of the day-to-day business of transacting insurance. By definition, a **fiduciary** is a person in a position of financial trust. Attorneys, accountants, trust officers and insurance producers are all considered fiduciaries.

As a fiduciary, producers have an obligation to act in the best interest of the insured. The producer must be knowledgeable about the features and provisions of various insurance policies as well as knowing the use of these insurance contracts. The producer must be able to explain the important features of these policies to the insured. The producer must recognize the importance of dealing with the general public’s financial needs and problems and offering solutions to these problems through the purchase of insurance products.

As a fiduciary, the producer must know and comply with the state’s insurance laws. Many of these laws are for consumer protection. It is the producer’s duty to comply with these laws and protect the interest of the insured at all times.

**Summary Of The Producer’s Responsibilities**

The insurance producer is a key person in the process of marketing, underwriting and delivery of insurance policies. As a marketing representative of the insurer, it is the producer’s responsibility to represent and market the insurer’s products in an ethical and professional manner. This requires knowledge of various insurance products, being aware of a prospect’s insurance needs and problems and the ability to solve these needs with the proper insurance products.

The producer also has a responsibility to be aware of insurance laws which pertain to marketing of insurance products; such as state required standards for advertising and sales literature. Generally all advertising, sales presentations and illustrations must be truthful, may not misrepresent or omit material information.

As part of the underwriting process, the producer is the primary source of underwriting information. It is the producer’s duty to accurately and thoroughly complete all applications for insurance, and collect initial premiums and promptly submit them to the company. In addition, the producer is responsible for providing the insurance applicant with privacy notices and information such as the Notice of Insurance Information Practices, and finally to provide the insurance applicant with necessary receipts for the initial premium collected.
Another objective of the producer as a field underwriter is to help protect the insurer from adverse risks. If an applicant is substandard, the producer is responsible for delivering the substandard policy and explaining its limitations and/or extra premium to the applicant.

**REVIEW**

1. Once a health insurance policy becomes effective, unless it is cancelled, it will stay in force
   - A. for one year.
   - B. for six months.
   - C. the length of the term.
   - D. indefinitely.

2. Legally, the policy is considered delivered in all of the following situations except
   - A. when the policy is approved by the company.
   - B. when the policy is mailed to the policyowner.
   - C. when the policy is turned over to the policyowner.
   - D. when the policy is turned over to someone acting on behalf of the policyowner.

3. An insurer might require personal delivery
   - A. to ensure the policy goes to the right person.
   - B. for verification of the continued good health of the insured at the time of delivery.
   - C. to ensure the correct policy is delivered.
   - D. to verify information listed on the application.

4. No-loss-no-gain legislation
   - A. requires a replacing policy to have exactly the same premium as the policy it replaces.
   - B. requires a replacing policy to have exactly the same limits of coverage as the policy it replaces.
   - C. requires a replacing policy to continue to pay claims ongoing under the policy it replaces.
   - D. requires a replacing policy to continue to use the same producer to manage the policy as the policy it replaces.

5. A statement that assures benefits provided under the old policy will continue under the new policy is
   - A. a transfer of benefits statement.
   - B. a continuation of benefits statement.
   - C. a preexisting conditions coverage statement.
   - D. a replacement statement.
6. Restrictions applying to the replacement of Medicare supplement policies

( ) A. are often less restrictive than regulations applying to the replacement of other policies.
( ) B. are generally the same as regulations applying to the replacement of other policies.
( ) C. are often more restrictive than regulations applying to the replacement of other policies.
( ) D. are prohibited entirely by federal law.

Answers:

1. C. the length of the term.
2. A. when the policy is approved by the company.
3. B. for verification of the continued good health of the insured at the time of delivery.
4. C. requires a replacing policy to continue to pay claims ongoing under the policy it replaces.
5. A. a transfer of benefits statement.
6. C. are often more restrictive than regulations applying to the replacement of other policies.
UNIT 3

POLICY PROVISIONS

LEARNING OBJECTIVES

After completing Unit 3—Policy Provisions, you will be able to:

1. Describe and explain the purpose of the following mandatory policy provisions:
   - Entire Contract: Changes
   - Time Limit of Certain Defenses
   - Grace Period
   - Reinstatement
   - Notice of Claims
   - Proof of Loss
   - Time of Payment of Claims
   - Payment of Claims
   - Physical Examination and Autopsy
   - Legal Actions
   - Change of Beneficiary

2. Describe and explain the purpose of the following optional policy provisions:
   - Change of Occupation
   - Misstatement of Age
   - Other Insurance with This Insurer
   - Other Insurance with Other Insurers (1 and 2)
   - Relation of Earnings to Insurance
   - Unpaid Premium
   - Cancellation
   - Conformity with State Statutes
   - Illegal Occupation
   - Intoxicants and Narcotics

3. Describe and explain the purpose of the following other policy provisions:
   - The Policy Face
   - Free Look
   - Insuring Clause
   - Consideration Clause
   - Renewability

(continued)
• Benefit Payment Clause
• Exclusions and Reductions
• Preexisting Conditions
• Nonoccupational Coverage
• Case Management Provisions
Since both state insurance laws and insurance policies vary greatly, an attempt has been made to make health insurance policies conform to certain standard regulations. To accomplish this, all states have adopted the Uniform Individual Accident and Sickness Policy Provisions Law. Nearly every state has modified the law to some extent, but all have adopted it in principle.

The law includes 12 mandatory provisions that must be included in individual health insurance policies and 11 optional provisions. Each of the mandatory provisions must be included in each policy, usually in a section of the policy entitled Mandatory or Required Provisions. Insurance companies need not use the exact wording of the provisions, but any variations must be at least as favorable to the insured as the original statutory wording. Each provision is presented as it appears in the law, followed by a short discussion of the content. Since the provision language is somewhat stilted “legalese,” don’t be surprised if you have to read a provision more than once.

**Required Provision 1:**
**Entire Contract; Changes**

Here is the exact wording of the provision:

This policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions.

This provision defines an entire contract as:

- The insurance policy,
- Endorsements, if any, and
- Attachments, if any.

So an entire contract means the policy itself, any endorsements, and any attached papers, such as the application and any riders. Nothing else is part of the contract.
An agent or producer may not change a policy nor waive any of its provisions, but changes may be made if they are approved by an executive officer of the insurance company. The insured will be aware of any such changes because they will be endorsed on or attached to the policy.

**Required Provision 2: Time Limit On Certain Defenses; Incontestability**

(a) After two years from the date of issue of this policy, no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of such two-year period.

(b) No claim for loss incurred or disability (as defined in the policy) commencing after two years from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition, not excluded from coverage by name or specific description effective on the date of loss, had existed prior to the effective date of coverage of this policy.

Unless an insured’s misstatements are fraudulent, after two years from the date the policy is issued, the policy becomes incontestable. Part (a) says that no material misstatements in the application (except for fraud) can be used to void the policy or deny a claim after two years have passed (three years in some states). Fraud can void the health insurance contract whenever it is found and can be proven by the health insurer.

Part (b) states that after two years, the policy cannot be voided, a claim may not be denied, and benefits may not be reduced on the grounds that an illness or a condition was preexisting. This does not prevent an insurer from specifically excluding coverage for a certain condition, but to be excluded the condition must be named or specifically described in the policy when it is written.

**Required Provision 3: Grace Period**

A grace period of . . . days (the period varies according to premium payment frequency: seven days for weekly-premium policies; 10 days for monthly-premium policies; 31 days for all other policies) will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force.

A policy that contains a cancellation provision may add, at the end of the above provision:

subject to the right of the insurer to cancel in accordance with the cancellation provision hereof.
A policy in which the insurer reserves the right to refuse any renewal shall have, at the beginning of the above provision:

unless not less than five days prior to the premium due date the insurer has delivered to the insured, or has mailed to the last address as shown by the records of the insurer, written notice of its intention not to renew this policy beyond the period for which the premium has been accepted.

The required grace period depends upon how often the insured pays the policy premiums, as illustrated here.

**Required Grace Period By Payment Frequency**

<table>
<thead>
<tr>
<th>WEEKLY PREMIUM POLICIES</th>
<th>MONTHLY PREMIUM POLICIES</th>
<th>ALL OTHER POLICIES</th>
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<tbody>
<tr>
<td><strong>Required a 7-DAY grace period.</strong></td>
<td><strong>Required a 10-DAY grace period.</strong></td>
<td><strong>Required a 31-DAY grace period.</strong></td>
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Insurers must allow the insured a period of grace for premium payment. This is a specified time following the premium due date during which coverage remains intact. During a grace period, the company continues coverage in full force and will accept the premium from the policy owner just as if it were not late.

If a policy is cancellable, the grace period is subject to the policy’s cancellation provision. In an optionally renewable policy the company has decided not to renew, the company must follow certain steps to avoid having the grace period affect its right not to renew. The insurer is required to mail written notice of its intention not to renew to the insured’s last known address at least five days before the premium due date. The insurer must keep a record of the mailing in order to protect its rights as well as the rights of the insured.

**Required Provision 4: Reinstatement**

Before you read this provision, let’s cover some information not specifically mentioned in the provision itself. The insured, unlike the insurer, may cancel a policy at any time. In addition, the insured can simply refuse or fail to pay the premium when it is next due. When this occurs, we say that the policy has lapsed. Whether the policy is cancelled by the insurer or the insured or it lapses, the end result is the same—the coverage terminates.
Because this provision is quite long, we’ll cover it in two parts. Here is the first portion:

If any renewal premium is not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by any agent duly authorized by the insurer to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy; provided, however, that if the insurer or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the insurer or, lacking such approval, upon the 45th day following the date of such conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of such application.

According to this part of the provision, with certain exceptions, a lapsed policy is reinstated when either the company or the company’s authorized agent accepts subsequent premiums.

However, an application for reinstatement might be required, and a conditional receipt could be issued to the insured for any premium payment. The insurer will then generally notify the applicant whether or not the policy has been reinstated. But if the insurer does not so notify the applicant, the policy is automatically reinstated on the 45th day after the date of the receipt.

Here’s the second portion of the reinstatement provision.

The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than 10 days after such date. In all other respects, the insured and insurer shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with the reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

The last sentence of the above may be omitted from policies guaranteed renewable to age 50, or if issued after age 44, guaranteed renewable for at least five years.

Once the policy is reinstated, there is

- A 10-day waiting period for sickness coverages
- No waiting period for accident coverages

Otherwise, both the insurer and the insured have all the same rights each had the day before the policy lapsed, subject to any endorsements or riders attached at the time of reinstatement.
Required Provision 5: Notice Of Claim

This lengthy provision is also presented in two parts. Here is the first portion.

Written notice of claim must be given to the insurer within 20 days after occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or in behalf of the insured or the beneficiary to the insurer at . . . . . . (insert the location of such office as the insurer may designate for the purpose), or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer.

When a claim arises, certain stipulations apply. If reasonably possible, the insured must give written notice of claim to the insurer within 20 days after the loss occurs. The insured may send the notice either to the address the insurer provides or to the agent.

While the term “reasonably” is not defined, an example will illustrate one possibility. An insured is injured in an accident and remains in a coma for five weeks, thus failing to provide written notice of claim within the required 20 days. The company is still liable for the claim since it could not reasonably have required the claim to be filed during the time the insured was in a coma.

Here is the remainder of Required Uniform Provision 5:

Policies providing loss-of-time benefits payable for at least two years may insert the following between the first and second sentences of the above provision:

Subject to the qualifications set forth below, if the insured suffers loss of time on account of disability for which indemnity may be payable for at least two years, he or she shall, at least once in every six months after having given notice of claim, give to the insurer notice of continuance of said disability, except in the event of legal incapacity. The period of six months following any filing of proof by the insured or any payment by the insurer on account of such claim or any denial of liability in whole or in part by the insurer shall be excluded in applying this provision. Delay in the giving of such notice shall not impair the insured’s right to any indemnity which would otherwise have accrued during the period of six months preceding the date on which such notice is actually given.

The essence of this provision is that if the policy provides disability income for an extended period, the insurer can require that the insured provide, every six months, written notice that the claim is continuing. This provision does not apply when the insured suffers a legal incapacity.
Required Provision 6: Claim Forms

The insurer, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice, the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

When an insurer receives a notice of claim, it should furnish the insured with forms to provide proof of loss within 15 days. If the insurer fails to do so, however, the insured is required to act to protect the claim by filing written proof of loss detailing the occurrence, the character, and the extent of the loss.

Exercise

A. According to the Entire Contract provision, the entire contract includes all of the following except

( ) 1. the insurance policy.
( ) 2. the premium payment.
( ) 3. any endorsements.
( ) 4. any attachments.

B. In most states, the policy becomes incontestable after

( ) 1. two years.
( ) 2. three years.
( ) 3. four years.
( ) 4. five years.

C. All insurance policies may be cancelled at any time by

( ) 1. the insurer only.
( ) 2. the insured only.
( ) 3. either the insurer or the insured.
( ) 4. neither the insurer nor the insured.

Answer: A. 2. the premium payment; B. 1. two years; C. 2. the insured only

Required Provision 7: Proof Of Loss

Written proof of loss must be furnished to the insurer at its said office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which the insurer is liable, and in case of claims for any other loss within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give such proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.
The following illustration shows the difference between filing a proof of loss when benefits are paid periodically versus filing proof for a one-time, nonperiodic loss as provided in the provision above.

### Filing Proof Of Loss

<table>
<thead>
<tr>
<th>INSURED XAVIER</th>
<th>INSURED YVONNE</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Receives periodic payments of disability income from May 1 through October 11.</td>
<td>• Submits a claim for hospital expenses after an accident at home on April 25.</td>
</tr>
<tr>
<td>• Must file proofs of loss within 90 days after October 11 - the date the insurer’s liability for payment ended.</td>
<td>• Must file proofs of loss within 90 days after April 25 - the date of the loss since no periodic benefits are involved.</td>
</tr>
</tbody>
</table>

**Both Insureds**

Have up to a year following the required filing dates to file proofs of loss if they cannot reasonably do so earlier. Legal incapacity excuses even this limit.

Normally, written proofs of loss must be furnished within 90 days after the date of loss. But when the claim involves periodic payments because of a continuing loss, proofs must be furnished within 90 days after the end of the period for which the company is liable.

If it was not reasonably possible for the insured to provide proofs of loss within the time required, the claim is not invalidated. Still, unless the insured suffers legal incapacity, proofs of loss must be furnished no later than one year from the date they were otherwise due.

### Required Provision 8: Time Of Payment Of Claims

Indemnities payable under this policy for any loss other than loss for which this policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid . . . . . (insert period for payment which must not be less frequently than monthly) and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

According to this provision, except for claims involving periodic payments over a specified time span, the insurer must make the payment immediately after receiving proof of loss.

Payment of periodic indemnities (for disability, for instance) must be made at least monthly.
Let’s look at an example of how this provision works. Wai-ling has been receiving $700 a month for a total disability, but she is able to return to work two weeks after her most recent indemnity payment. She has two more weeks’ benefits coming. She files a final proof of loss, including statements from her doctor (that she has been released) and her employer (that she has returned to work). Upon receipt of this final proof of loss, the insurer must pay the final two weeks’ indemnity immediately.

Notice that in every case, the insured must provide written proof of loss to the insurer.

**Required Provision 9: Payment Of Claims**

This long provision actually contains both a required portion and two optional paragraphs. Here is the required section.

Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured’s death may, at the option of the insurer, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the insured.

This *required* portion of the provision states that

- Death benefits will be paid to the named beneficiary.
- If there is no beneficiary designated, the company will pay the benefit to the insured’s estate.
- If the insured was receiving monthly indemnities under the policy and some accrued benefits remain at the time of death, the company may pay these accruals to either the beneficiary or the insured’s estate.
- While the insured is alive, all other benefits are paid to the insured unless otherwise specifically designated in the policy.

Here is the first of the two optional paragraphs that are included in Required Provision 9.

If any indemnity of this policy shall be payable to the estate of the insured, or to an insured or beneficiary who is a minor or otherwise not competent to give a valid release, the insurer may pay such indemnity, up to an amount not exceeding $. . . . . . . (insert an amount which shall not exceed $1,000), to any relative by blood or connection by marriage of the insured or beneficiary who is deemed by the insurer to be equitably entitled thereto. Any payment made by the insurer in good faith pursuant to this provision shall fully discharge the insurer to the extent of such payment.
This first optional paragraph is often called the **facility of payment** clause since it makes claim payment easier under the circumstances described. It stipulates

- If the insured or the beneficiary cannot legally release the company from further liability, as when the insured or beneficiary is a minor or is legally incapacitated, the company may pay the benefits to any relative by blood or marriage who is deemed to be entitled to the money.
- The amount paid to this person cannot exceed $1,000.

If a claim is paid under this provision, the payment absolves the company of further liability.

Here is the second of the optional paragraphs that may be included with Required Provision 9.

Subject to any written direction of the insured in the application or otherwise, all or a portion of any indemnities provided by this policy on account of hospital, nursing, medical or surgical services may, at the insurer’s option, and unless the insured requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the hospital or person rendering such services but it is not required that the service be rendered by a particular hospital or person.

According to this second optional paragraph, unless the insured specifically directs otherwise, the company may pay benefits to a hospital or person rendering medical or surgical services. However, the company may not require that the insured enter a specific hospital or see a particular doctor.

**Required Provision 10: Physical Examination And Autopsy**

The insurer at its own expense shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

According to this provision, while the insured is alive and receiving benefits, the insurer may require that he or she submit to physical examinations.

If an insured has died, apparently accidentally, the insurer may have an autopsy performed to determine the exact cause of death. However, any applicable state laws that might prevent such an autopsy take precedence.

The insurer is required to pay for examinations or autopsies, and may require only reasonable examinations.
Required Provision 11: Legal Actions

No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

When written proof of loss has been submitted, the company needs time to investigate the claim and make certain it is valid. To provide the insurer with this time, this provision prohibits the insured from suing the insurer for at least 60 days after filing a written proof of loss.

The maximum time during which suit can be filed is three years after written proof of loss is furnished.

Required Provision 12:
Change Of Beneficiary

Unless the insured makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the insured and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this policy or to any change of beneficiary or beneficiaries, or to any other changes in this policy.

The policyowner, who is usually the insured, may name a beneficiary either revocably, which means that the insured can change the beneficiary later, or irrevocably, which means the beneficiary designation may not be changed.

In other words, the right to change the beneficiary or dispose of the policy or its benefits in any manner one chooses is reserved to the insured unless he or she has named an irrevocable beneficiary.

For example, suppose Ben has named his wife the beneficiary of the accidental death benefit of his health insurance policy, and he has relinquished his right to change that designation. Now he wants to obtain a large loan and the lender agrees to make the loan if Ben will assign any payments under his policy to the lender. Ben may assign the policy only with his wife’s permission since she is the irrevocable beneficiary. Ben would not need this permission if his wife were a revocable beneficiary.

Exercise

A. Normally, written proofs of loss must be furnished within

   ( ) 1. 15 days after the loss.
   ( ) 2. 45 days after the loss.
   ( ) 3. 60 days after the loss.
   ( ) 4. 90 days after the loss.
B. If there is no beneficiary listed on a policy, benefits will be paid to

( ) 1. the state.
( ) 2. the insured’s estate.
( ) 3. the insured’s nearest blood relative.
( ) 4. the insured’s nearest relative by marriage or blood.

C. The insurer may generally require an autopsy at its own expense unless

( ) 1. the deceased requests in writing that an autopsy not be performed.
( ) 2. the deceased’s relatives request that an autopsy not be performed.
( ) 3. the deceased’s relatives have proven religious objections to an autopsy being performed.
( ) 4. the state has an applicable law that forbids autopsy.

Answer: A. 4. 90 days after a loss; B. 2. the insured’s estate; C. 4. the state has an applicable law that forbids autopsy

**OPTIONAL POLICY PROVISIONS**

The optional provisions are not required to be included in the policy, but if the subject of any of them is contained in the policy, it must be worded in accordance with the wording of the appropriate optional provision. An insurer may reword any of the optional provisions so long as the new wording is not less favorable to the insured or the beneficiary.

**Optional Provision 1: Change Of Occupation**

Here is the first optional provision:

If the insured be injured or contract sickness after having changed his or her occupation to one classified by the insurer as more hazardous than that stated in this policy, or while doing for compensation anything pertaining to an occupation so classified, the insurer will pay only such portion of the indemnities provided in this policy as the premium paid would have purchased at the rates and within limits fixed by the insurer for a more hazardous occupation. If the insured changes an occupation to one classified by the insurer as less hazardous than that stated in this policy, the insurer, upon receipt of proof of such change of occupation, will reduce the premium rate accordingly, and will return the excess pro rata unearned premium from the date of change of occupation or from the policy anniversary date immediately preceding receipt of such proof, whichever is the more recent. In applying this provision, the classification of occupational risk and the premium rates shall be such as have been last filed by the insurer prior to the occurrence of the loss for which the insurer is liable, or prior to date of proof of change in occupation with the state official having supervision of insurance in the state where the insured resided at the time this policy was issued; but if such filing was not required, then the classification of occupational risk and the premium rates shall be those last made effective by the insurer in such state prior to the occurrence of the loss or prior to the date of proof of change in occupation.
This provision relieves the insurer from paying benefits not anticipated when the premium was established. If an insured’s occupation is more hazardous than the insurer knew, and resulted in injury or illness, the insurer might be required to pay a larger benefit than the premium warrants. Here’s an example of how this provision works.

If Max, the insured, had continued at the occupation he had when he purchased his disability income policy, disability from an accidental injury would have resulted in a benefit of $1,600 per month based on the premium Max paid. However, Max changed to a more hazardous occupation without notifying the insurer, then suffered a disabling injury on the job. The insurer will pay only the amount of benefit that Max would have been able to purchase, with the premium already paid, for the more hazardous job, so Max’s benefit is reduced.

Suppose Max had changed to a less hazardous occupation, but paid premiums based on the more hazardous occupation. In this case, Max sends proof that he changed occupations to the insurer, the premium rate is reduced accordingly and the insurer returns the excess premium to Max on a pro rata (proportionate) basis.

When calculating how much of the extra premium to return, the company uses the more recent of:

- The date the occupation changed, or
- The policy anniversary date immediately preceding receipt of the proof of change

**Optional Provision 2: Misstatement Of Age**

If the age of the insured has been misstated, all amounts payable under this policy shall be such as the premium paid would have purchased at the correct age.

When an insured is younger, a premium dollar buys a certain amount of insurance. As the insured ages, the same premium dollar buys less insurance. This provision is similar to the previous provision regarding a more hazardous occupation. If the insured has misstated his or her age on the application, the company may adjust benefits to the amount the premiums paid would have bought had the insured’s correct age been known.

If an insured overstated his or her age—stated an older age than he or she actually was—when applying for the coverage, the insured has been paying a premium that is too high. Under this provision, the insurer could increase any benefits to the amount the premium paid for.
Or, if the insured had understated his or her age, the company would pay him or her (or a beneficiary, in the event of accidental death) a smaller benefit.

Whether the insured misstated his or her age intentionally or unintentionally, the company simply adjusts benefits accordingly.

Optional Provision 3:
Other Insurance In This Insurer

If an accident or sickness policy or policies previously issued by the insurer to the insured be in force concurrently herewith, making the aggregate indemnity for...(insert type of coverage or coverages) in excess of $...(insert maximum limit of indemnity or indemnities) the excess insurance shall be void and all premiums paid for such excess shall be returned to the insured or to the estate.

Or,

Insurance effective at any one time on the insured under a like policy or policies in this insurer is limited to one such policy elected by the insured, his or her beneficiary or estate, as the case may be, and the insurer will return all premiums paid for all other such policies.

This provision deals with insurance of the same type with the same insurer.

If an individual has so much insurance that it is more “profitable” to see a doctor, enter a hospital, or stay home from work, there might be some temptation to do just that rather than to have a quick recovery. Such an individual is overinsured—a situation insurers try to avoid.

This optional provision allows an insurer to control overinsurance through its own policies. The company can establish maximum amounts payable to any one insured for certain coverages—disability income insurance being the most common—so no matter how many policies an insured has with this particular company, there is a limit on the amount of benefits that will be paid.

Either of the two provisions may be included in the policy. If the insurer chooses the first paragraph, it is the insurer’s responsibility to decide upon the maximum indemnity that will be paid and the type of coverage to which the provision applies. When these limitations are included in the policy, any amount of like insurance over the specified maximum is considered void, and the insurer will return premiums paid for these void benefits to the insured or to the insured’s estate.
If the insurer uses the second paragraph, coverage is limited to one policy as selected by the insured, the beneficiary, or the administrator of the insured's estate. When the second optional provision is used, the premiums paid for the other policy or policies are refunded.

**Optional Provisions 4 & 5: Insurance With Other Insurers**

While the previous optional provision concerned overinsurance with the same insurer, the next two deal with other insurers. Since they are closely related, they are presented together.

**Provision 4:**

If there be other valid coverage, not with this insurer, providing benefits for the same loss on a provision of service basis or on a expense-incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability under any expense-incurred coverage of this policy shall be for such proportion of the loss as the amount which would otherwise have been payable hereunder plus the total of the like amounts under all such other valid coverages for the same loss, and for the return of such portion of the premiums paid as shall exceed the pro rata portion of the amount so determined. For the purpose of applying this provision when other coverage is on a provision of service basis, the “like amount” of such other coverage shall be taken as the amount which the services rendered would have cost in the absence of such coverage.

**Provision 5:**

If there be other valid coverage, not with this insurer, providing benefits for the same loss on other than an expense-incurred basis and of which the insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability of such benefits under this policy shall be for such proportion of the indemnities of which the insurer had notice (including the indemnities under this policy) bear to the total amount of all like indemnities for such loss, and for the return of such portion of the premium paid as shall exceed the pro rate portion for the indemnities thus determined.

The essence of Optional Provisions 4 and 5 is this: If an insured has two or more policies from different companies that cover the same expenses, and if the insurers were not notified that the other coverage existed, then each insurer will pay a proportionate share of any claim. This will prevent the insured from receiving benefits greater than the loss. The concept is illustrated on the next page.
Since the insured would have paid for benefits that cannot be collected, each company must also refund a proportionate share of the excess premiums on a pro rata basis.

When both of these optional provisions appear in the same policy, Provision 4 must be captioned expense-incurred benefits since it deals with losses to be reimbursed on that basis. Likewise, Provision 5 must be captioned other benefits since it deals with overinsurance for losses reimbursed on any basis other than expense-incurred.

The law also allows an insurer to include a definition of other valid coverage to cover more than just another insurer’s individual health policy. This allows other benefit sources such as auto medical payments, union welfare plans, or Blue Cross/Blue Shield benefits to be taken into account.

**Exercise**

A. When Betty purchased her insurance policy, her age was recorded as 32 when she was actually 34. Assuming her policy includes the misstatement of age provision, and the insurance company discovers this four years later,

( ) 1. Betty’s policy will be cancelled for misrepresentation.
( ) 2. Betty’s policy will be unchanged because the incontestable period has expired.
( ) 3. Betty’s policy limits will be lowered.
( ) 4. Betty’s policy limits will be raised.
NOTES

B. The optional provisions that deal with multiple insurance policies of the same type on a single insured were written to deal with the problem of

( ) 1. underinsurance
( ) 2. overinsurance.
( ) 3. inappropriate insurance.
( ) 4. incorrect insurance.

C. If a policyholder has two or more policies from different companies that cover the same expenses, and the insurers were not notified that the other coverage existed, then each insurer will

( ) 1. have the option to cancel the policyholder’s policy without notice.
( ) 2. have the option to cancel the policyholder’s policy with appropriate notice.
( ) 3. pay the claim regardless, as long as the premiums had been paid.
( ) 4. pay a proportionate share of any claim.

Answer: A. 3. Betty’s policy limits will be lowered; B. 2. overinsurance; C. 4. pay a proportionate share of any claim

Optional Provision 6:
Relation Of Earnings To Insurance—
Average Earnings Clause

This provision specifically concerns loss of time, or disability income, coverage.

If the total monthly amount of loss of time benefits promised for the same loss under all valid loss of time coverage upon the insured, whether payable on a weekly or monthly basis, shall exceed the monthly earnings of the insured at the time disability commenced, or the average monthly earnings for the period of two years immediately preceding a disability for which claim is made, whichever is greater, the insurer will be liable only for such proportionate amount of such benefits under this policy as the amount of such monthly earnings or such average monthly earnings of the insured bears to the total amount of monthly benefits for the same loss under all such coverage upon the insured at the time such disability commences, and for the return of such part of the premiums paid during such two years as shall exceed the pro rata amount of the premiums for the benefits actually paid hereunder; but this shall not operate to reduce the total monthly amount of benefits payable under all such coverage upon the insured below the sum of $200 or the sum of the monthly benefits specified in such coverages, whichever is the lesser, nor shall it operate to reduce benefits other than those payable for loss of time.

This optional provision is also designed to prevent overinsurance malingering—remaining disabled in order to collect insurance. The provision specifically addresses the relationship between what the insured actually has been earning on the job and the amount of insurance available by failing to return to work. Here’s an example of how insurance might pay more than the insured earns.
According to this provision, if the total monthly benefits from all policies are more than the insured's monthly income (and more than $200), each insurer will pay a proportionate share of the lost income. This will prevent the insured from receiving benefits greater than the loss. Since the insured paid for more coverage than can be collected, each company must refund a proportionate share of the excess premiums. Furthermore, benefits cannot be reduced below $200.

If the insurer that wrote Policy A in the previous illustration includes Optional Provision 6 in the policy, here is how it might work.
The insurer may define *other valid loss of time coverage* to take into account other benefit sources such as workers compensation, union welfare plans, or employee benefit payments.

Since this provision allows for computation of the insured’s average earnings over the course of two years, it is often called the *average earnings clause*. The following situation describes how it works.

Brian averages $3,000 a month income. He has two policies, each providing a $1,800 monthly disability income benefit. Total monthly benefits payable if neither policy contains an average earnings clause, nor any other provision limiting benefits in the event of overinsurance, are $3,600.

Average monthly earnings are 83% ($3,000 ÷ $3,600) of the total monthly benefits for which Brian is eligible. If the policy contains the provision we’ve been discussing, the insurer is liable to pay $1,494 each month since that is 83% of the $1,800 otherwise payable.

When an individual buys disability income coverage, the benefits are received tax-free. So if Brian is disabled and has a policy providing full monthly income, he will actually receive more than his take-home pay when he was working.

For this reason, many companies limit benefits to a percentage of monthly income, such as 60%. It’s still possible to have two policies, each providing a high percentage of monthly income. Let’s see what happens then.

Harold’s average earnings are $4,000 a month. He has two policies, each providing 75% of monthly income in disability benefits—$3,000 each or a total of $6,000. Both policies contain the average earnings provision. To determine the proportion, divide average monthly earnings by total available benefits. Then multiply the resulting proportion (percentage or fraction) times the individual benefit for each policy—$3,000 each in this case.
Harold's average monthly earnings are 2/3 or 66% of total monthly benefits for which Harold is eligible ($4,000 divided by $6,000). Each insurer is liable to pay $1,980 (66% of $3,000) each month.

Optional Provision 7: Unpaid Premium

Upon the payment of a claim under this policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

This very simple optional provision allows an insurer to deduct premiums that are due or past due as part of settling a claim. Some companies will also accept a promissory note from an insured, indicating the insured will pay at a stipulated time in the future. In return, the company agrees to continue coverage in force as if the premium had already been paid. When a company holds such a note and a claim is made, this provision allows the insurer to deduct the amount of the premium before paying the indemnity. With or without a promissory note, here is how this provision would operate.

Frederick sends his insurer a claim for $1,800 to cover hospital and medical expenses from an illness. CLAIM . . . . . . . . $1,800

The insurer notes that Frederick owes a past-due premium of $300, which the insurer UNPAID deducts from the claim... PREMIUM . . . . . . . . – 300

...then pays the $1,500 balance: CLAIM PAID . . . $1,500

Optional Provision 8: Cancellation

Let's break this optional provision down into two parts. Here is the first part.

The insurer may cancel this policy at any time by written notice delivered to the insured or mailed to the last address as shown by the records of the insurer, stating when, not less than five days thereafter, such cancellation shall be effective; and after the policy has been continued beyond its original term the insured may cancel this policy at any time by written notice delivered or mailed to the insurer, effective upon receipt or on such later date as may be specified in such notice.

While this provision may not be used in noncancellable policies, in policies that may be cancelled, the insurer may do so by delivering (usually by mail) written notice to the insured's last known address. Cancellation is effective no fewer than five days after the date of notice.
Here is the remainder of Optional Provision 8.

In the event of cancellation, the insurer will return promptly the unearned portion of any premium paid. If the insured cancels, the earned premium shall be computed by the use of the short rate table last filed with the state official having supervision of insurance in the state where the insured resided when the policy was issued. If the insurer cancels, the earned premium shall be computed pro rata. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.

When a policy is canceled before its expiration date, some of the prepaid premium is unearned—that is, the insurance company has not yet earned the premium since the period of time it was intended to cover has not yet passed. The way in which unearned premium is returned to the insured depends upon who canceled the policy—the insurance company or the insured. The explanations and illustrations following show what happens to a premium dollar.

When the insurance company cancels, the portion of the premium dollar the insurer has already earned is kept by the insurer and the entire unearned portion is returned to the insured. This is a pro rata return.

![Pro Rata Return Of Premium](image)

When the insured cancels, the insurance company is allowed to retain a portion of premium over and above that which it has earned. So the insurer keeps earned premium and a portion of unearned premium, returning the balance of unearned premium to the insured. This is a short rate return.

![Short Rate Return Of Premium](image)
When a premium is paid, the insurer assumes the insured will keep the policy in force for the entire period for which that premium was paid. On this assumption, the company invests the money, or at least plans its investments. If the insured cancels before expiration of the term for which premium was paid, it costs the company money to return the premium—a cost initiated by the insured when requesting cancellation. To help pay for these costs, insurers are permitted to compute the amount of premium to be returned on a short rate basis. Short rate tables are established and filed in advance with the state Insurance Commissioner’s office. Using short rates allows the insurer to retain more than a pro rata share of the premium.

Under the pro rata method, the insurer retains no more than the proportion of premium paid to the proportion earned during the period the policy was in force. Therefore, if an insurance company initiates the cancellation, it must bear the costs of cancellation as well.

A flat cancellation means that a policy is cancelled as of its effective date. Usually this means that no premium is charged. For example, when an insured returns a policy during a “free look” period, any premium payment will be fully refunded.

**Optional Provision 9: Conformity With State Statutes**

Any provision of this policy which, on its effective date, is in conflict with the statutes of the state in which the insured resides on such date is hereby amended to conform to minimum requirements of such statutes.

While this provision is usually optional, some states insist that it be included in all policies; so in some states, this provision is required.

Not only does the provision help insurers avoid issuing policies that conflict with existing state laws, it can also prevent reissuing policies that are in conflict with any ruling enacted during the time a policy is being or is about to be issued.

The provision applies to the laws of the insured’s state of residence.

**Optional Provision 10: Illegal Occupation**

The insurer shall not be liable for any loss to which a contributing cause was the insured's commission of or attempt to commit a felony or to which a contributing cause was the insured's being engaged in an illegal occupation.

In our discussion of common exclusions, you learned that most companies exclude coverage for injuries or accidental death suffered while the insured is committing or attempting to commit a felony. Therefore, you can assume that most policies do include the Illegal Occupation provision.
Suppose Dan’s policy contains this provision. Dan’s application stated that he is the proprietor of a small newsstand. After Dan was severely beaten one night by someone who apparently was trying to rob him, he applied for benefits under the hospital and medical provisions of his policy. Upon investigating the incident, police discover that Dan was using his newsstand simply as a front. His real employment is fencing stolen goods, and the beating he suffered was the result of a quarrel with other criminals. Since Dan was engaged in an illegal occupation that contributed to his injury, the insurer will not pay his claim.

If Dan’s injury had resulted from an auto accident instead of a beating, a complete investigation might not have been made, nor his illegal occupation discovered. If this had been the case, the insurer probably would have paid the claim.

**Optional Provision 11: Narcotics**

The insurer shall not be liable for any loss sustained or contracted in consequence of the insured’s being under the influence of any narcotic unless administered on the advice of a physician.

As was true of the illegal occupation provision, many insurers include this optional provision. Injuries or death resulting while the insured is under the influence of either alcohol or narcotics are commonly excluded. Following are two examples of how this provision works.

If Oliver wrecks his car and is injured while returning home from a party at which he used cocaine, even though this was his first experience with drugs, the insurance company will not pay any resulting claims.

Since Amy was in great pain when she visited her doctor, the doctor prescribed a prescription containing morphine. Later, under the influence of the drug, Amy fell down the stairs in her home. In this case, because Amy was using a drug administered by her physician, the insurer will likely reimburse her for any resultant medical expenses.

**Exercise:**

A. Laura stops to buy a newspaper at a newsstand without knowing that it’s a front for illegal activity. She is injured in a drive-by shooting determined to be related to the illegal activity. Her insurer will probably

(  ) 1. not pay the claim, since it is related to illegal activity.
(  ) 2. not pay the claim, since Laura cannot prove that she didn’t know about the illegal activity.
(  ) 3. pay the claim, because Laura was not involved in any illegal activity that contributed to her injury.
(  ) 4. appeal the necessity to pay the claim to the state department of insurance.
B. If a policy includes the conformity with state statutes provision, and the state changes the law to be in conflict with another provision of the policy

( ) 1. the policy will automatically be void.
( ) 2. the provision will be automatically “grandfathered” and able to stay the same.
( ) 3. the insurer will be able to apply for a “grandfather” provisions for those policies already in force.
( ) 4. the provision will automatically be amended to conform to the minimum requirement of the statutes.

C. A pro rata return is one in which the insurer returns

( ) 1. all of the unearned premium.
( ) 2. some of the unearned premium.
( ) 3. both earned and unearned premium.
( ) 4. neither earned nor unearned premium.

Answer: A. 3. pay the claim, because Laura was not involved in any illegal activity that contributed to her injury; B. 4. the provision will automatically be amended to conform to the minimum requirement of the statutes; C. 1. all of the unearned premium

OTHER HEALTH INSURANCE PROVISIONS

The Policy Face

The face of the policy is a standard printed form containing the name of the insurance company and providing enough information to give the insured a capsule summary of what type of policy and what type of coverage is provided by the contract. The policy face identifies the insured and states the term of the policy (when it goes into effect and when coverage expires). The policy face also states how the policy can be renewed.

The policy face usually gives a brief statement of the type or types of benefits. However, it is essential to examine the benefit provisions within the body of the contract to obtain a complete understanding of the coverage provided.

Free Look

Many states require that health policies contain a so-called free look provision, allowing individuals to look over the policy for a specified period with the right to refuse it. Usually, this is a 10-day trial period, and in some states, may be a 15- or 20-day period, beginning on the day the individual receives the policy. If the individual decides to return the policy by the end of the trial period, he or she receives a full refund of the prepaid premium.

This free look provision permits applicants to inspect the policy at their leisure and make a final decision about whether it meets their needs. If the individual cancels during the trial period, the insurance company is not liable for any claims originating during that period.
Let's say Sheila receives a new health policy on March 11. On March 16, she is involved in an auto accident, but suffers no apparent injury. On March 18, she exercises her 10-day free look right and notifies the insurer, BBB Health Company, to cancel the policy. On March 20, she is hospitalized with a neck problem that her doctor says is the result of the March 16th auto accident. Sheila has not received a premium refund from BBB, so she files a claim for medical expenses related to the accident. Since she has returned the policy under the free-look provision, the insurer is not required to pay the claim, but must fully refund the premium Sheila has already paid.

Under a free look provision, the policy usually may be returned either to the insurer or to its agent within the time specified. Check your state laws and your health policies to see if a free look provision is required. Your company may include such a provision even if it isn’t required by state law.

**Insuring Clause**

The *insuring clause* is usually the initial policy clause. In general, it represents the insurer's promise to pay under the conditions stipulated in the policy. The insuring clause performs these functions:

- Describes the general scope of coverage
- Provides any definitions required
- Sets forth the conditions under which benefits will be paid

This clause is often viewed as the foundation of a health policy in terms of the insurer's general agreement to provide coverage.

The insurer, ABC Mutual, agrees to pay disability income benefits to the insured upon receipt of proof of loss and the timely payment of premiums by the insured. All benefits will be paid in accordance with the policy’s provisions contained herein.

**Consideration Clause**

In legal terms, *consideration* is an exchange of something of value on which a contract is based. When both parties exchange consideration, the contract is validated.

In health insurance, the insurance company exchanges the promises in the policy for a two-part consideration from the insured. A health insurance contract is valid only if the insured provides consideration in the form of:

- The full minimum premium required, and
- The statements made in the application.

For example, if Joan completes an application, but does not pay the first premium due, she would not have a valid contract even if the policy were to be issued. On the other hand, if she pays the first premium and the policy is issued as applied for, the contract is valid because she provided the correct consideration.
In health policies, the consideration clause not only defines consideration, but also states:

• The date coverage begins and
• The length of the initial coverage period.

This clause may be stated separately or it may be part of a renewability clause in the policy.

**Policy Continuation**

**Optionally And Conditionally Renewable Policies**

To remain in force, health policies must be renewed periodically; that is, the coverage remains in force only for the length of time for which premiums have been paid. When the premium is due again, the policy may be renewed or it may expire. Both the policyowner and the insurer have a role in the renewal process.

A policyowner has the option of canceling a policy at any time by so notifying the insurer, as well as allowing it to lapse at a premium due date by not paying the premium.

Health policies also include specific provisions that determine whether the insurance company may refuse to renew a policy. When the insurer has the option to refuse to renew, the policy may be one of two types:

• Optionally renewable, which means the insurer may elect not to renew for any reason or for no reason, but may exercise that right only on the premium due date.
• Conditionally renewable, which means the insurer may elect not to renew only under conditions specified in the policy.

To protect the insured when a valid claim is being paid or is eligible for payment at the time the premium is due, the insurer may not prejudice that claim. That is, the claim will be paid even if the insurer elects not to renew the policy.

**Cancellable Policies**

With the optionally renewable policy described previously, the company must wait until a premium is due before it can terminate the policy by refusing to renew. However, with a cancellable policy, the insurer may cancel coverage at any time, provided it returns any unearned premiums to the insured. And, as is true of optionally and conditionally renewable policies, cancellation does not relieve the insurer from paying valid existing claims.

Cancellable policies are not common, and obviously are not advantageous to the insured. Unless the policy contains a clause that permits the company to cancel on other than a premium due date, it simply cannot be cancelled. The company may refuse to renew the policy on a premium payment date, but, unless specifically stated in the policy, health insurance policies usually are not cancellable by the insurer.
When canceling a cancellable policy, the company must notify the insured in writing, mailing the notice and the unearned premium to the insured's last known address. In most states, cancellation is effective not less than five days from the date of the notice.

Suppose an insurer decides to cancel Anthony's cancellable health policy. The company mails a notice of cancellation and a refund check for the amount of unearned premium to Anthony's last known address. A few months later, Anthony files suit to collect benefits for a claim which did not exist at the time the notice was mailed.

Anthony bases his suit upon the fact that he had moved and did not receive the notice of cancellation. Assuming the company has an accurate record of the transaction on file, including a copy of the cancellation notice and evidence that the unearned premium check was issued, the insurer is not liable for the claim since it followed proper cancellation procedures. However, if the claim had existed before the insurer cancelled, the insurer would be liable.

Guaranteed Renewable Policies

In some policies, the insurer relinquishes its rights to cancel at any time and to refuse renewal at a premium due date. This type of policy is called **guaranteed renewable**, and it includes several important features:

- Renewal is guaranteed as long as the insured pays the premium.
- The insurer may not cancel unless the insured fails to pay the premium.
- Premiums may not be increased on an individual basis.
- Premiums may be increased on the basis of an entire classification, such as occupation.
- The guarantee to renew ends at a specified age.

Nonpayment of premium is the only reason an insurer may cancel or refuse to renew a guaranteed renewable policy. Furthermore, the insurer is not permitted to increase the premiums based on the individual insured’s experience. It may, however, increase the premiums on a class basis. One common classification, for example, is by occupational groups. Based on experience, insurers know that certain occupations are subject to a higher risk of accidental injury or death than are other occupations. For example, compare the different risks faced by a typist and by a construction worker.

With a guaranteed renewable policy, the company must renew. However, based on new experience ratings within the insured's occupational class, the insurer may increase the premiums for all insureds in that class of risk. The guaranteed renewable feature is often limited. In some policies, the insurer regains the rights to cancel and to refuse to renew when the insured reaches a specified age. Commonly, the policy will stipulate this right when the insured reaches a normally accepted retirement age, such as 60, 65, or 70. However, the company's right to do this is limited in many states if the insured is over age 54 when the policy is issued. In this case, the insurer may not cancel or refuse to renew until at least five years after the policy is issued.
Since insurers expose themselves to higher risks by relinquishing the rights to refuse renewal and to cancel a policy, guaranteed renewable policy premiums are higher than those for cancellable policies. Suppose a 56-year-old person buys a guaranteed renewable policy, paying the higher premiums required for that type of coverage. When the person reaches, say, age 60, the company could conceivably cancel the policy if that age were stipulated in the policy. However, the insured has paid an extra premium to obtain the coverage. So, some states require that if an insured is over age 54 when the policy is issued, the company must keep the policy in force for a minimum of five years, even though it might otherwise have cancelled or elected not to renew when the insured reached the specified age.

### Noncancellable Policies

The terms *noncancellable* and *noncancellable and guaranteed renewable* are often used interchangeably to describe a noncancellable policy. As the name implies, an insurer may not cancel or refuse to renew a noncancellable policy. While this appears to be the same as a guaranteed renewable policy, there is one important difference. With a guaranteed renewable policy, the insurer may increase the premiums by classifications. With a noncancellable policy, however, the insurer may never increase the premiums. That is, the initial premium is the premium the insured will pay throughout the life of the policy.

Other features of noncancellable policies are the same as for guaranteed renewable policies:

- The only reason the insurer may cancel is for nonpayment of premium.
- The insurer regains the right to cancel or nonrenew at a stipulated age—usually 60, 65 or 70.
- If the insured is over age 54 when the policy is issued, the policy term must be at least five years.

You can see that the insurer assumes a higher risk by being unable to adjust future premiums. Therefore, premiums for noncancellable policies are somewhat higher than for other health policies. As a general rule, only disability income policies (not medical expense policies) are noncancellable.

To reiterate: Aside from the fact that premiums are somewhat higher for noncancellable policies, there is only one basic difference between these policies and guaranteed renewable policies. That is, the insurer may not increase the premiums on a noncancellable policy.

### Term Policies

In some situations, an individual may need health insurance for a fixed, limited time period. Coverage that extends only for a specified length of time is called *term insurance*. A term health policy cannot be renewed at all. When it expires, the insured must purchase another policy.

Flight insurance is a well-known example of term accident insurance. Coverage begins when the flight starts and terminates when the flight is over. Student accident policies are another example, beginning when the school term begins and ending when the term is over.
**Unit 3—Policy Provisions**

**Benefit Payment Clause**

Health insurance benefits are paid differently depending upon the type of policy. How benefits will be paid is set out in the policy's *benefits provision*. Typically, benefits are paid in the form of:

1. periodic income under disability policies;
2. lump-sum reimbursements for expenses incurred under hospital, medical, surgical and major medical policies;
3. lump-sum indemnity payments for death or dismemberment under accidental death and dismemberment policies.

Suppose the benefits provision of Mitchell’s policy indicates that if he is unable to work under certain conditions, he will be paid a specified amount monthly. This is known as a *periodic income* payment under his disability income policy.

On the other hand, Tom’s medical expenses resulting from hospitalization for surgery will be paid under his major medical policy in the form of a *lump-sum reimbursement*.

According to the benefits provision of Carla’s policy, she will receive $10,000 if one of her limbs is accidentally amputated. This is an example of a *lump-sum indemnity* payment under an accidental death and dismemberment policy.

**Exclusions And Reductions**

These provisions limit the insurer’s obligation to pay. An *exclusion* or *exception* is a provision that entirely eliminates coverage for a specified risk. A *reduction* is a decrease in benefits as a result of specified conditions.

Most health insurance policies exclude war and acts of war, self-inflicted injuries, aviation, military service and overseas residence. Benefits will not be provided if the cause of a loss is due to military service, a war or civil disorder, a self-inflicted injury such as an attempted suicide, or if the loss is due to aviation as a pilot.

Generally, coverage is temporarily suspended if an individual resides in a foreign country for a specified period of time or if the individual is serving in the military. Coverage is reinstated or reactivated when the insured returns to the United States or not longer is serving in the military.

**Preexisting Conditions**

Preexisting conditions can be excluded from coverage under a health insurance policy. This exclusion may be permanent or temporary. By definition, a preexisting condition is any condition for which the insured sought treatment or advice prior to the effective date of the policy.

Further, a preexisting condition can also be defined as any symptom that would cause a reasonable and prudent person to seek diagnosis and medical treatment. This concept prevents an applicant who suspects that he or she may have a serious medical problem from buying health insurance and then going to a doctor for diagnosis and treatment.
Preexisting conditions may be covered by the insurer if they are indicated on the application. The insurer will then review the medical information and depending on the condition may elect to cover the problem or exclude it. Usually, only serious or chronic conditions will be excluded.

**Nonoccupational Coverage**

Some people work in occupations that are considered extremely hazardous, such as railroad switchers or steeplejacks. Many insurance companies won't assume the risk of covering such people for the hazards involved in their occupations. To provide these individuals with general accident and sickness and/or disability income coverage, some companies issue policies that contain a provision excluding job-related injuries.

Since policies with this provision do not cover occupational hazards, they are usually called *nonoccupational* policies. Without the exposure to everyday work hazards, the insurer takes a lesser risk, so the premiums are generally lower than for policies that cover occupational hazards. Remember, though, that neither do nonoccupational policies provide full coverage—for both on- and off-the-job injuries.

Occupational coverage is basically full coverage. If the health policy provides 24-hour coverage, then occupational losses will be covered as well as any other type of loss.

**Case Management Provisions**

In order to control the costs associated with medical care, many insurers are instituting methods to reduce costs while giving the insured options for health care. As health care costs have risen, more and more policies provide for some type of administrative oversight in an attempt to contain costs. These provisions are variously called *case management, managed care, claims control, cost containment* or similar terms.

The *second surgical opinion* is a provision that can be included in policies that offer surgical expense benefits. This coverage allows the insured to consult a doctor, other than the attending physician, to determine alternative methods of treatment. While the use of this provision is sometimes optional, it is more often mandatory for certain procedures, such as tonsillectomy, cataract surgery, coronary bypass, mastectomy, and varicose veins. Some insurance companies have medical examiners review claims, and the examiner's decision to approve or deny a claim is considered the required second opinion.

One cost control mechanism being used by insurers and employers is *utilization review*. Utilization review consists of an evaluation of the appropriateness, necessity, and quality of health care, and may include preadmission certification and concurrent review.

Under the *precertification provision* (also known as precertification authorization or prospective review) the physician can submit claim information prior to providing treatment to know in advance if the procedure is covered under the insured's plan and at what rate it will be paid. This way both the physician and the insured know in advance what the benefit will be and can plan accordingly. This provision allows the insurance company to evaluate the appropriateness of the procedure and the length of the hospital stay.
Under the concurrent review process the insurer will monitor the insured's hospital stay to make sure that everything is proceeding according to schedule and that the insured will be released from the hospital as planned.

Recent evidence has shown that many treatments can be satisfactorily provided without the need for a hospital stay. Ambulatory outpatient care is the alternative to the costly inpatient diagnostic testing and treatment. Today, ambulatory care is best known to operate in hospital outpatient departments. However, this care can be provided by special ambulatory care health centers, group medical services, hospital emergency rooms, multi-specialty group medical practices, and health care corporations. These ambulatory facilities provide, in addition to diagnosis and treatment, preventive care, health education, family planning, and dental and vision care.

**Waiver Of Premium**

Under this provision, the insurer waives premium payments after the insured has been totally disabled (as defined in the policy) for a specified period of time, usually three or six months. If the insured remains totally disabled, no further premium payments will be required from the insured. The insurer will pay the premiums until the insured attains age 65. If the insured recovers from the disability, then he or she will resume paying the premiums.

**REVIEW**

1. The grace period varies according to
   ( ) A. premium payment frequency.
   ( ) B. premium payment amount.
   ( ) C. method of premium payment.
   ( ) D. type of policy.

2. Mike allows his policy to lapse, then applies for reinstatement using the company’s required application. The company does not inform Mike either that the policy has been accepted or that the policy is being rejected. At what point can Mike consider the policy reinstated?
   ( ) A. Not until the insurer notifies him that it has been reinstated
   ( ) B. As soon as the application has been submitted
   ( ) C. After 45 days
   ( ) D. After 90 days

3. A reinstated policy will cover
   ( ) A. sickness immediately, and accidents after 10 days.
   ( ) B. both sickness and accidents after 10 days.
   ( ) C. accidents after 10 days, and sickness after 30 days.
   ( ) D. accidents immediately, and sickness after 10 days.

4. If an insured is disabled for at least two years, the insurer may require proof of continuance of disability every
   ( ) A. month.
   ( ) B. two months.
   ( ) C. six months.
   ( ) D. year.
5. Because the insurer needs time to respond to a claim, the law provides the insurer with a window during which the insured cannot sue to recover under a claim. This window lasts for

   ( ) A. 30 days.
   ( ) B. 60 days.
   ( ) C. 90 days.
   ( ) D. 120 days.

6. The maximum time during which suit can be filed is

   ( ) A. one year after written proof of loss is furnished.
   ( ) B. two years after written proof of loss is furnished.
   ( ) C. three years after written proof of loss is furnished.
   ( ) D. four years after written proof of loss is furnished.

7. A revocable beneficiary

   ( ) A. has the right to refuse assignment of the policy.
   ( ) B. may stop the policyowner from disposing of the policy.
   ( ) C. may be changed without the beneficiary's consent.
   ( ) D. is assigned for life.

8. Which of the following is not a required provision under the Uniform Provisions Model Act?

   ( ) A. Grace period
   ( ) B. Change of occupation
   ( ) C. Time of payment of claims
   ( ) D. Proof of loss

9. Which of the following is an optional provision under the Uniform Provisions Model Act?

   ( ) A. Cancellation
   ( ) B. Physical examination and autopsy
   ( ) C. Legal actions
   ( ) D. Reinstatement

10. Julia worked as a race car driver until recently, when she took a job in the promotions office handling media inquiries. If she has the same health insurance, her premiums are likely to

    ( ) A. stay the same.
    ( ) B. go up.
    ( ) C. go down.
    ( ) D. stop, since the policy will be cancelled.
11. Joe’s took out a disability policy while working as a very successful stockbroker. A few years later, he decides to take a less stressful job at a not-for-profit organization, writing about financial issues. He loves his new job, and doesn’t mind the fact that he makes a lot less money. When he becomes disabled three years later, his disability benefit is more than he has made in salary in three years. If the policy contains an average earnings clause, Joe’s benefit will

(  ) A. be the same as listed in the policy.
(  ) B. be the lesser of Joe’s monthly earnings at the time the disability started, or the average monthly earnings for the period of two years immediately preceding his disability.
(  ) C. be the greater of Joe’s monthly earnings at the time the disability started, or the average monthly earnings for the period of two years immediately preceding his disability.
(  ) D. be the greater of Joe’s monthly earnings at the time the disability started, or the average monthly earnings for the period of two years immediately preceding his disability. In addition, the insurer will return some of the excess premiums that paid for the benefit Joe is not eligible to receive.

12. Cindy has a claim for $2,000, and a past due premium of $200. The insurer will

(  ) A. Refuse to pay the claim until the past due premium is paid
(  ) B. Pay the claim minus the past due premium
(  ) C. Pay the claim and forgive the past due premium
(  ) D. Pay the claim and bill Cindy for the past due premium

13. If Lois cancels her health insurance policy, the insurer will

(  ) A. issue a pro-rata refund of all of the unearned premium.
(  ) B. issue a pro-rata refund of most of the unearned premium.
(  ) C. issue a short-rate refund of all of the unearned premium.
(  ) D. issue a short-rate refund of most of the unearned premium.

14. Joel is hit by a car while crossing the street against the light. If Joel’s policy contains the Illegal Occupation provision

(  ) A. the insurer is not liable for the claim, because Joel was engaged in illegal activity at the time of the accident.
(  ) B. the insurer is not liable for the claim because Joel’s illegal activity was the direct cause of the accident.
(  ) C. the insurer will pay the claim, because crossing the street against the light is not a felony or a regular occupation.
(  ) D. the insurer may or may not pay the claim, depending on Joel’s occupation.
15. Carmen gets her health insurance policy on May 1, and on May 3 she decides she doesn’t want it and returns it to the company. On May 6, she is hit by a car. The company

( ) A. will pay any resulting claim, because she was injured within the 10-day free look period.
( ) B. will pay any resulting claim only if the premium has not yet been returned to Carmen.
( ) C. will pay any resulting claim minus the amount of the returned premium.
( ) D. will only return any premium Carmen has paid, and not any resulting claim.

16. The insuring clause does all of the following except

( ) A. describe the insured.
( ) B. describe the general scope of coverage.
( ) C. provide any definitions required.
( ) D. set forth the conditions under which benefits will be paid.

17. Consideration for a health policy includes

( ) A. the premium only.
( ) B. the statements made in the application only.
( ) C. the statements made in the application and the insuring clause.
( ) D. the statements made in the application and the premium.

18. Jennifer takes out an optionally renewable health policy with an annual premium due on June 14. The insurer decides it no longer wants to insure people with first names longer than five letters. The insurer may

( ) A. not cancel the policy, because it does not have a good reason.
( ) B. not cancel the policy unless the number of letters in the first name is a condition specified in the policy.
( ) C. cancel the policy, but only on June 14 of the next year.
( ) D. cancel the policy whenever it wants to.

19. CeeCee’s policy is guaranteed renewable. Which of the following may the insurer not do?

( ) A. Refuse to renew the policy if CeeCee fails to pay the premium.
( ) B. Increase the premiums on all members of CeeCee’s class.
( ) C. Increase the premiums on CeeCee’s policy only.
( ) D. Refuse to renew the policy once Cee Cee reaches a specified age.

20. George has a noncancellable policy. Which of the following may the insurer do?

( ) A. Cancel the policy if George fails to pay premiums.
( ) B. Increase the premiums on all members of George’s class.
( ) C. Increase the premiums on George’s policy only.
( ) D. Cancel the policy if the insurer chooses to no longer do business in George’s state.
21. Which of the following statements is true?

( ) A. An exclusion is a provision that eliminates coverage for a specified condition, a reduction is a provision that decreases benefits as a result of a specified condition.

( ) B. A reduction is a provision that eliminates coverage for a specified condition, an exclusion is a provision that decreases benefits as a result of a specified condition.

( ) C. A reduction is a provision that eliminates coverage for a specified condition, an exception is a provision that decreases benefits as a result of a specified condition.

( ) D. A reduction is another term for an exception.

Answers:

1. A. premium payment frequency.
2. C. After 45 days
3. D. accidents immediately, and sickness after 10 days.
4. C. six months.
5. B. 60 days.
6. C. three years after written proof of loss is furnished.
7. C. may be changed without the beneficiary’s consent.
8. B. Change of occupation
9. A. Cancellation
10. C. go down.
11. D. be the greater of Joe's monthly earnings at the time the disability started, or the average monthly earnings for the period of two years immediately preceding his disability. In addition, the insurer will return some of the excess premiums that paid for the benefit Joe is not eligible to receive.
12. B. Pay the claim minus the past due premium
13. D. issue a short-rate refund of most of the unearned premium.
14. C. the insurer will pay the claim, because crossing the street against the light is not a felony or a regular occupation.
15. D. will only return any premium Carmen has paid, and not any resulting claim.
16. A. describe the insured.
17. D. the statements made in the application and the premium.
18. C. cancel the policy, but only on June 14 of the next year.
19. C. Increase the premiums on CeeCee's policy only.
20. A. Cancel the policy if George fails to pay premiums.
21. A. An exclusion is a provision that eliminates coverage for a specified condition, a reduction is a provision that decreases benefits as a result of a specified condition.
UNIT 4

DISABILITY INCOME INSURANCE

LEARNING OBJECTIVES

After completing Unit 4—Disability Income Insurance, you will be able to:

1. Explain why disability insurance is an important part of an individual's insurance portfolio.

2. List and describe four practical considerations to be taken into account when determining disability income needs.

3. List four possible alternatives to disability income insurance, and explain why they are less desirable than they may first seem.

4. Explain the importance of the elimination period, and how it affects benefits.

5. Explain when the benefit period begins and list some typical benefit periods.

6. Explain the factors that go into determining total disability, and how it is defined in each policy.

7. Explain the difference between own occupation and any occupation when determining total disability.

8. Explain the difference between injury and sickness disability.

9. Explain the difference between occupational and nonoccupational disability.

10. Explain the concept of presumptive disability and list three conditions that are generally considered to be presumptive disabilities.

11. Explain the criteria for partial disability.

12. Explain the concept of residual disability, and how it is being used.

13. Explain the concept of recurrent disability, and how it is used.

14. Explain the difference between permanent and temporary disability.

15. Explain the difference between confining and nonconfining disability.

16. Explain the difference between “accidental bodily injury” and “injury by accidental means.”

17. Explain the function of short-term disability coverage.

18. Explain the function of long-term disability coverage.

(continued)
19. List six common exclusions found in disability income policies.

20. Explain the use and function of the following riders: Rehabilitation benefit, future increase option, cost of living benefit, lifetime benefits, Social Security, social insurance supplements, additional monthly benefit, hospital confinement, non-disabling injury, waiver of premium, and accidental death and dismemberment.
DISABILITY INCOME INSURANCE

When people are disabled and unable to work, the chances are high their income will stop—sooner or later. Unfortunately, even when income stops, the costs of day-to-day living continue. That's why disability is often called the living death. Earning power, in a sense, dies while life goes on—expenses continue and may even increase.

Disability income insurance is available to continue a portion of earnings while an insured is disabled. Too few people consider the possibility that they will be unable to continue earning an income by working. However, it is a fact that a person who is 25 years old today has better than a 50% chance of being disabled for more than 90 days before reaching age 65, while the likelihood of dying before age 65 is much less. Yet people are likely to insure with life insurance and to buy health insurance to cover medical expenses, while ignoring the need for disability insurance.

Disability income insurance, sometimes referred to as loss of time coverage, is designed to protect an individual's most important asset—the ability to earn an income.

Financial Planning Considerations

The importance of disability income protection cannot be overestimated as it relates to the overall planning of family finances. No matter what other safeguards may have been taken, the family's future is at stake when the ability to work is in peril. Here are some practical considerations in determining disability income needs.

- Establish the minimum income that would be required if income stops because of disability.
- Consider the need for retirement plan maintenance if the individual has such a plan that would be disrupted in the event of long-term disability.
- After establishing the insured's total needs, allow for any benefits that would be provided by Social Security and Workers Compensation.
- Include enough long-term disability coverage for both occupational and nonoccupational sickness or injury as well as short-term disability coverage to provide income during the Social Security waiting period or to supplement Workers Compensation.
Alternatives To Disability Income Insurance

When people consider purchasing disability income insurance, they may ask about other alternatives that would allow them to use money they would devote to premiums differently. Listed below are some other options people might consider if they develop a disability and their consequences.

- **Using Savings.** According to one source, if an individual saved 5% of his or her income each year, 6 months of total disability could wipe out 10 years of savings—savings that may have been designated for another purpose such as retirement or children's education.
- **Borrowing.** The problem is: who is going to lend money to someone who can’t work?
- **Depending on Spouse's Income.** Will it be enough? If two incomes were needed before, one income may be insufficient.
- **Liquidating Assets.** Can the individual get a fair market price when forced to liquidate? By their very nature, disabilities are unexpected and the market may be down for the stocks, real estate or other asset to be liquidated.

DEFINITIONS AND BENEFITS

Disability income insurance can be defined as a contract which normally pays a monthly benefit, following the elimination period, for total disability due to accident or sickness. Disability benefits may also be paid for partial or residual disability as well as total disability. An understanding of each of these terms is important because as a producer, you must be able to explain to the insured how this policy will work if he or she becomes disabled. Benefits will be paid in accordance with the policy's terms and conditions.

**Probationary Period**

A [*probationary or qualification period*](#) may be found in some disability income policies. It is a time period that begins when a policy goes into effect. During this period, no benefits will be paid under the policy. The period is often 15 or 30 days, or even 60 days for long-term policies. This probationary period generally applies to sickness, but not to accidents. Its major purpose is to relieve the insurance company from paying benefits for [*preexisting conditions*](#)—health problems that existed prior to the policy's inception, but its effective result is that no benefits are paid for any otherwise covered events during the stipulated period.

**Elimination Period**

An elimination period is the period of time an insured person must be disabled before benefits begin. The elimination period may be thought of as a time “deductible” rather a dollar deductible, because benefits are not payable for the elimination period. Benefits begin only after this period of time is satisfied. For example, if an insured has an elimination period of 30 days and is totally disabled for 75 days, benefits would be payable only for the 45 days in excess of the elimination period.

The elimination period may be 30, 60, 90, 180 days or longer depending on the period elected by the insured. The longer the elimination period, the smaller the insurance premium, since the insured is willing to go without benefits for a longer period of time and the insurer will not have to pay for short term claims.
**Benefit Period**

After the elimination period has been satisfied and monthly disability benefits begin, they will be paid for a specific period of time provided the insured remains totally disabled. This period of time is known as the **benefit period**. Typical benefit periods are one year, two years, five years and to age 65.

Thus, if an insured has a disability income policy with a monthly benefit of $1,000 payable after a 30-day elimination period with a benefit period of five years, the insured would be entitled to five full years of benefits following the elimination period for each total disability (assuming that he or she continues to be totally disabled throughout the benefit period).

The longer the benefit period, the higher will be the policy's premium.

**Defining Total Disability**

Since the major purpose of disability income policies is to provide income when the insured is totally disabled and unable to work, the meaning of total disability is important. **Total disability** is always defined in the policy, and different companies may use different definitions. These definitions are based upon work activity, and insurers look at work activity in terms of two dimensions: the insured's own occupation and any occupation the insured may be qualified to perform.

**Own Occupation**

The first way total disability might be defined concerns the occupation in which the particular individual is normally engaged. In this case, total disability is defined as:

\[ \text{The insured's inability to perform any or all of the duties of his or her own occupation.} \]

This refers to the insured's own occupation at the time disability begins. Suppose Lee, who is a word processing typist, is involved in an accident in which three fingers on one hand and four on the other are severed. Using the definition above, Lee has a total disability since he is unable to use the keyboard—a primary duty of his occupation.

**Any Occupation**

An alternative and more restrictive definition of total disability is:

\[ \text{The insured’s inability to perform the duties of any occupation for which he or she is reasonably qualified by education, training or experience.} \]

Again consider Lee, the word processing typist whose fingers were severed. Under the previous definition, he was totally disabled because he was unable to perform the duties of his own occupation. Suppose, however, that Lee is qualified to teach word processing. Under this second definition, Lee is not totally disabled since he can work as an instructor, an occupation for which he is qualified by training and experience.

The “own occupation” definition, which is less restrictive and therefore more favorable to the insured, is more commonly used than the “any occupation” definition.
Later in this unit, we'll talk about both short-term and long-term disability income policies. Long-term policies generally use both definitions to cover different periods during the insured's disability. The “own occupation” definition is generally used for the initial period of disability, which might extend from two to five years as stated in the policy. Then, the “any occupation” definition applies to disability continuing beyond the initial period.

Once again, remember Lee, the word processing typist. Suppose Lee’s policy includes both of these provisions, and identifies the initial period as two years. If Lee performed no work at all during the two years following the loss of his fingers, he could collect total disability benefits under the “own occupation” definition.

Suppose Lee neither wants to be a word processing instructor nor do any other kind of work except his previous occupation, which he is now unable to do. After two years, he could no longer claim total disability and continue receiving benefits because the “any occupation” definition becomes effective. Since he is qualified and able to perform other work, he is no longer classified as totally disabled.

**Loss of Earnings**

Between these two definitions of total disability, there are several variations. In fact, some policies use a two-tier definition that refers to the insured's “own occupation” during an initial period of disability and then shifts to “any occupation.” These policies usually define total disability as the inability to perform the duties of the insured's own occupation for a period of two to five years, and thereafter the inability to perform the duties of any occupation for which the insured is suited by reason of education, training, experience or prior economic status. This is known as the loss of earnings test for disability.

**Injury Vs. Sickness**

Total disability is occasionally further defined in terms of its cause. For example, some policies may cover only, or cover differently, disability caused by accidental injury and some may cover only disability caused by sickness. In these cases, the terms total accident (or injury) disability and total sickness disability might be used.

If you see these terms, you know that total accident disability is disability caused by an accident, and total sickness disability is caused by sickness.

**Occupational Vs. Nonoccupational**

While short-term policies often cover only nonoccupational disability, most long-term plans cover both occupational and nonoccupational sickness and accidents. When occupational benefits are provided, they are often reduced by benefits received from Workers Compensation and Social Security.

**Medically Defined**

Some older policies also require that in addition to meeting the definition of total disability, the insured must also be confined to the house and under the treatment of a doctor. This is called medically defined disability.
Presumptive Disability

Aside from the occupational considerations, many disability income policies have another criterion by which total disability may be classified. This is called *presumptive disability*, which is a condition that automatically qualifies the insured for total disability classification, regardless of whether he or she can work. Conditions that are generally considered to be presumptive disabilities are:

- Loss of use of any two limbs
- Total and permanent blindness
- Loss of speech and hearing

Under these criteria, if Bruce's right arm and leg are severed in an accident, he is presumptively disabled. However, if Allen's left leg is amputated, he is not since only one limb is involved.

Presumptive disability may also be determined using a loss of earnings test. The insured's level of earnings prior to disability is compared to his or her level of earnings after disability. If post-disability earnings fall below pre-disability earnings by a given percentage, the insured is considered totally disabled and eligible for a full benefit even if some level of earnings remains.

Partial Disability

While total disability is the insured's inability to perform any duties of his or her own occupation, not every disability is total. Some people may suffer a *partial* disability. This means the person:

- cannot perform every duty of his or her occupation, but
- can perform one or more important duties of the occupation.

Bob works in a warehouse where his duties involve moving materials both with a mechanical lift-truck and by hand. Bob injures his back and is unable to perform the part of his job that involves moving heavy materials by hand, but he can use the lift-truck. Since Bob is able to perform some of the duties of his occupation, but not all of them, he is partially disabled.

Partial disability is generally not a factor in sickness disability. The insured usually either is or is not sick enough to stay off the job. Partial disability applies largely to accident disability, although some policies apply the concept to certain illnesses, such as heart attacks or ulcers.

Therefore, to receive sickness benefits from a disability income policy, the insured usually must be totally disabled. However, certain accident benefits may be payable when the insured is either totally or partially disabled.

The usual partial disability indemnity is 50% of the monthly or weekly indemnity for total disability. If a policy pays, for example, $3,000 per month for total disability, it will probably pay $1,500 for partial disability. These benefits are usually paid for a relatively short period—commonly three or six months.
An insured might receive both total and partial disability benefits as the result of a single accident. For example, a person might be totally disabled for three months, then able to return to work, but able to perform only a few of the usual duties for some time—let’s say two months. If the policy so stipulates, the individual described above would be eligible to receive total disability benefits during the first three months and partial disability benefits for the next two months.

**Residual Disability**

Many recent policies have replaced the partial disability provision with a residual disability provision. A residual disability benefit is usually a percentage of the total disability benefit for periods of partial disability as defined in the policy.

Earnings come into play in the residual benefit provision. Earnings during partial disability must be at least a stated percentage less than earnings prior to disability—20% less, for example. For instance, if earnings prior to disability were $2,000 per month and the policy required earnings during partial disability to be reduced at least 20% in order to receive residual benefits, a partially disabled person could earn no more than $1,600 per month.

The percentage of reduction in earnings is multiplied by the normal benefit to determine the residual benefit. So, if in the previous example, the normal benefits were $1,000 per month, the residual benefit would be $200—20% (reduction in earnings) x $1,000 (normal benefit). If the reduction in earnings is not at least the minimum stated percentage, no benefits are payable under this option.

**Recurrent Disability**

Occasionally, after a period of disability appears to be over, the disability will recur later as a result of the same illness or accident. When a second period of disability arises due to the same or a related cause of a prior disability, the second event is called a recurrent disability.

Most disability income policies stipulate that if the insured returns to work for a specified period of time after the original disability, a recurrence must be handled as a new claim for a new period of disability, requiring a new elimination period, rather than as a continuation of a prior claim. Usually, the specified period is 90 days, although some insurers permit six months.

Assume a policy specifies that no new elimination period is required if the disability recurs within 90 days. The insured suffers a disability as the result of an accident, returns to work for six months and then suffers the same type of disability. In this situation, the disability claim would be treated as a new event rather than a recurrent disability since more than 90 days have passed. Had the insured returned to work for, say, only two months before the disability recurred, no new elimination period would have been required.
**Permanent Disability**

Disability is usually defined as to whether it is permanent or temporary, in addition to whether it is total or partial. A permanent disability is one that reduces or eliminates the insured's ability to work for the rest of his or her life. Permanent disability results from any injury from which the insured is not expected to recover, such as loss of sight or one or more limbs.

**Temporary Disability**

A temporary disability occurs when an insured is unable to work while recovering from an illness or injury, but is expected to fully recover from that illness or injury. Examples would be a broken leg or a sprained back.

**Confining Vs. Nonconfining Disability**

Some policies may include a provision that differentiates between disabilities in still another way—whether the disability is confining or nonconfining.

- A total, confining disability refers to a condition that requires the individual to stay indoors, perhaps in the hospital or at home except for visits to the doctor.

Suppose Lana is at home recuperating from tuberculosis. If she may not leave her home until she is completely recovered, she has a total, confining disability.

- A total, nonconfining disability refers to a condition that disables but does not require the individual to remain confined indoors.

While Warren was recovering at home from a serious illness, his doctor encouraged him to take a short walk each day. Warren’s is a total, nonconfining disability.

You should be aware of this terminology, but unless a policy specifically includes this provision, the absence or presence of confinement does not affect the total disability classification.

**Accidental Means**

Of the different terms used to define “accident” the two that will be discussed here are accidental bodily injury and accidental means.

- Accidental bodily injury or
- Accidental bodily injury by **accidental means**

A policy that includes the *accidental means* wording is more restrictive than one that refers simply to accidental bodily injury. To help you understand the restrictive nature of accidental means, let’s look at an example.

For example, Mary is carrying a heavy bag of groceries and strains her back. This accident would be defined as accidental bodily injury because Mary did not intentionally strain her back. However, while the injury was caused by accident it could not be defined as accidental means because the cause of the
accident was foreseeable. That is, using reasonable judgment Mary could foresee that carrying too heavy a load could produce problems, such as the bag breaking and the contents spilling out and injuring her foot, or, as in this example, the heavy load creating a strain on her back. If the policy under which Mary was covered defined accident in terms of accidental means, she would not receive benefits.

On the other hand, if while carrying this same heavy bag of groceries, a dog runs in Mary’s path causing her to fall and break her arm, she would be covered under the definition of accidental means. This is because the injury was caused by circumstances that could not reasonably be foreseen. Mary could not possibly foresee that a dog would run in her path; and that in running in front of her the dog would cause her to fall; and that in falling she would break her arm. There are too many contingencies to be planned for. Also, the cause of the fall was not based on any action taken by Mary, or by any activity in which Mary was engaged.

The term “accidental bodily injury” encompasses almost all but self-inflicted injuries, subject to any other events the policy excludes. “Accidental means,” on the other hand, involves a more literal interpretation of accident—an event that is completely unforeseen and unintended.

There is a fine line of distinction between accidental bodily injury and injury by accidental means . . . so fine, in fact, that the courts have often been required to determine whether an insurer is liable. Most courts have interpreted policies in favor of the insureds or their beneficiaries. As a result, though at one time many policies contained the “accidental means” stipulation, today most—but not all—policies use only the “accidental bodily injury” wording.

Since some policies being issued today do contain this wording, you should be aware of the implications. If your company’s policies do not use accidental means as a criterion for receiving accidental injury or death benefits, you may be able to use this as a sales point. For example, a prospective client might be considering the purchase of either your policy or a competitor’s. If your competitor’s policy contains the “accidental means” wording, you could point out that your policy’s wording is more favorable.

**Definition Of Sickness**

Sickness or illness may not be defined in any manner that is more restrictive than, “sickness or disease which first manifests itself after the effective date of the policy.” If a policy provides nonoccupational coverage only, the definition of sickness may exclude work-related disabilities.

For example, Susan applies for and is issued a disability income policy with an effective date of May 1, 1996. Approximately one month later she begins to have a digestive problem which is subsequently diagnosed on August 15, 1996, as a gall bladder problem requiring surgery. Medically, her symptoms first appeared after the effective date of the policy and thus, this sickness claim would be honored by the insurer.
On the other hand, let’s assume that Susan begins to have the digestive problem on May 1, 1996. She contacts her doctor and he suggests that she take some antacid medication which she purchases from her local drug store. By June 1, the problem appears to be no better but Susan does nothing about it. Susan purchases some disability income insurance with an effective coverage date of July 1, 1996. One month later she consults with her doctor who after prescribing some tests, diagnoses her gall bladder problem. Even though the diagnosis occurred after the effective date of the disability income policy, the symptoms appeared prior to the effective date of the policy. Should a claim arise and all the facts become known, the insurer could determine that the gall bladder problem preexisted the effective date of the insurance and deny the claim.

The definition of sickness is very important because it could be used to permanently exclude benefits for conditions that existed prior to the effective date of coverage.

**BENEFIT CALCULATIONS**

Following are some sample benefit calculations which utilize the concepts discussed thus far.

Beth has a disability income policy with a 30-day elimination period, a $2,000 monthly income benefit for total disability, and a benefit period to age 65. Beth becomes totally disabled on January 1, and is unable to work for three months. She returns to work on a part-time basis, April 1, and is able to earn 40% of her pre-disability compensation during the month of April. In May she earns 60% of her pre-disability income. By June 1, she is working full time, earning 100% of her pre-disability income. Let’s consider how Beth’s benefits would differ under a policy that provides total and residual disability benefits and a policy that provides total disability benefits only.

It can be seen in the benefit calculation that a policy that pays residual disability benefits provides an incentive for the insured to return to work, because it pays proportional benefits. A more traditional “total disability only” policy implies that an insured cannot return to work for any length of time without losing all benefits. While it appears that the insurance company in the example would pay less (by terminating benefits as soon as Beth returned to work on a part-time basis in April), it might actually end up paying as much or more than the policy providing residual benefits (because without partial benefits Beth might not return to work until she is fully recovered in June, and might claim total disability benefits for two additional months).

<table>
<thead>
<tr>
<th>Month</th>
<th>Income Loss</th>
<th>Total And Residual Benefit Policy</th>
<th>Total Disability Only Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>January</td>
<td>100%</td>
<td>None—satisfying the elimination period</td>
<td>None—satisfying the elimination period</td>
</tr>
<tr>
<td>February</td>
<td>100%</td>
<td>$2,000—100% of the total disability benefit</td>
<td>$2,000—total disability benefit</td>
</tr>
<tr>
<td>March</td>
<td>100%</td>
<td>$2,000—100% of the total disability benefit</td>
<td>$2,000—total disability benefit</td>
</tr>
<tr>
<td>April</td>
<td>60%</td>
<td>$1,200—60% of the total disability benefit</td>
<td>None—performing occupational duties</td>
</tr>
<tr>
<td>May</td>
<td>40%</td>
<td>$800—40% of the total disability</td>
<td>None—performing occupational duties</td>
</tr>
<tr>
<td>June</td>
<td>0</td>
<td>None—no loss of income</td>
<td>None—performing occupational duties</td>
</tr>
</tbody>
</table>
TYPES OF DISABILITY BENEFITS

**Short-Term Disability**

Most group short-term policies provide for short elimination periods (usually 30 days or less) and short benefit periods. The benefit period is normally for six months but not longer than one year. The benefit amount is limited to a percentage of compensation, such as 60 or 70%.

One of the rationales for short-term disability has been that the worker presumably is eligible for Social Security disability benefits after the five-month Social Security waiting period. In reality, this may or may not be true depending on whether the worker can qualify for Social Security disability benefits. In addition, if the person does qualify for benefits, the first benefit check will likely not be received before one year from the onset of disability. In any event, short-term disability benefits were designed to fill the gap until Social Security began paying benefits to the claimant.

**Long-Term Disability (LTD)**

LTD policies provide for longer elimination and benefit periods than short-term. Typically, the elimination period will be 90 days or six months with benefits provided for two or five years or to age 65. Most often LTD policies provide benefits to age 65.

The amount of the long-term benefit is limited to a percentage of the worker’s compensation such as 60% or 70%. Like short-term policies, LTD coverage may be occupational or non-occupational.

Additionally, LTD policies usually provide for integration of plan benefits with other disability income benefits payable to the insured. The LTD benefit may be offset by any of the following:

- Any benefits provided by another formal employer plan
- Benefits payable under workers compensation or any similar statutory program
- Any benefits payable under Social Security

The purpose for having integration with these other sources of disability income is to prevent overinsurance on the part of the insured.

**Lump Sum Benefits**

Lump sum payments under disability policies were once paid more often than they are today. Modern safety measures and enforcement, coupled with advancements in medical technology, have made total and permanent disabilities less common. While lump sum benefits may be paid for presumptive disability, or under special disability policies covering business buy-sell agreements, it is more common for disability income benefits to be received in the form of installment payments.
Unit 4—Disability Income Insurance

EXCLUSIONS

Common exclusions found in disability income policies are losses arising from war, military service, attempted suicide, overseas residence, aviation under certain circumstances (pilot or crew of aircraft), and losses that result when an insured is injured while committing a felony.

Exercise

Match the definitions with the numbered terms below.

___ A. Often defined as inability to perform duties of any occupation for which the individual is suited by education, training, or experience

___ B. Type of health insurance providing periodic payments when an insured cannot work because of sickness or injury

___ C. The period of time immediately following the onset of disability during which benefits are not payable

___ D. The inability of an insured to perform one or more of the regular duties of his occupation

___ E. When the insured is unable to work, but is expected to fully recover from illness or injury

___ F. Injury which is unintentional and unforeseen

___ G. The most time disability benefits will be paid

___ H. Disability policies with a benefit period of two years or more

___ I. War, military service, attempted suicide, aviation under certain circumstances

___ J. Benefits are based on the insured’s loss of earnings rather than inability to perform the duties of an occupation.

1. Elimination Period
2. Total Disability
3. Disability Income
4. Partial Disability
5. Temporary Disability
6. Residual Disability
7. Accidental Bodily Injury
8. Long-Term
9. Common Exclusions
10. Maximum Benefit Period

Rehabilitation Benefit

Because of disability, the insured may not be able to return to his or her normal occupation but still be able to work at some kind of job. The rehabilitation benefit facilitates vocational training to prepare the insured for a new occupation.

The rehabilitation benefit applies when the insured is totally disabled and receiving benefits. If that is the case and the insured chooses to participate in a vocational rehabilitation program approved by the insurer, then total disability benefits will continue as long as the insured actively participates in the training program and remains totally disabled.

Some insurers may provide a lump sum benefit for vocational training. Whether a lump sum or a monthly disability benefit, this benefit enables the insured to take positive steps toward returning to work, even though it may be in another occupation. Thus, this option benefits both the insured and the insurer.

Future Increase Option

This option may also be referred to as the Guaranteed Insurability Option or Guaranteed Purchase Option, since it enables the insured to purchase additional disability income protection, regardless of his or her insurability, at specified future dates. However, the rate for this additional coverage will be at the insured’s attained age at the time of purchase, not the age when the policy was originally issued.

This benefit has some limitations. The insured will only be able to purchase a specified predetermined amount of disability income insurance at each option date. To guard against overinsurance, the insurer will usually limit the amount of additional coverage to possibly $500 or less on each option date. Also, the insured’s earned income must warrant additional coverage. That is, it is presumed that every few years, the insured’s earned income will increase substantially, thus “leaving room” for additional disability insurance.

Another limitation is the number of option dates on which the insured may purchase additional coverage. Usually, these option dates will be every two or three years from ages 25 to 40 or possibly, even to age 50. These dates may be arbitrarily selected by the insurer or they may coincide with the insured’s birthdays, marriage, and the birth of children.

Cost Of Living Benefit

The purchasing power of fixed disability benefits may be eroded due to inflation and increases in the cost of living. To protect against these trends, most insurers will offer an optional cost of living benefit.
Under the provisions of this option, the insured’s monthly disability benefit (total or residual) will be automatically increased once the insured is on claim (receiving disability income benefits). Typically, this increase will occur after the insured is on claim for 12 months and each 12-month period thereafter as long as the insured remains on claim.

**Lifetime Benefits**

This option extends the benefit period from age 65 to lifetime. This extension may apply to accident only benefits or to accident and sickness benefits. Normally, if the total disability is due to an accident and it occurs prior to age 65, benefits will be paid for the lifetime of the insured provided he or she remains totally disabled.

Most companies will place some time limitations for the lifetime sickness benefit. That is, the disabling sickness must begin prior to a specified age such as 50, 55 or 60. A policy providing lifetime sickness benefits may stipulate that if the sickness begins at age 55 or earlier, then 100% of the total disability benefit will be provided for the lifetime of the insured. However, if the disability begins after age 55, but before age 65, a reduced benefit will be paid for life.

For example, a policy might state the following:

If total disability, due to sickness, begins at age 55 or earlier, total disability benefits will be paid for the lifetime of the insured. If total disability benefits begin at age:

- 56—total benefits are paid to age 65; then 90% of the benefit for the lifetime of the insured
- 57—total benefits are paid to age 65; then 80% of the benefit for the lifetime of the insured
- 58—total benefits are paid to age 65; then 70% of the benefit for the lifetime of the insured
- 59—total benefits are paid to age 65; then 60% of the benefit for the lifetime of the insured
- 60—total benefits are paid to age 65; then 50% of the benefit for the lifetime of the insured

This progression of benefits would continue in this manner until age 65. If the total disability began at age 65 (normally the policy is not renewed past age 65), then the payment of total disability benefits would be limited to one or two years.

**Social Security Rider**

The Social Security Administration defines total disability as the inability to perform any substantial gainful work which may exist in the national economy. In addition, the disability must be expected to last at least 12 months or end in death. This is a very rigid and ultra-conservative definition of total disability. As a result, many disabled people do not qualify for Social Security disability benefits. In fact, the Social Security Administration denies about two-thirds of all disability claims.
NOTES

Even when Social Security benefits are payable, there is a five-month waiting period and benefits do not begin until the sixth month of disability. When a Social Security rider is added to an individual’s disability income policy, an additional monthly benefit is payable during the waiting period.

The rider may or may not continue to pay benefits after Social Security benefits begin. There are two different methods by which this type of rider may provide benefits:

- **All or Nothing Rider**: Under this approach, the insured will be paid a benefit only if Social Security pays nothing. Conversely, if Social Security provides any benefit, then the rider pays nothing.
- **Offset Rider**: Under this approach, the benefit provided by the rider will be reduced, or offset, by the amount of any benefit provided by Social Security.

**Social Insurance Supplements**

Some insurers offer social insurance supplements which are designed to fill gaps left by various government benefit programs. The concept is similar to the Social Security rider, except that this coverage may also mesh with workers compensation benefits and benefits provided by state disability funds. These supplemental benefits may be included as part of the disability income policy or may be added to the policy by rider. The benefits are usually payable during any waiting periods for social insurance benefits or if the social insurance benefits are denied. Benefits will be paid monthly until government benefits begin. If, for any reason, the government benefits stop, the insurer will step in and begin the monthly payments again. However, the benefits are only payable during the benefit period specified in the contract and only while the insured remains disabled.

**Additional Monthly Benefit (AMB) Riders**

Most insurers offer short term riders to provide additional benefits during the first six months or 12 months of a claim. Some companies may call these “Social Security Riders” because the benefit is payable during the Social Security waiting period, although the rider itself may not even refer to Social Security benefits. More commonly, the term “Additional Monthly Benefit Rider” is used. The additional benefits during the early months of disability may be used to supplement government benefits or short-term disability benefits provided by an employer, or may be used to help pay extra transitional expenses that might be incurred when an insured is first disabled.

**Hospital Confinement Rider**

This optional benefit results in the elimination period being waived when the insured is hospitalized as an inpatient. The payment of any disability benefits usually requires satisfying the elimination period. The hospital confinement benefit pays the regular total disability benefit during the elimination period when the insured is hospitalized.

The factor which triggers the payment of the benefit is any period of hospitalization during the elimination period. Benefits will only be paid for as long as the insured is hospitalized.
For example, an insured has a disability income policy with a 30-day elimination period and a $1,000 per month benefit for total disability, payable to age 65. The insured also has the hospital confinement option and is hospitalized for minor surgery for a period of two days. Following the hospitalization, the insured returns to work within three days. Total disability benefits will be paid for the period of two days. The amount paid would be 2/30 (or 1/15th) of $1,000, or $67.

**Impairment Rider**

When an applicant for insurance has an existing medical problem or chronic condition, an insurer might attach an impairment rider to the standard policy. This rider excludes coverage for a specific ailment or condition that would otherwise be covered. Since the condition currently exists, the insurance company would be unlikely to take the risk, so would normally refuse coverage. Using the impairment rider to exclude this specific condition, however, benefits both the applicant and the insurer in the following ways:

- The applicant is able to obtain coverage that might not otherwise be available for his or her other health care needs.
- The insurance company is able to protect itself from undue risk from this particular condition and is still able to provide health coverage.

Impairment riders are written on an individual basis for a specific person’s medical condition, such as heart disease, cancer or diabetes. The exclusion in the rider applies only to the person with the impairment and not to any other insureds, such as family members covered by the same policy.

**Non-Disabling Injury Rider**

This benefit does not pay a disability benefit but rather provides for the payment of medical expenses incurred due to injury which does not result in total disability.

**Waiver Of Premium (With Disability Income)**

This rider specifies that in the event of disability, premiums will be waived retroactively to the beginning of the disability. The definition is usually “permanent and total” disability. Again, however, a few companies have gone to a definition in terms of occupation, as previously discussed.

**Accidental Death And Dismemberment (AD&D)**

Accidental death policies or riders include a death benefit which is payable in the event of death resulting from accidental bodily injury. A companion coverage is provided for loss of limbs or sight, often called dismemberment coverage.

A schedule is made a part of the policy which lists various dismemberments and losses of sight for which a specified sum will be paid to the insured. In policies with weekly disability income benefits, the sum payable is usually expressed as a multiple of the weekly indemnity. In policies without weekly disability income benefits, the sums payable are usually expressed as percentages of the death benefit limit or sometimes as percentages of a limit in the policy known as the capital sum. The capital sum might be $20,000 and the death benefit is usually the same amount ($20,000).
Unit 4—Disability Income Insurance

NOTES

SAMPLE SCHEDULE

<table>
<thead>
<tr>
<th>Loss Of:</th>
<th>Sum Equal To Weekly Indemnity For:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Both hands, or feet, or sight of both eyes</td>
<td>200 weeks</td>
</tr>
<tr>
<td>One hand and one foot</td>
<td>200 weeks</td>
</tr>
<tr>
<td>Either hand or foot and sight of one eye</td>
<td>200 weeks</td>
</tr>
<tr>
<td>Either hand or foot</td>
<td>100 weeks</td>
</tr>
<tr>
<td>Sight of one eye</td>
<td>65 weeks</td>
</tr>
<tr>
<td>Thumb and index finger of either hand</td>
<td>50 weeks</td>
</tr>
</tbody>
</table>

The intent of the dismemberment feature is to provide insureds with a lump sum which will help them over the period when they go through rehabilitation and, probably, training for work other than that for which they previously were qualified. If the policy has a disability income feature, once a dismemberment sum is paid, the disability income payments stop. In some cases the insured might be disabled for a while, and during the disability suffer one of the losses listed above. In that event, the insured would be paid disability income up to the time of the loss of limb or sight only.

Most company policies provide that, even if the insured is not disabled after an accident, if a loss of limb or sight occurs within 90 days of the date of the accident, the sums in the schedule will be paid.

Accidental death and dismemberment coverage provides both a life insurance and a health insurance benefit. However, the life insurance benefit applies only to accidental death and is not paid for death by natural causes.

Other Provisions

While disability income policies do not typically accumulate cash value or have a life insurance component, it is possible to purchase riders to the policy that provide benefits similar to life insurance policies. Thus, an annual renewable term life insurance feature may be attached to a disability income policy, providing a death benefit as well as disability income coverage.

Similarly, a return of premium rider may be attached to a disability income policy. This rider provides for the return of a percentage of premiums paid (usually 80%) during a specific term period (usually every 10 years) minus the claims paid during the term period. The refund is made every 10 years and at age 65 or as of the date of death. Essentially, for an additional premium, the policyholder gets 80% of his or her money back either in claims, premium refunds, or a combination of both. Various settlement options are offered for receiving the premium refund. Amounts left on deposit with the insurance company earn interest and constitute cash value and/or may be applied toward future premium payments.

Exercise

A. The benefit which enables a disabled insured to learn to work in another occupation is known as the:

   ( ) 1. cost of living benefit.
   ( ) 2. rehabilitation benefit.
   ( ) 3. guaranteed insurability option.
   ( ) 4. lifetime benefit option.
B. The benefit which protects against the erosion of purchasing power for fixed disability benefits is known as the:

( ) 1. cost of living benefit.
( ) 2. rehabilitation benefit.
( ) 3. offset rider.
( ) 4. lifetime benefit.

C. The rider which provides more benefits during the first six months or year of a claim is known as the:

( ) 1. cost of living rider.
( ) 2. rehabilitation rider.
( ) 3. additional monthly benefit rider.
( ) 4. lifetime benefit rider.

D. The benefit which pays the regular total disability benefit during the elimination period when the insured is hospitalized is known as the:

( ) 1. hospital confinement rider.
( ) 2. rehabilitation benefit.
( ) 3. non-disabling injury rider.
( ) 4. offset rider.

E. The option which allows an insured to purchase additional amounts of disability income protection is known as the:

( ) 1. lifetime benefit option.
( ) 2. additional monthly benefit option.
( ) 3. all or nothing option.
( ) 4. future increase option.

F. Social insurance supplements provide disability income:

( ) 1. before workers compensation and social security begin payments
( ) 2. after workers compensation and social security end payments
( ) 3. both are correct
( ) 4. neither is correct

Answer: A. 2. rehabilitation benefit; B. 1. cost of living benefit; C. 3. additional monthly benefit rider; D. 1. hospital confinement rider; E. 4. future increase option; F. 3. both are correct

**BUSINESS USES OF DISABILITY INCOME INSURANCE**

Disability income insurance is designed to protect an individual’s most important asset—the ability to earn an income. By protecting against the loss of income during periods of disability, this type of coverage enables the disabled insured to continue to provide for the basic necessities of life. The application and use of disability income coverage is not confined to individuals but also is very relevant in business situations.

The life insurance section of this book identified business uses of life insurance, i.e., to fund buy-sell agreements, key person insurance, etc. Life insurance benefits are paid to the business upon the death of a key person or the business owner so that the business may continue. A similar concept applies...
for the business with regard to the disability of a key person or the business-owner. The living death of disability can have a serious impact on the continued existence and profitability of a business.

**Business Overhead Expense (BOE)**

The BOE policy is designed for the small business owner. Its purpose is to cover certain overhead expenses which continue when the business owner is disabled. Most insurers will limit the BOE policy to those businesses which are relatively small.

For example, General Motors would not be eligible for a BOE policy but a small firm consisting of the owner and three to four employees could purchase a BOE policy.

The policy will indemnify the business (not the owner) for such business expenses as: rent, taxes, insurance premiums, utility bills, employees’ compensation (not the owner’s salary), etc. By covering these expenses when the owner is disabled, the business is able to keep its doors open and continue to operate.

Naturally, the overall concept is that the small business owner is so important to the profitability of the business that when he or she becomes totally disabled, the business will suffer economically and may even be forced to close. An example of such a situation would be a dentist. Typically, if the dentist cannot practice his or her profession, business income will eventually be impaired and the few employees working in the dentist’s office may lose their jobs. As the business income slows, the bills still have to be paid as do the employees. The BOE policy will solve this problem.

Generally, BOE policies will have elimination periods of usually 15 or 30 days and benefit periods of one or two years. The benefit amount will be determined by the average eligible overhead expenses of the business. If the business owner becomes disabled, after the elimination period is satisfied, the business will receive benefits equal to the actual overhead expenses incurred during the owner's disability.

BOE premiums are tax deductible to the business. The disability benefits received are thus taxable to the business. However, these taxable benefits are then used to pay tax deductible business expenses.

**Key Person Disability Insurance**

Just as key person life insurance serves to indemnify the business for the lost services of a key person, so too does a key person disability income policy. This type of coverage pays a monthly benefit to a business to cover expenses for additional help or outside services when an essential person is disabled. The key person could be a partner or working stockholder of the business. The key person could also be a management person who is personally responsible for some very important functions such as a sales manager.

The key person’s economic value to the business is determined in terms of the potential loss of business income which could occur as well as the expense of hiring and training a replacement for the key person. The key person’s value then becomes the disability benefit which will be paid to the business. The
benefit amount may be paid in a lump sum or in monthly installments. Generally, the policy’s elimination period will be 30-90 days and the benefit period will be one or two years.

The business is the owner and premium payor of the policy. Benefits are received by the business tax free because the premium paid is not tax deductible.

**Disability Buy-Sell Insurance**

When there is a buy-sell agreement funded with life insurance to buyout the interest of a deceased owner or partner, there should also be a provision in the agreement for the buyout of the owner’s business interest in the event of disability. Naturally, this disability provision should be funded with buy-sell disability income insurance.

One of the critical considerations with reference to the disability buy-sell policy is the elimination period. Once the elimination period is satisfied benefits will begin to be made to the business for the purpose of buying out the interest of the disabled owner or partner. Generally, once the buyout begins it cannot be stopped. Thus, for example, a disabled partner does not want to be bought “too soon” and then possibly recover from the disability and find that he or she has no job and no business interest.

For this reason, the elimination period for disability buy-sell insurance will normally be one or two years. The buy-sell agreement will specify the value or a method of determining the value of the owner’s business interest. This value will be paid to the business following the elimination period. The benefits may be paid in a lump sum or in monthly installments. If the policy provides a monthly benefit, usually the benefit period will not exceed five years. The business of course uses the policy proceeds to buy out the interest of the disabled person.

Usually, the business is the owner and premium payor for the policy or policies. The premiums are not deductible but the benefits are received by the business, tax free.

**Disability Reducing Term Insurance**

It may happen that a business owner incurs a loan or other financial obligation that requires monthly payments. However, the monthly payment can only be made as long as the business owner remains able to run the business (is not disabled).

To protect the financial obligation, and the assets that could be lost in case of default, the business can purchase a “disability reducing term policy” which provides a monthly benefit in the case of total disability sufficient to cover the monthly financial obligation until it is satisfied (the end of the loan repayment period).

The business purchases and owns the policy, the business owner is the insured, and the business is the beneficiary of the monthly benefit. Premiums are not tax-deductible to the business, but benefits are received tax free. “Reducing term” refers to the fact that the full monthly benefit is payable only for the remaining term of indebtedness or obligation.
1. The elimination period may be thought of as
   ( ) A. a dollar amount deductible.
   ( ) B. a time deductible.
   ( ) C. a dollar amount copayment.
   ( ) D. a time copayment.

2. The longer the benefit period
   ( ) A. the higher the policy’s premium will be.
   ( ) B. the lower the policy’s premium will be.
   ( ) C. the higher the policy’s benefits will be.
   ( ) D. the lower the policy’s benefits will be.

3. Which definition of total disability is more favorable to the insured?
   ( ) A. Own occupation
   ( ) B. Any occupation
   ( ) C. They are the same in terms of benefits to the insured.
   ( ) D. There is no way to determine from the information provided.

4. Occupational disability benefits are often reduced by
   ( ) A. benefits received from Social Security only.
   ( ) B. benefits received from Workers Compensation only.
   ( ) C. benefits received from either Social Security or Workers Compensation.
   ( ) D. benefits received before the end of the elimination period only.

5. Which of the following is **not** generally considered to be a presumptive disability?
   ( ) A. Loss of the dominant hand
   ( ) B. Loss of use of any two limbs
   ( ) C. Total and permanent blindness
   ( ) D. Loss of speech and hearing

6. Which of the following statements is **not** true about partial disability?
   ( ) A. The person is not able to perform every duty of his or her prior occupation.
   ( ) B. The person is able to perform one or more important duties of his or her occupation.
   ( ) C. Sickness disability is more likely than accident disability to be partial.
   ( ) D. An insured might receive both total and partial disability benefits as the result of a single accident.

7. Some policies have replaced the partial disability provision with a
   ( ) A. reduced disability provision.
   ( ) B. redundant disability provision.
   ( ) C. recurrent disability provision.
   ( ) D. residual disability provision.
8. Brandon injures his back working at a warehouse. Six months later, he is well enough to go back to work lifting boxes. Two weeks into working, however, he strains his back again, and has to go back on bed rest. This is an example of a

( ) A. redundant disability.
( ) B. residual disability.
( ) C. recurrent disability.
( ) D. reduced disability.

9. Lee is helping a friend move his pool table when he strains his back, causing a disability. The insurer declines coverage, saying the injury was not accidental under the terms of Lee’s policy. Lee’s policy must include

( ) A. an accidental bodily injury definition of accidental.
( ) B. an accidental means definition of accidental.
( ) C. a confining definition of accidental.
( ) D. a nonconfining definition of accidental.

10. Most often, LTD policies provide benefits

( ) A. for two years.
( ) B. for five years.
( ) C. to age 60.
( ) D. to age 65.

11. Common exclusions under disability policies include all of the following except

( ) A. disability caused by flying as a passenger on a commercial aircraft.
( ) B. disability resulting when an insured is injured while committing a felony.
( ) C. disability caused by self-inflicted injury.
( ) D. disability caused by an act of war.

12. Which of the following statements is not true regarding the future increase option rider?

( ) A. The rate for additional coverage will be at the insured’s attained age at the time of purchase.
( ) B. The rider guarantees the ability to increase coverage to a prede-termined limit, regardless of change in the insured’s income.
( ) C. The rider generally limits the number of option dates on which the insured may purchase additional coverage.
( ) D. The rider usually limits the amount of additional coverage available at each option date.

13. Disability benefits will generally be paid for the lifetime of the insured if total disability due to sickness begins at age

( ) A. 45 or earlier.
( ) B. 50 or earlier.
( ) C. 55 or earlier.
( ) D. 65 or earlier.
14. Which of the following statements is true regarding Social Security disability benefits.

( ) A. For benefits to be paid, the disability must be permanent and expected to end in death.

( ) B. For benefits to be paid, the disability must prevent the individual from being able to perform any substantial gainful work existing in the national economy.

( ) C. Most of the people who apply for disability under Social Security are able to get benefits.

( ) D. Social Security provides a fairly liberal definition of total disability, in order to keep individuals able to spend and support the national economy.

15. Which of the following is not true about Accidental Death and Dismemberment coverage?

( ) A. A schedule listing various dismemberments and the sums that will be paid for them will be listed in the policy.

( ) B. The sums payable are generally expressed as percentages of the death benefit limit or the capital sum.

( ) C. If the policy has a disability income feature, the disability income payments continue even after the dismemberment sum is paid.

( ) D. Even if the insured is not disabled after an accident, if a loss of limb or sight occurs within 90 days of the date of the accident, the sums in the schedule will be paid.

16. Which of the following organizations would be most likely to be eligible for Business Overhead Expense insurance?

( ) A. A law firm with 15 partners

( ) B. A doctor’s office

( ) C. A major multinational corporation

( ) D. A public library

17. To protect the business owner, the elimination period for disability buy-sell insurance will normally be

( ) A. one to two weeks.

( ) B. three to six months.

( ) C. six months to one year.

( ) D. one to two years.

Answers:

1. B. a time deductible.

2. A. the higher the policy’s premium will be.

3. A. Own occupation

4. C. benefits received from either Social Security or Workers Compensation.

5. A. Loss of the dominant hand

6. C. Sickness disability is more likely than accident disability to be partial.

7. D. residual disability provision.

8. C. recurrent disability.

9. B. an accidental means definition of accidental.
10. D. to age 65.
11. A. disability caused by flying as a passenger on a commercial aircraft.
12. B. The rider guarantees the ability to increase coverage to a predetermined limit, regardless of change in the insured's income.
13. C. 55 or earlier.
14. B. For benefits to be paid, the disability must prevent the individual from being able to perform any substantial gainful work existing in the national economy.
15. C. If the policy has a disability income feature, the disability income payments continue even after the dismemberment sum is paid.
16. B. A doctor's office.
17. D. one to two years.
UNIT 5

MEDICAL EXPENSE INSURANCE

LEARNING OBJECTIVES

After completing Unit 5—Medical Expense Insurance, you will be able to:

1. Explain the purpose of medical expense insurance.
2. Describe the types of coverage generally offered under basic medical expense policies.
3. Explain the difference between a scheduled and a nonscheduled plan.
4. List and describe 18 exclusions common to medical expense policies but not disability income policies.
5. Explain the difference between basic and major medical expense policies.
6. List and describe the two main groups of major medical expense policies.
7. Explain the function of deductibles, coinsurance, stop-loss limits, and maximum benefits.
8. Describe how supplemental major medical benefits work.
9. List and describe 19 things covered in most major medical plans.
10. List and describe 15 items generally subject to limitations on benefits under medical expense plans.
11. Explain when alternative providers may be able to receive payment under medical expense policies.
12. List and describe five types of benefits sometimes added to medical expense policies.
MEDICAL EXPENSE INSURANCE

Medical expense insurance provides benefits for medical care. Contracts may provide for payment of medical expenses incurred on a reimbursement basis (by paying benefits to the policyowner), on a service basis (by paying those who provide the services directly), or a contract may provide for payment of an indemnity (by paying a set amount regardless of the amount charged for medical expenses). Medical expense or hospitalization insurance may be written on an individual basis or on a group basis. Benefits provided cover the individual and eligible dependents.

Although there are many types of benefits available, medical expense insurance can generally be categorized as basic medical expense insurance, major medical insurance, comprehensive medical insurance and special policies. It should be noted that these products have largely been replaced by managed care alternatives and are not sold as standalone coverages any longer. These types of plans have been modified and replaced in response to changes in the health care field relative to cost containment and market competition. However, an understanding of basic medical, hospital and surgical plans can serve as a foundation for understanding the hybrid plans currently being marketed.

BASIC MEDICAL EXPENSE

Basic coverages provided by an individual medical expense policy include hospital expense, surgical expense and medical expense. These three basic coverages may be sold together or separately. Frequently this is written as “first dollar” coverage, which means it does not have a deductible.

Hospital Expense Benefits

As the name implies, hospital expense coverage provides benefits for expenses incurred during hospitalization. Hospital indemnities are usually classified into two broad groups:

- Room and board, including nursing care and special diets
- Miscellaneous medical expenses, including X-rays, lab fees, medications, medical supplies, and operating and treatment rooms
NOTES

In some cases, surgical benefits may be included for certain types of surgery and associated costs.

**Room And Board Benefit**

Hospital expense coverage provides benefits for daily hospital room and board and miscellaneous hospital expenses (not including telephone and television) while the insured person is confined to the hospital. The policy may provide for a certain dollar amount for the daily hospital room and board benefit, although the trend is toward coverage of not more than the semi-private room rate unless a private room is medically necessary.

The room and board benefit may be paid on either an indemnity basis or a reimbursement basis, depending upon the particular policy.

When room and board are covered on an indemnity basis, the insurer pays a specified, pre-established amount per day, as shown in a schedule in the policy, for a stated maximum number of days. For example, the policy might pay $125 per day for up to 90 days. Thus, if the hospital’s room and board charge is $135 per day and an insured is hospitalized for 10 days, the total charge would be $1,350 ($135 x 10) and the policy would pay $1,250 ($125 x 10). If the insured were hospitalized for more than 90 days, no additional room and board would be covered.

Indemnity policies are sometimes called dollar amount plans. Room and board (R&B) rates will vary by geographical location but it is not unusual to find R&B rates ranging from $300–$500 per day or more. Typically, the maximum number of days is from 90 up to 365.

More commonly, room and board expenses are paid on a reimbursement basis. This is also referred to as an expenses-incurred basis. Under this arrangement, the policy will pay in one of two ways:

1. The actual charges for a semiprivate room or
2. A percentage of the actual charges

with no specific dollar limit. A maximum number of days will still be specified.

Under the first reimbursement option above—actual charges—the insurer will pay the full actual semiprivate room rate, regardless of what it is, as indicated in the illustration that follows.

**Actual Charges/Option A**
Under this same arrangement, however, the insurer still pays only the semi-private room rate if the insured must be in a private room, as indicated in the following chart.

**Actual Charges/Option B**

<table>
<thead>
<tr>
<th>Hospital’s private rate is $400 per day</th>
<th>Insured must pay $50 per day difference in rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital’s semi-private rate is $350 per day</td>
<td>Insurer pays $350 per day</td>
</tr>
</tbody>
</table>

Under the second reimbursement option—payment of a percentage of the actual charges—the insurance company pays a specified percentage, regardless of what the actual charges are. A common percentage is 80%. Here is how it would apply to Insureds A and B from the previous illustration:

**Percentage Of Actual Charges**

<table>
<thead>
<tr>
<th>Actual Charges</th>
<th>Insured Pays</th>
<th>Insurer Pays 80%</th>
</tr>
</thead>
<tbody>
<tr>
<td>$350</td>
<td>$280</td>
<td>$340</td>
</tr>
</tbody>
</table>

To summarize: under the actual charges type of reimbursement plan, the policy will pay the actual amount charged for a semiprivate room without regard to a specific dollar limit.

Under the percentage type of reimbursement plan, the policy will pay a specified percentage of the actual charges.

Some room and board benefits include intensive care, which may be paid in full or in part. Hospital plans with this provision generally provide for a maximum intensive care benefit of some multiple of the room and board maximum—usually two or three times. For example, if the room and board maximum is $400 per day, the plan might pay twice that amount, or $800 per day, for intensive care. A limit might also be placed on the number of days for which this benefit will be paid.
**NOTES**

**Miscellaneous Medical Expenses Benefit**

Benefits for *miscellaneous medical expenses* are generally stated as a limit separate from the room and board benefits. Usually, the limit is expressed as some multiple of the per-day limit for room and board—such as 10 or 20 times—for each period of hospital confinement. For example, a policy might state that it will pay 10 times the semiprivate room rate. If the semiprivate rate is $500 per day, a total of $5,000 (10 x $500) is available for miscellaneous expenses during this single stay in the hospital. If, a year later, the rate has risen to $550 per day, $5,500 would be available.

**Surgical Expense Benefits**

**Scheduled Plan**

Surgical expense policies pay surgeons’ fees and related costs incurred when the insured has an operation. Related costs might include fees for an assistant surgeon, an anesthesiologist, and even the operating room, when it is not covered as a miscellaneous medical item.

Basic surgical coverage is often included in the same policy as basic hospital and medical expense. Benefit amounts are included in a schedule that lists major commonly performed operations and benefits payable for each. The fact that a particular type of surgery is not listed in the schedule does not mean that no benefit is available to cover it. Instead, insurers indemnify on the basis of the *absolute value* and the *relative value* of each surgical procedure.

For example, suppose the insurer has determined that the prevailing “value” or cost of a certain type of surgery is $4,000 as indicated in the schedule that accompanies the policy. This is the *absolute value* of that procedure. Another procedure, not listed in the schedule, might be relatively less complicated; let’s say the company has determined that it is only 50% as complex as the $4,000 procedure. Therefore, its *relative value* is $2,000, and that is the benefit that will be paid for the unscheduled, less complicated procedure.

In some cases, the schedule itself may be referred to in terms of the maximum benefit paid for the most costly procedure, with all other surgical benefits paid as a percentage of that maximum. For example, under a $10,000 schedule, that amount might be paid for open-heart surgery. A less complex procedure, say, a tonsillectomy, might trigger a benefit equal to 10% of that, or $1,000.

**Nonscheduled Plan**

When surgical benefits (and sometimes other benefits as well) are not listed by a specific dollar amount in a schedule, a policy will pay on the basis of what is considered *usual, customary and reasonable (UCR)* in a certain geographical area. This type of indemnity is more often found in the major medical and comprehensive policies discussed later in this unit.

Under this type of arrangement, the definition of UCR is based on the amount physicians in the area usually charge for the same or similar procedures. These nonscheduled plans allow policies to stay apace of inflation and to avoid policy restructuring every time medical costs increase. The insurer still reserves the right to agree or disagree that a particular charge is usual, customary, and reasonable.
Regular Medical Expense Benefits

Another category, regular medical expense benefits, is sometimes called physicians’ nonsurgical expense. Remember that some states refer to this particular category as basic medical expense. Coverage is for nonsurgical services a physician provides. Sometimes, it is quite narrowly applied to physician visits to patients confined in the hospital. If so, the benefit will usually pay for:

- A specified maximum number of visits per day,
- A specified maximum dollar amount per visit, and
- A specified maximum number of days coverage applies.

For example, this type of limited benefit might pay for up to three visits per day at $10 per visit for no more than 30 days.

In other policies, the benefit might be for nonsurgical services a physician performs whether the patient is in the hospital or not. Again there are limits, such as $25 per visit for up to 50 visits a year.

Other Medical Expense Benefits

In addition to the hospital, surgical and medical benefits just discussed, there are other benefits that might be included, or which may be added at the insured’s option, or for which separate policies might be written. Different insurers may include different options as part of their standard policies, so each policy must be considered individually. Some coverage options are:

- Maternity
- Convalescent/nursing home
- Emergency first-aid
- Home health care
- Mental infirmity
- Hospice care
- Prescription drugs
- Dread disease
- Outpatient treatment
- Dental
- Private duty nursing
- Vision

We will discuss the most common options here, and in another unit you’ll learn about those that are more typically written as separate policies.

In-Hospital Physician Visits

Frequently, a basic medical expense policy will include a daily benefit for expenses incurred when the insured’s physician visits him or her in the hospital. This benefit is limited to a dollar amount such as $25 or $30 per day. This amount would be paid for any charges made by the doctor for visiting the patient.

Maternity Benefits

Some policies provide maternity benefits subject to certain conditions and limitations—the most usual of which is a 10-month waiting period designed to prevent purchase of health insurance solely to cover pregnancy and childbirth expenses. You should be aware, however, that group policies for employee groups of 15 or more are required by law to provide maternity benefits on the same basis as nonmaternity benefits. Thus, under a group plan with 15 or more employees, a 10-month waiting period would not apply unless nonmaternity benefits also required a 10-month waiting period.
Note: Beginning June 1, 1997, pregnancy may not be subject to a waiting period if the worker has already met the waiting period required by the group coverage of a previous employer.

Aside from group plans as described above, many policies exclude maternity benefits, but make them available at extra cost. Often, a maternity benefit is a lump sum paid for normal childbirth. The actual amount might be:

- usual, customary and reasonable charges,
- a specified amount, or
- a multiple of the daily hospital benefit.

The benefit generally includes routine newborn care while the mother is hospitalized.

Other benefits that might be available under the same maternity coverage, but scheduled at amounts different from the benefit for normal childbirth include:

- Cesarean deliveries
- Natural abortions
- Elective abortions

**Emergency First-Aid Coverage**

An accident may require immediate first-aid on the scene. When a medical professional who happens upon an accident provides first-aid service, he or she might bill the insured. Sometimes, such treatment must be performed without the insured's knowledge or assent. Some policies offer coverage for such contingencies by including emergency first-aid coverage for treatment expenses incurred within a very short time after an accident. This length of time is specified in the policy.

**Emergency Accident Benefits**

A basic plan may include a specific benefit for expenses incurred due to an accident when the insured is taken to the emergency room of a hospital as an outpatient. Typically, this benefit is stated as $300 or possibly, $500. The benefit is to cover the cost of treatment in the emergency room including physician expenses, X-rays, stitches, etc.

**Mental Infirmity**

While some policies exclude coverage for mental infirmities, more and more now include this coverage. Typically, the benefits will be lower than for physical infirmities, usually a stated percentage of the benefit paid for other types of medical care. For example, the physical infirmity benefit might be $100,000 and the mental infirmity benefit, 70% of that amount.

Alternatively, a policy might specify a particular dollar amount for mental infirmity that is different from the amount for physical infirmity, such as $50,000 for physical infirmity and $25,000 for mental infirmity.
Suppose Brad's policy will pay a maximum benefit of $100,000 for any one hospitalization, but only 60% of the maximum benefit if the impairment is mental. The most Brad could receive under his particular policy if he is hospitalized for mental infirmity is $60,000, which is 60% of $100,000.

**Hospice Care**

Most states require that any hospitalization policy (individual or group) include benefits for hospice expenses. The hospice is a facility designed to control pain and suffering of terminally ill patients until their death. It does not treat diseases nor does it attempt to cure. In addition, the hospice also provides counseling for the patient and the family of the terminally ill. Expenses covered include R&B, medication as well as outpatient services and expenses.

**Home Health Care**

This is usually an optional benefit which provides for reimbursement of expenses incurred by the insured for the services of a visiting nurse, a therapist or some other support-type person who due to a medical necessity, visits the insured in his or her home and provides necessary medical services.

**Outpatient Care**

Outpatient care refers to expenses incurred by the insured for doctor's office visits, out-of-the-hospital diagnostic services such as lab work and X-rays. Often a basic medical expense policy only covers in-hospital expenses (inpatient) whereby treatment is provided to the patient who has been assigned a room and a bed and is staying in the hospital for some period of time. Basic plans may add coverage for certain medical services provided to the insured as an outpatient.

**Common Exclusions And Limitations**

Both disability income and medical expense policies exclude or limit coverage for certain types of injuries and illnesses. One example of a limitation is the smaller benefit for mental infirmity just discussed. Exclusions, on the other hand, are conditions that are completely omitted from coverage.

The exclusions and limitations below are representative of common items a policy might list. Many policies will, in fact, include benefits for all or part of some in the following list. It is important for you to be aware of your own state laws and your company’s policies regarding each specific item.

- Pre-existing conditions, as defined in the policy and according to state law.
  Note, however, that some states have so-called no loss-no gain laws that require a replacing health insurance policy to cover any conditions for which there are ongoing claims under existing coverage, thus overriding the preexisting conditions exclusion in the replacing policy.
- Hernia, although the trend is to cover this condition
- Self-inflicted injuries
- Suicide
- War or acts of war resulting in death or injury, whether or not war is officially declared
NOTES

• Military duty, usually a suspension of the policy that ends when the insured is released from such duty
• Noncommercial air travel, which is any air travel other than as a scheduled airline passenger
• Injury while committing a felony
• Injury, illness or death while under the influence of intoxicants or narcotics
• Cosmetic surgery, except for surgery required as the result of an accidental injury or a congenital defect
• Dental expense, although some policies will cover such expenses resulting from accidental injury
• Vision correction, such as eye exams and eyeglasses
• Care provided in a government facility, normally paid by the Veterans Administration or by Workers Compensation
• Sexually-transmitted diseases
• Experimental procedures
• Organ transplants
• Infertility services
• Alcohol and/or drug abuse treatment

Here are some examples of situations that would be excluded by most policies:

• The insured is severely cut while breaking the plate glass window of a jewelry store from which he intends to steal gems. (Injury while committing a felony.)
• When the insured is injured in an auto accident, the police administer an alcohol test and discover he is legally intoxicated. (Injury while under the influence of intoxicants.)
• The insured is injured by shellfire while touring another country torn by guerrilla fighting. (Injury caused by an act of war.)

In summary, it is quite evident that basic medical expense plans definitely have time and/or benefit amount limitations. Thus, the insured may well expect to have to pay a considerable amount out of pocket for medical expenses. The solution to this problem is another type of hospitalization coverage referred to as major medical insurance.

Exercise

A. Lauren’s policy covers hospital expenses by paying a specified, predetermined amount per day, as shown in a schedule in the policy. Lauren’s policy pays on a

( ) 1. reimbursement basis.
( ) 2. expenses-incurred basis.
( ) 3. indemnity basis.
( ) 4. capitation basis.

B. Intensive care benefits under hospital plans are

( ) 1. never included.
( ) 2. generally provided at the same level as the room and board maximum.
( ) 3. generally provided at some multiple of the room and board maximum.
( ) 4. generally provided without limit based on the need of the insured.
C. When benefits are not listed by a specific dollar amount in a schedule, a policy will generally pay

( ) 1. the usual, customary and reasonable charge for the procedure.
( ) 2. the universal, customary and reasonable charge for the procedure.
( ) 3. the usual, capitated and reasonable charge for the procedure.
( ) 4. the usually charged rate for the procedure.

Answer: A. 3. indemnity basis; B. 3. generally provided at some multiple of the room and board maximum; C. 1. the usual, customary and reasonable charge for the procedure

**MAJOR MEDICAL INSURANCE**

We have discussed “basic” benefits designed to cover even some hospital, medical, and surgical costs that are considered relatively minor. When these basic benefits are purchased piecemeal, the total benefits provided can be substantially less than the actual expenses incurred. Providing more complete coverage with fewer gaps, *major medical insurance* covers a much broader range of medical expenses with generally higher individual benefits and policy maximums.

These more extensive health policies are divided roughly into two groups:

1. **Comprehensive** major medical expense, in which the more traditional basic coverages and essentially any other type of medical expense are combined into a single comprehensive policy

2. **Supplemental** major medical expense, in which coverage begins with a traditional basic policy, which pays first, and the major medical coverage is added to pick up expenses not covered by the basic policy

**Comprehensive Major Medical Benefits**

**Deductibles**

Most major medical benefits begin to be paid after the deductible is satisfied. The policy’s deductible is considered satisfied as long as the insured can show evidence of having incurred the necessary expense.

There are essentially two types of *comprehensive major medical* plans—one with first dollar coverage and one without.

*First dollar coverage* means that as soon as covered medical expenses are incurred, the policy begins to pay. Policies with first dollar coverage effectively have a deductible of zero. Without first dollar coverage, the insured must pay a specified *deductible* amount first, and when that amount of expenses incurred has been paid by the insured, the policy starts reimbursing. Deductibles are generally an important feature of major medical policies.

For example, before Jim’s major medical policy will pay benefits, Jim must pay the first $400 of medical expenses each year. He does not have first dollar coverage; that is, he must pay a deductible. On the other hand, as soon as Rona was hospitalized, her major medical policy began reimbursing her for expenses. She has first dollar coverage.
Another important feature of major medical coverage is *coinsurance*. Coinsurance means that the insurer and the insured share any expenses above the deductible amount. The insurer always carries the bulk of the expense, usually paying 80% of covered expenses as compared to 20% for the insured. Other proportions, such as 75%/25%, may be used, so it is important to read the policy. In some areas, coinsurance is referred to as *percentage participation*.

Here’s an example of how coinsurance works. An insured's major medical policy includes a $200 deductible and 80%/20% coinsurance. The insured incurs medical expenses totaling $1,200. The insured will pay $400 of this amount: the initial $200 deductible, leaving $1,000 to be shared 80/20, of which the insured pays 20% or an additional $200. The insurance company will pay $800 of the $1,200 total. This is 80% of the $1,000 remaining after the insured has paid the deductible.

In some policies, certain types of medical expenses are not subject to the deductible, while others are. It is not uncommon, for example, for no deductible to apply to initial hospital and/or surgical expenses up to a specified amount, say the first $5,000 of such expenses. In this case, the insured would pay no deductible—in essence would get first dollar coverage on the first $5,000 of hospital and surgical expenses—but would be required to pay the deductible before major medical covered any additional expenses. Then, the insurer and the insured would share in remaining expenses at 80%/20% or whatever percentage applies.

The illustration that follows shows how a comprehensive major medical plan works both without first dollar coverage and with first dollar coverage on specified hospital/surgical benefits.

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### Comprehensive Major Medical Expense

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<thead>
<tr>
<th>Without First Dollar Coverage</th>
<th>With First Dollar Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>COINSURANCE</strong></td>
<td><strong>COINSURANCE</strong></td>
</tr>
<tr>
<td>$80% of covered expense paid by INSURER</td>
<td>100% of covered hospital and surgical expense paid by INSURER</td>
</tr>
<tr>
<td>DEDUCTIBLE paid by insured</td>
<td>DEDUCTIBLE paid by insured</td>
</tr>
</tbody>
</table>

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### Stop-Loss Limit And Maximum Benefits

More and more major medical policies include a *stop-loss limit*, which is a dollar amount beyond which the insured no longer participates in payment of the expenses. The stop-loss limit is sometimes known as the “out of pocket limit.” After the insured’s total coinsurance and deductible payments reach
that amount, the insurer picks up the entire cost of remaining expenses, up to a stated maximum benefit. Currently, the lifetime maximum limits on health policies might range from $100,000 to $1,000,000 and some policies even have unlimited benefits.

Just as the maximum benefit varies considerably, so does the amount of the stop-loss limit, depending upon the insurer. Graphically, here is how the stop-loss limit and the maximum benefits limit work, assuming a $5,000 stop-loss and $1,000,000 lifetime maximum.

**Stop-Loss Limit And Maximum Benefits**

Assume an insured has the comprehensive plan illustrated above, with a $300 deductible. Following a severe injury, the insured incurs covered medical expenses totaling $28,000. The insured will pay a total of $5,000, which is the stop-loss limit. The insurance company will pay $23,000, the balance remaining after the insured has paid up to the stop-loss limit.

**Supplemental Major Medical Benefits**

When major medical benefits are provided through a supplemental policy, the major medical portion supplements a basic policy that includes hospital, surgical and medical coverage with an additional policy covering the broader range of medical expenses.

Generally the basic plan will pay covered medical expenses with no deductible, up to the policy limit. Above that limit, the supplemental policy operates identically to a comprehensive policy that provides no other first dollar coverage. That is, after the basic policy limits are exhausted, the insured must pay a deductible, after which the major medical coverage begins. Since the deductible comes between the basic policy and the major medical policy, it is often called a corridor deductible.
Like the comprehensive major medical policy, a supplemental plan is likely to include a stop-loss limit and a maximum benefit limit. Here is how a supplemental major medical plan looks:

**Supplemental Major Medical**

Suppose Jill has a supplemental major medical policy. The basic policy will pay $500 for her scheduled surgery. The corridor deductible is $250, and the plan includes an 80%/20% coinsurance provision above the base plan, up to a stop-loss level of $5,000. The policy will pay 100% of covered expenses above the $5,000 limit, up to a limit of $1 million. Jill has covered medical expenses of $4,750 following an illness. Here is how these expenses are paid.

<table>
<thead>
<tr>
<th>Insurance (Pays)</th>
<th>Jill (Pays)</th>
</tr>
</thead>
<tbody>
<tr>
<td>First $500 of expenses</td>
<td>$500</td>
</tr>
<tr>
<td>Corridor deductible</td>
<td>-0-</td>
</tr>
<tr>
<td>Remaining expenses = $4,000 @ 80%/20%</td>
<td>3,200</td>
</tr>
<tr>
<td>Total insurance payment</td>
<td>$3,700</td>
</tr>
<tr>
<td>Total Jill pays</td>
<td></td>
</tr>
</tbody>
</table>

Let's change the scenario slightly. If Jill's expenses had totaled over $5,000, she would pay nothing over that amount because the insurer pays 100% of covered expenses over the stop-loss limit, which is $5,000 in Jill's policy.

Here's another possibility. If Jill's expenses had totaled only $400 for benefits the basic policy provides, she would have paid nothing because her basic policy provides first dollar coverage.
Covered Expenses

Major medical policies, whether supplemental or comprehensive, cover a wide range of medical expenses. The precise services covered may vary somewhat from policy to policy, but many of the following will be included in most major medical plans.

- Hospital inpatient room and board including intensive and cardiac care
- Hospital medical and surgical services and supplies
- Physicians' diagnostic, medical and surgical services
- Other medical practitioners' services
- Nursing services including private duty service outside a hospital
- Anesthesia and anesthetist services
- Outpatient services
- Ambulance service to and from a hospital
- X-rays and other diagnostic and laboratory tests
- Radiologic and other types of therapy
- Prescription drugs
- Blood and blood plasma
- Oxygen and its administration
- Dental services resulting from injury to natural teeth
- Convalescent nursing home care
- Home health care services
- Prosthetic devices when initially purchased
- Casts, splints, trusses, braces and crutches
- Rental of durable equipment such as hospital-type beds and wheelchairs

Expenses that are excluded from major medical policies generally parallel the exclusions listed previously in this unit.

Exercise

A. The out of pocket limit is also known as the
   ( ) 1. deductible.
   ( ) 2. copayment.
   ( ) 3. stop-loss limit.
   ( ) 4. maximum benefit.

B. Which of the following is least likely to be covered by a major medical policy?
   ( ) 1. Outpatient services
   ( ) 2. Vision correction
   ( ) 3. Prescription drugs
   ( ) 4. Blood and blood plasma

   Answer: A. 3. stop-loss limit; B. 2. Vision correction

Other Major Medical Concepts

Deductible Features

There are a number of ways deductibles might be handled in major medical policies. Some policies include a per-cause—injury or sickness—deductible, while others may have an all-cause deductible, which is also referred to as a cumulative or calendar year deductible.
NOTES

With a per-cause deductible, the insured pays one deductible for all expenses incurred for the same injury or illness. The benefit period for each cause begins when the deductible for that particular injury or illness has been satisfied, and may run for one or two years. It works like this: Yu-Long suffered a major illness early in the year that required his incurring continuing medical expenses through mid-year. Then, in September, he was injured in an auto accident that hospitalized him for two weeks. Yu-Long had to pay a separate deductible for each of these incidents because his policy has a per-cause deductible.

On the other hand, with an all-cause deductible, expenses for any number of different or the same type of illness or accidents are accumulated to meet the deductible during a single calendar year. Once enough expenses have been paid by the insured to meet the stated deductible, all other covered charges are paid during the remainder of the calendar year.

Under this latter deductible arrangement, there is also usually a carryover provision that permits expenses incurred during the last three months of the calendar year to be carried over into the new year if needed to satisfy the deductible for the next year. For example, suppose Laura had no medical expenses until November and December. Her illness continued into January. Laura will be able to count the expenses in November and December toward her deductible in the new year.

Policies that cover entire families usually have a family deductible rather than individual deductibles. For example, although a policy’s individual deductible is, say, $200, the family deductible amount might be $400. Thus, even a family with six members would pay no more than a $400 deductible as opposed to the $1,200 that would be required if every member had to meet the $200 deductible.

Another deductible provision that can be advantageous to families is the common injury or illness provision. Under this provision, only one deductible must be paid when two or more members of the same family are injured in a common accident or become ill concurrently from the same sickness. Suppose Myra and Rick, wife and husband, are riding in Rick’s car when they are both injured in an accident on the freeway. The deductible for each person under their health policy is $200, but their policy requires them to pay only $200 in this case.

Benefit Periods And Inside Limits

The time during which benefits are paid, known as benefit periods, are generally tied to the deductible and to any inside or internal limits included in the major medical policy.

When a deductible must be paid, the benefit period might begin either on the first day of the accident or illness or on the date the insured has satisfied the deductible (if later than the date of the event) and may extend for up to two years. In other cases, the benefit period ceases at the end of the calendar year and begins anew with the new deductible.
Inside or internal limits are benefit limitations placed on specified coverages in a major medical policy. For example, the policy might limit both the room and board benefit and the number of days benefits will be paid. In this case, the benefit period for hospital room and board would be whatever number of days is specified. Other examples of internal limits might be restrictions placed on convalescent care days, mental health care, X-rays per claim, and similar items.

**Restoration Of Benefits**

Since lifetime maximums on major medical policies have risen dramatically to $1 million and more, the restoration or reinstatement of plan benefits is not so important as in the past when maximums were much lower. However, some policies in force today carry fairly low maximums, and most major medical policies still include a provision that allows restoration of the maximum to the original level.

For example, a lifetime level might be $100,000. An insured with a severe injury or illness could easily use up half or more of that in a single year, leaving only $50,000 for the rest of his or her life. Generally, a policy allows the maximum to be restored after a certain amount of benefits are used, though sometimes the insured must prove he or she is once again insurable. Many policies have an automatic reinstatement provision that restores a specified number of dollars each January 1, or after a given period of time elapses, without requiring the insured to prove insurability.

**Medical Expense Limitations**

Reimbursement-type medical expense policies frequently provide limited coverage or benefits for certain medical conditions. Many plans will include limitations on the benefits to be provided for the following:

- Rehabilitation and skilled nursing/extended care facilities care
- Home health care
- Hospice care
- Ambulance services
- Outpatient treatment
- Medical equipment and supplies
- Reconstructive cosmetic surgery
- Treatment of AIDS
- Infertility and sterilization
- Maternity/complications of pregnancy/well baby care
- Psychiatric conditions
- Substance abuse
- Organ transplants
- Preexisting Conditions
- Reimbursement for non-physician services

**Mental Or Emotional Disorders**

Lifetime benefit amounts are limited for outpatient treatment of these disorders. For example, a major medical policy may have a lifetime maximum of $1 million but the policy may limit coverage for outpatient treatment of mental or emotional disorders to a lifetime benefit of $25,000. In addition, frequently
there may be a limitation with regard to the number of outpatient psychiatric visits per calendar year (such as a maximum of 26 visits per year) and/or the benefit amount paid per visit (such as a maximum benefit of $50 per visit or coverage for no more than 50% of the actual charges). These limits would not apply to inpatient treatment of mental or emotional disorders. (Note: New federal laws effective in 1997 remove these limitations for group coverage.)

Maternity
As previously discussed, maternity benefits are often optional. When elected, the amount of the maternity benefit is often limited. This limitation is frequently due to the high cost of a maternity claim and the corresponding high premium charged for the benefit.

For example, a maternity benefit may be limited to a total benefit of $1,000 regardless of the actual expenses incurred. Usually, the only time additional benefits are paid is if there are certain complications during the pregnancy or at the time of delivery. A very liberal maternity benefit (and a costly one) would be that maternity is treated as any other illness and thus a full range of benefits would be payable.

Substance Abuse
Outpatient treatment for drug or alcohol problems is usually limited in much the same way that coverage for nervous or emotional disorders is limited. Usually, if the insured is hospitalized as an inpatient for treatment of the substance abuse problem, then regular medical expense benefits would be payable.

Chiropractic Services
The treatment rendered by a chiropractor is normally a covered expense subject to a limitation with regard to total benefits (i.e. $10,000 lifetime) or a limitation with regard to the number of visits that will be covered in a given year and/or the amount that may be paid per visit.

Preexisting Conditions
Generally, a preexisting condition is any condition for which the insured sought treatment or advice prior to the effective date of coverage. Many policies contain a preexisting conditions limitation which excludes coverage for unspecified conditions for a period of time (usually six months). If an insurer wants to permanently exclude a preexisting condition, it usually has to specify the condition by name in the issued policy. Depending on the severity of the condition, it may be permanently excluded or temporarily excluded (i.e., the first 12 months following the effective date of coverage). Seldom is a preexisting condition covered by means of limited benefit amounts. Generally, it is either excluded or covered in full as any other condition.

BENEFITS FOR OTHER PRACTITIONERS
In past years, many health insurance contracts placed limitations on the kind of provider who could perform covered treatments and services. In many cases, coverage was limited to treatment rendered by a “physician.” In effect, this eliminated coverage for treatments rendered by chiropractors, midwives, and other nontraditional healers.
In recent years, it has become recognized that many alternative providers who are subject to state licensing and/or standards of conduct imposed by professional organizations are qualified health care providers. Use of alternative providers can help to minimize health care costs and reduce the demand on hospitals and doctors. Under current laws in many states, policies must provide benefits for services given by various providers if benefits would be payable for the same services when given by a physician, as long as the providers are properly qualified and are acting within the scope of their profession. As a result, benefits for various services are often provided and may not be excluded when performed by the following types of health care professionals, if they are practicing within the scope of their license when rendering treatment:

- Chiropractors
- Optometrists
- Opticians
- Psychologists
- Podiatrists
- Clinical Social Workers
- Dentists
- Physical Therapists
- Professional Counselors

**MEDICAL EXPENSE EXCLUSIONS**

Medical expense policies contain many exclusions that are found in all health and disability policies: preexisting conditions, war, intentionally self-inflicted injuries, and active military duty. Medical expense policies also commonly exclude:

- Workers compensation
- Government plans (care in government facilities)
- Well-baby care
- Cosmetic surgery
- Dental care
- Eyeglasses
- Hearing aids
- Custodial care
- Routine physicals and medical care

Workers compensation and other government plans are excluded to prevent overpayment of claims or overinsurance. If an injured employee will have his claim taken care of by workers compensation because the injury was work related, then individual or group medical expense plans will not pay the same claim. The same concept applies if for example an individual’s medical care is to be provided by a veterans administration facility.

Some plans exclude well baby care since the purpose of medical expense coverage is to indemnify an individual who sustains a loss due to an accident or an illness. If a newborn baby is normal and healthy (a well baby) following delivery, then no benefits would be paid for any hospital claim while the child is in the hospital’s nursery pending discharge of the mother. If the newborn has a medical problem following birth, then normal benefits would be paid.
Cosmetic surgery is usually excluded unless the reason for the surgery is due to a medical necessity such as an accident or a disease which disfigures a person. Cosmetic surgery is viewed as voluntary and thus not covered.

Routine dental care is usually excluded with individual medical expense policies but is frequently offered as an optional benefit under a group contract. Again, if a person is injured such as in an automobile accident and needs dental surgery for repair of damaged teeth, then this type of care would normally be covered.

Eyeglasses and hearing aids are normally excluded unless there is a medical reason for acquiring these devices such as injury which causes loss of hearing or vision. Reduced hearing or vision due to age and similar factors would not be covered.

Custodial care is care provided to assist the individual in the activities of daily living, which does not contribute to the improvement of a medical condition, and which can be performed by a person who does not have medical training. Coverage for these types of services may be excluded by a medical expense policy.

Routine physicals are normally also excluded from coverage. Routine physicals would include a person’s “annual check up” when the reason for the physical is simply that it has been a year since the individual had a physical. Also excluded would be pre-employment physicals or a child’s pre-school physical. There must be a medical reason for the physical before it would be considered a covered expense.

Routine medical care such as immunizations is usually excluded. On the other hand, if an insured is injured and requires a tetanus shot as a result of an accident, then the immunization would be covered. If a doctor simply told a patient that he or she should have a tetanus shot because it has been 10 years since the last shot, then it would not be covered.

It should be noted that some insurers offer coverage for routine physicals and medical care because it is generally recognized that these preventive health care measures benefit the insured and the insurer. A routine physical exam could result in a potential major medical problem being diagnosed before it develops into a very large claim for the insurer.

### OPTIONAL FEATURES AND BENEFITS

#### Prescription Drugs

The prescription drug benefit is most often found in group health insurance policies. Some individual health insurance policies offer this benefit as a rider. Different policies offer different prescription card benefits. For example, some policies will cover birth control pills as part of the benefit, and in other policies they are specifically excluded. Usually prescription drug coverage requires a small deductible of typically $2, $3 or $5.
A prescription drug benefit generally works one of two ways. Either insureds can be reimbursed for their prescription drug expenses using standard claim forms, or a prescription drug card can be issued. A prescription drug card allows prescriptions to be paid for by paying only the deductible with each prescription purchase. The pharmacy bills the insurer issuing the card directly for the prescription.

For example, Sally has a prescription drug card as part of her group medical plan which has a $5 deductible per prescription. Her doctor prescribes two medications for a serious cold. Each of these medications would cost Sally $5. The balance of the prescription cost will be billed to the insurer by the pharmacy.

**Vision Care**

Vision care includes eye examinations (refractions) and eyeglasses. Although not a very common benefit, it occasionally is offered as an optional benefit under group health insurance. Generally, this option will pay a specific amount or the entire cost of an annual eye examination. It normally also covers all or part of the cost of prescribed eyeglasses once in every two-year period.

**Hospital Indemnity Rider**

A hospital indemnity benefit provides for the payment of a daily benefit for each day that the insured is hospitalized as an inpatient. Available amounts are usually $50 to $100 per day or possibly slightly higher. In addition to any other medical benefits paid to the insured, the hospital indemnity benefit will pay the daily amount as long as the insured is hospitalized, usually for a benefit period of one or two years.

**Nursing/Convalescent Home**

Under this benefit, a daily maximum amount is paid for each day the insured is confined to a nursing or convalescent home after a hospital stay. Benefits are paid generally for as short as one month or up to one year.

**Organ Transplants**

More and more insurers are offering this coverage as it becomes less experimental and more commonplace. To provide coverage, many insurers require that a transplant must only be performed for life-threatening situations. Some of the more commonly covered transplants include bone marrow and kidney.

**REVIEW**

1. Carmen falls and breaks her leg, incurring $2,000 in medical expenses. Her policy pays the entire amount. Carmen has a

   ( ) A. hospital expense policy.
   ( ) B. surgical expense policy.
   ( ) C. medical expense policy.
   ( ) D. policy with first dollar coverage.
2. A hospital room and board benefit may be paid
   ( ) A. on an indemnity basis.
   ( ) B. on a reimbursement basis.
   ( ) C. on either an indemnity basis or a reimbursement basis.
   ( ) D. on neither an indemnity basis nor a reimbursement basis.

3. The type of health insurance providing high maximum coverage for medical care is
   ( ) A. a basic medical expense policy.
   ( ) B. a major medical expense policy.
   ( ) C. a comprehensive medical expense policy.
   ( ) D. a supplemental medical expense policy.

4. The type of health insurance which pays expenses not paid by a traditional basic policy is
   ( ) A. a basic medical expense policy.
   ( ) B. a major medical expense policy.
   ( ) C. a comprehensive medical expense policy.
   ( ) D. a supplemental medical expense policy.

5. A combination of basic medical expense coverage and major medical expense coverage is
   ( ) A. a basic medical expense policy.
   ( ) B. a major medical expense policy.
   ( ) C. a comprehensive medical expense policy.
   ( ) D. a supplemental medical expense policy.

6. Type of policy covering doctor visits while the insured is in the hospital is
   ( ) A. a basic medical expense policy.
   ( ) B. a major medical expense policy.
   ( ) C. a comprehensive medical expense policy.
   ( ) D. a supplemental medical expense policy.

7. Maternity benefits must be provided on the same basis as nonmaternity benefits
   ( ) A. in all cases.
   ( ) B. only if the insurer chooses to do so.
   ( ) C. if the policy covers an employee group of 15 or more people.
   ( ) D. if the policy provides disability income coverage.

8. Among individual policies that include coverage for mental infirmities, the benefit will generally be
   ( ) A. lower than the benefit for physical infirmities.
   ( ) B. higher than the benefit for physical infirmities.
   ( ) C. unlimited.
   ( ) D. the same as the benefit for physical infirmities.
9. A hospice

( ) A. works to treat diseases only, not accident-related medical issues.
( ) B. works to control pain and suffering as well as to treat illness.
( ) C. works to alleviate pain and suffering among terminally ill patients until their death, but does not attempt to cure.
( ) D. works with medical professionals when they become ill, to provide treatment in a private setting away from lay patients.

10. No-loss no gain laws require

( ) A. replacing health insurance policies to cover any conditions for which there are ongoing claims under existing coverage.
( ) B. replacing health insurance to remove preexisting condition exclusions from all policies replaced.
( ) C. existing insurers to continue to cover ongoing claims after a policy has been replaced.
( ) D. existing insures to remove preexisting condition exclusions from all policies being replaced.

11. Purchasing basic benefits on an individual basis usually

( ) A. provides a broader range of coverage than a single major medical policy.
( ) B. provides less complete coverage with more gaps than a major medical policy.
( ) C. provides exactly the same coverage as a major medical policy.
( ) D. is prohibited by state law.

12. The dollar limit beyond which the insured no longer participates in payment of expenses is the

( ) A. deductible.
( ) B. coinsurance.
( ) C. stop-loss limit.
( ) D. maximum benefit.

13. The dollar limit beyond which the insurer no longer participates in payment of expenses is the

( ) A. deductible.
( ) B. coinsurance.
( ) C. stop-loss limit.
( ) D. maximum benefit.

14. The expenses that must be incurred before major medical benefits begin to be paid is the

( ) A. deductible.
( ) B. coinsurance.
( ) C. stop-loss limit.
( ) D. maximum benefit.
NOTES

15. The sharing of expenses between the insured and the insurer is an example of
   ( ) A. deductible.
   ( ) B. coinsurance.
   ( ) C. stop-loss limit.
   ( ) D. maximum benefit.

16. A deductible that runs between the first dollar coverage of a basic policy and the comprehensive coverage of a supplemental policy is known as a
   ( ) A. stop-loss deductible.
   ( ) B. capitated deductible.
   ( ) C. corridor deductible.
   ( ) D. limited deductible.

17. Which of the following would be most likely to be covered under a medical expense policy?
   ( ) A. Gertrude steps on a rusty nail and requires a tetanus shot.
   ( ) B. Carmelita decides to get a flu shot this year.
   ( ) C. Gary goes to the doctor each year for an annual checkup.
   ( ) D. Earl requires some help getting dressed in the morning.

Answers:
1. D. policy with first dollar coverage.
2. C. on either an indemnity basis or a reimbursement basis.
3. B. a major medical expense policy.
4. D. Supplemental medical expense policy.
5. C. Comprehensive medical expense policy.
6. A. a basic medical expense policy.
7. C. if the policy covers an employee group of 15 or more people.
8. A. lower than the benefit for physical infirmities.
9. C. works to alleviate pain and suffering among terminally ill patients until their death, but does not attempt to cure.
10. A. replacing health insurance policies to cover any conditions for which there are ongoing claims under existing coverage.
11. B. provides less complete coverage with more gaps than a major medical policy.
12. C. stop-loss limit.
15. B. coinsurance.
16. C. corridor deductible.
17. A. Gertrude steps on a rusty nail and requires a tetanus shot.
UNIT 6

SPECIAL TYPES OF MEDICAL EXPENSE POLICIES

LEARNING OBJECTIVES

After completing Unit 6—Special Types of Medical Expense Policies, you will be able to:

1. Describe how special policies differ from other types of policies.
2. List the two types of traditional dental coverage, describe which is more commonly issued and how they differ.
3. List eight type of dental care generally considered to be nonroutine, and explain how they are generally covered under comprehensive policies.
4. List six common exclusion or limitations.
5. Explain what a closed list is and why it is used.
6. List and describe seven methods insurers use to minimize adverse selection.
7. Explain how prepaid dental plans differ from traditional plans.
8. Explain the difference between an open panel and a closed panel system.
9. Describe the function of limited policies.
10. Explain what is covered by the following types of policies: dread disease, travel accident, hospital income, vision care, prescription drug.
11. Explain the purpose of credit insurance.
12. Describe how credit health insurance differs from credit life insurance.
SPECIAL TYPES OF MEDICAL EXPENSE POLICIES

INTRODUCTION

In this unit we will discuss several special types of health insurance plans that are designed for very specific and limited insurance needs, including:

• Dental care policies
• Limited policies, including dread disease, travel accident, hospital income, vision care, and long-term care
• Credit insurance policies

In each case, a special type of policy is one that covers a limited number of situations as described in the policy itself.

DENTAL CARE INSURANCE

Traditional Dental Coverages

The number of companies offering dental care insurance is increasing rapidly, as coverage for dental care is being offered more frequently as part of group health plans. Occasionally, dental insurance is part of a health benefits package with a single deductible called an integrated deductible, applying to both medical and dental coverages. More often, dental coverage and dental claims are handled separately (though they may be part of a larger package) with a separate deductible for health insurance coverage and for dental insurance coverage. There may also be a probationary period in group dental insurance to help hold down coverage for preexisting conditions.

Some dental policies are scheduled; that is, benefits are limited to specified maximums per procedure, with first dollar coverage. Most, however, are comprehensive policies that work much the same way as comprehensive medical expense coverage.
In addition to deductibles, coinsurance and maximums may also affect the level of benefits payable under a dental plan. Coinsurance percentages may apply to reimbursements that are either the reasonable and customary (R & C) type or the scheduled type. A plan based on R & C will apply coinsurance percentages to the dentist’s usual and customary fee, provided it is reasonable. This type of plan is also known as UCR (usual, customary and reasonable) or U & P (usual and prevailing). A plan that is scheduled will apply coinsurance percentages to a schedule or list of fixed-dollar amounts for each covered benefit. Scheduled benefits are generally lower than R & C allowances.

Comprehensive dental plans usually provide routine dental care services without deductibles or coinsurance to encourage preventive dental care. Generally there is a specified maximum dollar amount payable per year, and sometimes, per family member covered. There may also be a lifetime maximum per individual.

**Nonroutine** dental care includes the following:

- Restorative—Repairing or restoring dental work that has been damaged in some way
- Oral surgery—Surgery performed in the oral cavity; for example, the removal of wisdom teeth
- Endodontics—Treatment of the pulp (the soft tissue substance located in the center of each tooth
- Periodontics—Treatment of the supporting structures of the teeth
- Prosthodontics—Artificial replacements
- Pediatric dentistry—Patient management and preventive and restorative techniques particularly suited to children and adolescents
- Oral pathology—Microscopic analysis of tissue biopsy material for diagnosis of oral diseases including oral cancer
- Orthodontics—Correction of irregularities of the teeth; most commonly, braces

For nonroutine treatments, a comprehensive policy pays a percentage, such as 80%, of the reasonable and customary charges. The patient pays an annual deductible and whatever expense remains. Typically, the deductible is per person or per family, and most policies limit benefits to stated maximums per year.

Policies that provide for orthodontic care generally have separate limits and deductibles for orthodontia. The coinsurance percentage is likely to be 50%, rather than the higher 75% or 80% that applies to other types of nonroutine dental care.

Many plans offer a selection of providers from which plan participants must choose. In some plans, if a course of treatment is expected to exceed a certain amount, say $200, a report must be submitted to the insurer by the dentist. The report describes the proposed treatment and itemizes the expected charges. The insurer reviews and evaluates this report and sends the dentist an estimate of benefits to be paid.
Benefits may be on a fixed prepaid basis rather than a fee-for-service plan in which the plan participant is reimbursed. Such plans often provide 100% coverage for

- Routine visits to the dentist
- Protective fluoride treatments
- Diagnostic x-rays
- Dental exams and diagnosis
- Local anesthetics
- Teeth cleanings (usually once every six months)
- Preventive care

**Exclusions And Limitations**

An insurer will often reduce its liability for payment of dental expenses by contractual provisions that state what a plan *does cover* and what it *will not cover*. A closed list is a method of defining which procedures are covered. If an unlisted procedure is performed, coverage is either denied or paid on the basis of the most similar procedure included on the list. The following are examples of common exclusions and limitations.

- The **cosmetic exclusion** stipulates that benefits are not payable for dental work that is not necessary for sound dental health.
- The **missing tooth provision** excludes coverage for teeth that are missing at the time coverage becomes effective.
- The **five-year replacement exclusion** does not allow replacement of prosthetic appliances (such as retainers or spacers) for five years after a benefit is paid.
- The **vertical dimension, splinting and restoring occlusion exclusion** limits liability for exotic and highly optional procedures.
- Expenses for **oral hygiene instructions** and **plaque control programs** are often limited or excluded.
- Some plans may offer members coverage up to a certain amount for emergency dental treatment required when outside the service area.

**Minimizing Adverse Selection**

Because the nature of dental coverage is quite different from medical coverage, the underwriting of dental coverage requires a few special considerations. There are three circumstances that cause dental coverage to be unique.

- Patients have wider choices in treatment options. For instance, a patient can choose bridgework that is fixed or removable and inlays that are gold or nongold. These choices represent a wide range in treatment costs.
- A person who needs dental work can often postpone treatment until an insurance plan becomes effective, causing the insurer to be liable for larger benefits than it would otherwise expect to pay. (For this reason, few individual dental plans exist; most plans are sold on a group basis to further offset this type of adverse selection.)
- Many dental expenses are cosmetic; therefore, underwriting must often limit benefits for cosmetic procedures in order to avoid paying excessive claims.
In order to offset these additional (and often costly) factors, a new program of dental insurance will often include provisions to minimize adverse selection. The following are examples of such provisions:

- A reduced maximum annual benefit to encourage an insured to choose less-costly courses of treatment whenever possible
- A lower coinsurance percentage for expenses that are optional
- A graduated coinsurance factor that begins at 60% and increases each plan year
- An advance approval requirement for treatment plans that exceed a certain minimum, usually $200
- A provision that bases the benefit on the least costly treatment option
- A longer eligibility period before an employee’s coverage is effective
- A limited benefit for late entrants

**Prepaid Dental Plans**

Another increasingly popular way to offer dental insurance is through a prepaid dental plan. Prepaid dental plan means a corporation, partnership, or other entity which, in return for a prepayment, provides or arranges for the provision of dental care services to enrollees or subscribers. The plan may be owned by a corporation, partnership, association trust, etc. and operated by a board of directors or trustees, executive committee, and/or principal officers.

Prepaid dental plans operate in much the same way as health maintenance organizations. They offer services based on capitation, or fixed per member per month payments where the provider assumes the full risk for the cost of contracted services without regard to the type, value, or frequency of the services provided.

**Dentist Access To Membership**

A prepaid dental plan shall provide that any licensed dentist may participate as a provider in the prepaid dental plan.

**Benefits**

Individual group contracts, evidence of coverage, and solicitation materials shall provide a statement of the services and benefits each member may receive. Reasonable exclusions, limitations, copayments, and deductibles may be included, provided they are clearly disclosed in contracts, evidence of coverage, and solicitation documents.

**Member Choice Of Provider**

Subscribers must have the right to select any participating dentist as a provider. If a prepaid dental plan would restrict an enrollee’s ability to receive services from a class of providers, the limitations must be described in the evidence of coverage, and in all solicitation documents.
Provider Contracts

The prepaid plan may contract with licensed dentists to provide dental care to subscribers in a specific service area or geographic location.

The dentists are paid (other than the copayment or deductible) by the prepaid dental plan. Provider contracts are subject to state laws designed to protect enrollees from becoming liable for services the prepaid dental plan fails to pay because of insolvency.

In an open panel system, dentists render services to both prepaid dental plan subscribers and to nonmembers. In a closed panel system, services are provided only to subscribers to the prepaid dental plan. The Plan must publish a list of participating providers, and enrollees are asked to choose a “primary” provider.

Under the precertification or prior authorization requirement, when the enrollee’s dentist prescribes any course of treatment expected to exceed a specific amount (such as $200), the treatment must be outlined on a precertification form and submitted to the insurer for review and approval before it may be undertaken.

Evidence Of Coverage

All enrollees must be issued an evidence of coverage describing the dental services covered, limitations on those services (including deductibles and copayments), how to obtain services and information, and methods for resolving complaints.

Complaint Procedure

The complaint system must establish reasonable procedures for resolving written complaints from both enrollees and providers. The organization must respond promptly to written complaints. Responses to written complaints regarding quality or appropriateness of care shall include a statement that the complainant may have the complaint reviewed by a consulting dentist and may submit the complaint to a professional peer review organization. Copies of complaints and responses must be maintained for three years.

Service Area—Geographic Location

Subscribers must have reliable access to qualified providers in the geographic area served by the prepaid dental plan. They also must have access to short-term emergency dental care services within the areas served, and the plan must pay for services when a dental emergency occurs outside the service area.

Quality Assurance Program

Each prepaid dental plan must provide appropriate, necessary, cost-effective, and professional services. Prepaid dental plans must have a quality assurance program to evaluate the quality of care given to enrollees, and provide for ways to correct deficiencies in provider or organizational performance. Provider contracts shall give disincentives (including termination) for providers rendering inappropriate, unnecessary or excessively costly care, or low quality care.
**Unit 6—Special Types Of Medical Expense Policies**

**NOTES**

**Underwriting**

The underwriting procedures for group dental insurance are similar to those that apply to other types of group health insurance. Generally, when a group dental plan is initially effective, all employees or members must be covered or eligible for coverage. Under a contributory plan where the employee pays all or part of the premium, each eligible employee must elect to be covered. In order to minimize adverse selection, a probationary period usually applies to new employees who join the group after the effective date. Limitations on benefits may also be imposed on any employees who do not choose to be covered when first eligible, in order to avoid premium payments, but who elect coverage at a later date when they know they need dental treatment.

Since dental coverage is usually available only on a group basis, most plans do not include a conversion privilege. Members cannot convert to individual insurance when their membership in the group ends or the group plan is terminated.

**Exercise**

A. Scheduled benefits are generally
   ( ) 1. lower than reasonable and customary allowances.
   ( ) 2. higher than reasonable and customary allowances.
   ( ) 3. the same as reasonable and customary allowances.
   ( ) 4. paid in addition to reasonable and customary allowances.

B. Which of the following is **not** a common exclusion or limitation of dental policies?
   ( ) 1. Benefits are generally not payable for dental work that is not necessary for sound dental health.
   ( ) 2. Teeth that are knocked out in an accident will generally not be replaced under a dental policy.
   ( ) 3. Oral hygiene instructions and plaque control programs are often limited or excluded.
   ( ) 4. Prosthetic appliances generally may not be replaced for five years after a benefit is paid.

C. The ability of an individual to wait until covered by dental insurance before seeking treatment for dental issues is an example of
   ( ) 1. improper insurance.
   ( ) 2. improper selection.
   ( ) 3. adverse selection.
   ( ) 4. adverse insurance.

D. Prepaid dental plans offer services based on
   ( ) 1. capitulation.
   ( ) 2. captive member selection.
   ( ) 3. concentration.
   ( ) 4. capitation.

**Answer:**  A. 1. lower than reasonable and customary allowances; B. 2. Teeth that are knocked out in an accident will generally not be replaced under a dental policy; C. 3. adverse selection; D. 4. capitation
LIMITED POLICIES

Dread Disease

In this section, we will look at a series of policies, each of which covers only a limited, specified risk. Collectively, they are called limited policies, and the first of these is often referred to as a dread disease policy.

Dread disease policies can be purchased to cover specific diseases as named in the policy, such as heart disease or cancer. Generally, these policies cover illnesses that do not occur frequently, but incur significant costs when they do occur. Because of the low frequency of the disease covered, these policies are often fairly inexpensive in comparison to full health coverage.

Insurance regulatory bodies do not always look favorably upon these policies since less-sophisticated insurance buyers have sometimes purchased them believing the coverage was much broader, when major medical coverage was actually needed instead.

Travel Accident Insurance

Special policies can be purchased to cover loss from travel accidents. Travel accident insurance may be offered as a benefit of either an individual or a group accidental death and dismemberment policy. Benefits are limited to losses caused by accidents while traveling, usually by common carriers such as airlines or bus lines.

A frequent use of such coverage under a group policy limits benefits to losses suffered while traveling on business for one’s employer. Air travel insurance purchased at airports for individual, one-time coverage is probably the best-known type of travel accident policy.

Hospital Income (Indemnity) Insurance

A policy that pays a specific amount of insurance for each day an individual is hospitalized is called hospital income or hospital indemnity coverage. These policies pay an indemnity directly to the insured, not to the hospital. They are not intended to cover expenses for hospitalization, but to provide a flow of income that begins when the insured is confined to the hospital and ends on the final day of hospitalization. Some individuals use this kind of policy to meet the deductible and coinsurance requirements of their medical expense policies.

Limitations may apply. Some hospital indemnity policies include an elimination period, in which case coverage does not begin on the first day of confinement. Limits also may be placed on benefits paid for preexisting conditions.

Usually, the amount of insurance available is indicated as a monthly amount for a specified number of months. For example, Sin Lan has such a policy that pays $3,000 per month for up to 12 months. However, Sin Lan will be indemnified only for actual continuous days in the hospital, and the monthly amount is the aggregate of a daily amount times 30 days. Sin Lan’s $3,000 policy, then, pays $100 for each day the insured is hospitalized.

Since these policies provide a fixed number of dollars, they should be updated periodically to stay apace of inflation.
Vision Care Insurance

While basic, comprehensive and major medical policies often cover disease and injury to eyes, there is generally no coverage for eye exams and corrections such as eyeglasses or contact lenses. To close this gap, insurers may offer vision care policies, which usually cover:

- Eye examinations
- Cost of lenses and frames
- Cost of contact lenses
- Other corrective items

Typically, vision care policies operate with a network of eye doctors and providers of eyeglasses which the policyholder must use in order to receive benefits. Co-payments will vary according to the type of plan. The plan member simply presents the vision care card to the provider and is told the amount of the co-payment. Individual and family coverage is generally available.

Limitations normally apply. For example, the policy may pay for only one eye exam and one set of lenses per year. Common exclusions are:

- Replacement frames or lenses required because of loss or breakage
- Sunglasses and safety glasses
- Medical and surgical costs of the type covered by basic and major medical policies

Suppose Avtar has a vision care policy with the features described above. The policy also covers Avtar’s spouse and children. Avtar’s family incurs costs for the following:

- A pair of glasses to replace a pair Avtar lost
- Eye surgery for Avtar’s spouse
- One eye exam each year for each member of the family
- Contact lenses just prescribed for Avtar’s son
- A new lens prescription for Avtar to correct a further deficiency since his last exam 18 months ago

Only the last three items will be covered under the policy described.

Prescription Drug Policies

Prescription drug policies can be described as discount plans for members. Very often an individual health policy does not cover prescription drugs. For an annual fee or premium, an individual can join a plan that provides discounts of one degree or another for doctor-prescribed drugs. Prescription drug plans operate with a network of pharmacies that members must use in order to receive benefits. Sometimes a mail order service may be provided for drugs used on a regular basis. Plan members receive cards that must be presented to the pharmacy when a prescription is filled. There is a co-payment. Usually generic drugs are dispensed. Some drugs may be excluded such as fertility drugs, vitamins, experimental drugs, or drugs covered by other programs. There is a dispensing limit such as 34 days worth or 100 units whichever is larger. Premiums are guaranteed for one year. Individual and family coverage is generally available.
CREDIT INSURANCE

Credit health insurance covers a debtor, with the creditor receiving the benefits to pay off the debt if the debtor is disabled or dies accidentally. Credit insurance may be written as an individual policy covering a single debtor, or it can be sold to a master policyowner on a group basis to cover more than one debtor.

Individual credit health insurance is handled essentially the same way as any other individual health insurance policy. The applicant applies for the policy and receives it on the basis of individual selection. In this case the policyowner is the debtor and he or she names the creditor as the recipient of the policy's benefits.

The most common type of credit health insurance is group coverage sold as a master policy to a creditor that acquires many new debtors each year. For example, an auto dealership that provides financing for the vehicles it sells might have a group credit policy to cover all clients who finance their cars through the dealership.

Group credit health insurance is somewhat more complicated than individual coverage. In most states, a creditor must have a minimum number of debtors per year, often 100, before it qualifies for group credit insurance. Check your own state laws to determine minimum group size requirements.

Group credit health insurance has many of the same features as any other group coverage. No individual selection occurs, so no evidence of insurability is required. Group credit coverage is nearly always contributory, and a high percentage, usually 75%, of those to whom it is offered must want the coverage.

Limits On Coverage Amounts

The objective of credit insurance is to ensure that the outstanding indebtedness will be paid if the insured is disabled or dies accidentally before the loan is repaid. Since this is the case, the accidental death benefit may not exceed the total amount of indebtedness at any given point. Nor may the monthly disability benefit exceed the amount of the monthly payment on the loan. Consider this situation.

Raoul has a loan for which he makes payments of $340 a month. His creditor provides group credit health insurance. The monthly disability indemnities covering Raoul under this policy must be no more than $340, the amount of the monthly loan payment.

Now suppose the policy that covers Raoul contains accidental death benefits. Raoul's original loan was for $13,500. Raoul is accidentally killed when the balance due is $7,180. The benefit payable to the creditor is $7,180 because at any given time the death benefit may be no more than the total outstanding loan at the time of death.

Debtors usually pay for group credit health insurance as a portion of the monthly loan payment. Some lending institutions have their own or affiliated insurance companies through which they would like to write all of their credit insurance. However, a debtor is not required to carry insurance through the company suggested by the creditor.
In some states, and under certain conditions, a creditor can insist that the debtor have some type of insurance to help secure the loan. Even so, the debtor, not the creditor, has the option of selecting the insurer.

Suppose Joan finances her car through the Friendly Loan Company. Friendly Loan has its own wholly owned subsidiary insurance company. In Joan’s state, a lender may require the debtor to purchase credit insurance, and Friendly Loan would like Joan to purchase coverage from its subsidiary. As a prerequisite to financing the car, Friendly Loan may insist that Joan buy the coverage, but it may not require that she buy coverage from Friendly’s subsidiary.

**Notice Of Proposed Insurance**

When the loan is closed, the creditor must inform the debtor that he or she may be covered by the group plan if desired. Even if the creditor pays the full cost of the coverage, the debtor must be notified. Creditors are not permitted to place insurance on debtors without telling them about it.

The notification to a debtor that he or she will be covered under a credit health policy is called a *notice of proposed insurance*. This notice takes the place of the Certificate of Insurance until the Certificate can be prepared by the insurer and forwarded to the debtor.

In some states, a *modified application*, rather than a notice of proposed insurance, can be furnished in lieu of the Certificate of Insurance when the loan is closed.

In still other states, a creditor is permitted to incorporate the notice of proposed insurance in the loan or sales contract. This means that the debtor receives the notice when signing for the loan. If the debtor doesn’t read the contract carefully, he or she may not be aware of the insurance since no verbal notification is required. In states where this practice is allowed, including the notice in the contract fulfills the creditor’s obligation to provide notice of proposed insurance.

Once a debtor has received a notice of proposed insurance, the Certificate of Insurance must be delivered within 30 days of the date the indebtedness is incurred.

Sometimes, coverage might be terminated because the debtor pays off the loan early or because of refinancing. Any such termination requires the insurance company to refund unearned premiums.

Sid obtains a loan from a local finance company, and at the same time agrees to have credit health insurance placed on the amount of indebtedness. Sid receives a notice of proposed insurance at the time he signs for the loan. Since this is group coverage, Sid will receive a Certificate of Insurance, rather than an insurance policy, and he must receive it within 30 days.

After the loan is four months old, Sid decides he needs more money. He asks the loan company to refinance his loan, giving him an additional $1,000. This causes termination of the credit insurance, and the insurer must return the unearned premium to Sid.
Credit Life: A Corollary Coverage

Let’s talk briefly about credit life insurance. In the previous section, you learned that credit health insurance covers death only when it is accidental. Therefore, if a debtor were to die a natural death, the credit health insurance policy would not apply.

Credit life, on the other hand, will pay death benefits whether death occurs accidentally or by natural causes. If you are required to take an examination for your health insurance license, you may encounter a test question concerning credit life insurance. However, keep in mind that it is not considered health insurance, since it provides for natural death benefits, whereas health insurance covers only accidental death.

Credit life insurance, which may be either individual or group coverage, names the creditor as the beneficiary of the policy. The proceeds or face amount of the policy may not exceed the indebtedness at the time of death. A credit life policy intended to cancel a given indebtedness is usually decreasing term life insurance. This means that the policy is in force for the period of indebtedness, and the face amount of the policy equals the amount owed at any given time, as shown in the following illustration.

![Decreasing Term Life Insurance](image)

**REVIEW**

1. A special type of policy

   ( ) A. tends to cover more areas than basic medical expense.

   ( ) B. tends to cover a broad number of situations as described in the policy itself.

   ( ) C. tends to cover a limited number of situations as described in the policy itself.

   ( ) D. tends to cover whatever the insured wants to be covered.
2. Comprehensive dental policies

( ) A. limit benefits to specified maximums per procedure.
( ) B. work much the same way as comprehensive medical expense coverage.
( ) C. never require deductibles.
( ) D. seldom require coinsurance.

3. Which of the following is not likely to be considered nonroutine dental care?

( ) A. Treatment of the soft tissue substance located in the center of each tooth
( ) B. Microscopic analysis of tissue biopsy material for diagnosis of oral diseases including oral cancer
( ) C. Annual checkups and cleaning of teeth, including x-rays to check the health of the teeth
( ) D. Repairing or restoring dental work that has been damaged in some way

4. For nonroutine treatments, a comprehensive policy generally pays

( ) A. the full amount.
( ) B. a percentage of the reasonable and customary charges from the first dollar.
( ) C. a percentage of the reasonable and customary charges after a deductible.
( ) D. nothing.

5. Which of the following is not a common way dental insurance programs work to minimize adverse selection?

( ) A. Increasing the maximum annual benefit to encourage the insured to maintain dental health for the long term.
( ) B. Lowering the coinsurance percentage for expenses that are optional.
( ) C. Basing the benefit on the least costly treatment option.
( ) D. Graduating the coinsurance percentage to increase each plan year.

6. The main difference between a prepaid dental plan and a comprehensive dental plan is that

( ) A. comprehensive dental plans pay based on reasonable and customary charges, while prepaid dental plans pay on a capitation basis.
( ) B. comprehensive dental plans pay on a capitation basis, while prepaid dental plans pay based on reasonable and customary charges.
( ) C. comprehensive dental plans cover routine services, while prepaid dental plans do not.
( ) D. comprehensive dental plans do not cover routine services which are covered by prepaid dental plans.
7. A prepaid dental plan that wants to restrict an enrollee’s ability to receive services from a class of providers

( ) A. is out of luck, because such limitations are prohibited by law.
( ) B. must request permission from the insurance commissioner for the limitations.
( ) C. must request permission from the federal department of insurance for the limitations.
( ) D. must describe the limitations in the evidence of coverage and in all solicitation documents.

8. Dread disease policies

( ) A. are purchased to cover a variety of conditions that fall under the category of dreaded diseases.
( ) B. cover any disease defined by the ADA as a dread disease.
( ) C. cover specific diseases as named in the policy, such as heart disease or cancer.
( ) D. are a good replacement for general health insurance.

9. Benefits of travel accident insurance

( ) A. are limited to losses caused by accidents while traveling, usually by common carriers such as airlines or bus lines.
( ) B. are limited to losses caused while in transit, generally in personal vehicles such as cars or vans.
( ) C. are limited to accident losses caused while outside of the state of residence.
( ) D. are limited to accident or illness losses caused while outside of the state of residence.

10. Hospital indemnity insurance pays

( ) A. medical costs only while the insured is confined to the hospital.
( ) B. supplemental costs, such as television or phone charges, while the insured is confined to the hospital.
( ) C. an income for each day the insured is confined to the hospital.
( ) D. an income for each month the insured spends partially confined to the hospital.

11. Vision care insurance is generally needed to cover all of the following except

( ) A. injury to the eye.
( ) B. eye examinations.
( ) C. costs of contact lenses.
( ) D. costs of prescription lenses.

12. Prescription drug policies generally exclude

( ) A. any narcotic substance.
( ) B. any drugs not covered by other programs.
( ) C. experimental drugs.
( ) D. drugs for ongoing medical conditions.
13. Credit health insurance covers
   ( ) A. a creditor.
   ( ) B. a debtor.
   ( ) C. either a creditor or a debtor.
   ( ) D. neither a creditor nor a debtor.

14. The amount of coverage available under a credit insurance policy is generally limited to
   ( ) A. the total amount of indebtedness at any given point.
   ( ) B. the total amount of the loan covered.
   ( ) C. the amount the policy is written for.
   ( ) D. there is no limit.

15. The creditor must notify the debtor that he or she may be covered by the group insurance plan
   ( ) A. only if the debtor is to be charged the full premium for the insurance.
   ( ) B. if the debtor is to be charged more than half the premium amount.
   ( ) C. even if the creditor pays the full cost of the coverage.
   ( ) D. only if the creditor chooses to make the disclosure.

Answers:
1. C. tends to cover a limited number of situations as described in the policy itself.
2. B. work much the same way as comprehensive medical expense coverage.
3. C. Annual checkups and cleaning of teeth, including x-rays to check the health of the teeth
4. C. a percentage of the reasonable and customary charges after a deductible.
5. A. Increasing the maximum annual benefit to encourage the insured to maintain dental health for the long term.
6. A. comprehensive dental plans pay based on reasonable and customary charges, while prepaid dental plans pay on a capitation basis.
7. D. must describe the limitations in the evidence of coverage and in all solicitation documents.
8. C. cover specific diseases as named in the policy, such as heart disease or cancer.
9. A. are limited to losses caused by accidents while traveling, usually by common carriers such as airlines or bus lines.
10. C. an income for each day the insured is confined to the hospital.
11. A. injury to the eye.
12. C. experimental drugs.
13. B. a debtor.
14. A. the total amount of indebtedness at any given point.
15. C. even if the creditor pays the full cost of the coverage.
UNIT 7

GROUP HEALTH INSURANCE

LEARNING OBJECTIVES

After completing Unit 7—Group Health Insurance, you will be able to:

1. List and describe five common types of group health insurance plans.
2. List and describe five coverage provisions that apply solely or primarily to group policies.
3. List the events that generally trigger an employee's conversion privilege.
4. Explain who qualifies as a dependent under group coverage, and how dependency is legally determined.
5. Explain how the coordination of benefits rule determines which insurer is primary, and what each insurer pays.
6. Explain how the coordination of benefits rule determines which parent's insurance plan is primary for covered children.
7. Describe what happens if a clerical error prevents information from getting to an insurer.
8. Explain the scope and impact of the following federal regulations: HIPPA, COBRA, OBRA, TEFRA, ERISA, the Age Discrimination in Employment Act, and the Americans with Disabilities Act.
9. Explain how pregnancy is treated under the Civil Rights Act.
10. Describe some of the types of regulation commonly adopted by states in regards to group insurance.
GROUP HEALTH INSURANCE

Most people have at least a superficial acquaintance with group insurance since the most common type of group coverage is provided through employment. Many employers make health insurance available to their employees—either by paying the premiums for the employees, by sharing in premium payment, or by deducting the premiums from employees’ paychecks. Group insurance is covered in General Insurance Unit Five. The information in this unit is specific to group health insurance.

GROUP HEALTH INSURANCE POLICY TYPES

Group health plans may include any of the several types of insurance we discussed earlier, so this section will serve as a review of those individual coverages. Group plans need not include all coverages, but most will include at least two or more. In addition, disability income coverage may be offered under a group arrangement, but it is usually offered separately from hospital, medical and surgical coverage.

The first possible group coverage, then, pays benefits for lost earnings resulting from accident or sickness disability, and is commonly called disability income insurance.

Another common type of group coverage deals with accidental loss of life and accidental loss of one or more limbs or of eyesight. You’ll recall that accidental loss of life is referred to as accidental death and accidental loss of one or more limbs or of eyesight is known as dismemberment.

Still another type of group coverage is hospital expense. These policies can pay for hospital expenses whether treatment is on an inpatient or resident basis—the insured is admitted to the hospital—or outpatient basis—where the insured is not admitted for an overnight stay, but is treated and released the same day. The fees of an attending physician during hospital treatment may also be covered.
Eloise’s employer provides a group insurance plan covering expenses incurred for hospital care of any type. Eloise is involved in an auto accident on her way home from work and she is rushed to the hospital for emergency treatment. She is not admitted to the hospital, but does receive emergency room treatment. In this particular case, Eloise is an outpatient.

If Eloise’s group insurance covers only situations such as the one described, and does not provide disability income or any other benefits, the coverage is strictly a hospital expense policy.

If Eloise’s group coverage provides a separate benefit in the event Eloise loses her sight in an accident, this type of benefit is called accidental dismemberment.

Some group policies might cover only surgical expenses. Suppose Paul is hospitalized to have his appendix removed. His group policy specifies that the surgeon who performs an appendectomy will receive $450. The hospital charges are not paid. Although this would be fairly unusual today, such policies do exist, and in this situation, Paul’s group policy covers only reimbursement for surgical expenses.

Group health policies frequently provide coverage for medical expenses involving physician or nursing services, but no surgical expense. If Mihail becomes ill and must see his physician regularly, as well as remain under the care of a private nurse for several weeks, any health care reimbursement for these expenses is considered medical expense coverage.

We’ve now mentioned five forms of group health coverage, all of which have counterparts in individual policies. To summarize, they are:

- Disability income
- Accidental death and dismemberment
- Hospital expense
- Surgical expense
- Medical expense

**GROUP COVERAGE PROVISIONS**

Several provisions apply solely or primarily to group policies. They are provisions that

- Describe who is eligible for the group plan
- Describe when individuals become eligible for the plan
- Specify the minimum number of individuals and the minimum participation by eligible people required to sustain the plan
- Specify the amounts of insurance to which individual group members are entitled
- Describe the responsibilities of the master policyowner
As was mentioned previously, not all members of a group are necessarily eligible for coverage under a group plan. An employer may establish certain eligibility requirements, such as limiting coverage to people who have been employed for a specified period.

Often, an employee becomes eligible for coverage after working with a company for a given period of time, commonly 90 days. The employee is then eligible to apply for coverage during another period of time, usually 31 days, within which no medical examination will be required. This is the eligibility period discussed previously.

Any such qualifications or limitations must be indicated in the policy.

**Conversion Privilege**

The conversion privilege allows the insured to convert his or her group coverage to individual coverage without evidence of insurability. This privilege goes into effect only when the insured is no longer eligible for group coverage when:

- The insured's employment is terminated
- The insured becomes ineligible for coverage because the “class” he or she was insured under is no longer eligible for coverage. (For example, to save expenses, a company that formerly provided coverage for all employees working not less than 20 hours per week, may now only provide coverage to the “class” of employees who do not work less than 40 hours per week.)
- The insured's dependent child reaches the age specified in the policy as the age of terminating dependent coverage.

The insured has 31 days from the time of ineligibility to convert to the new plan of insurance. The new plan of insurance is an individual plan, normally a hospitalization policy, which will not provide the same benefits that the group plan did. Usually, the group medical expense benefits are more liberal than the converted policy's benefits. Often, those who elect to exercise this conversion privilege, do so because frequently they may have insurability problems. To limit adverse selection against the company, the insurer typically offers this conversion plan with reduced or limited benefits.

**Dependent Coverage**

Life or health insurance benefits may be extended to the primary insured's dependents. Dependents may be any of the following individuals:

- The insured's spouse
- The insured's children
- The insured's dependent parents
- Any other person who is dependent upon the insured

The insured's children can be stepchildren, foster children or adopted children. Dependent children must be under a specified age (usually age 19, or 21 if attending school full time). The law further requires that any other person dependent on the insured is eligible for coverage. Such dependency is proved by the relationship to the insured, residency in the home, or the person being listed on the insured’s income tax return as a dependent.
NOTES

A child may be a dependent beyond the ages of 19 or 21 if that child is permanently mentally or physically disabled prior to the specified age.

Also a dependent child may be offered coverage beyond the limiting age of 19 if he or she is a full time college student in an accredited college. Usually, dependent coverage for a student will be extended until age 21 or even to age 25.

**Coordination Of Benefits Provision**

Many working couples are doubly covered by group health insurance. Both husband and wife often have employment—provided group coverage, and each is covered as a dependent by the other’s plan. This type of double coverage can result in individuals being *overinsured*, creating the temptation to realize a profit from being ill.

To avoid this situation, a special provision is required by law in most states. The *Coordination of Benefits Provision* is designed to give insureds as much coverage as possible while eliminating overinsurance. Here is an example of how it works.

In double coverage situations, the insurer covering the employee who has the claim is called the *primary* insurance company. The primary company must pay as much of the claim as the policy limits permit.

Basil and Kendra, husband and wife, work at different companies. Both are covered by group plans that extend to dependents, so they have double coverage. Let’s assume that Basil has $2,200 in medical bills resulting from an illness. Basil’s policy is primary. Basil has major medical coverage and a $200 deductible, so the primary insurer (Basil’s insurance company) first deducts that amount from the $2,200 bill, leaving $2,000.

The primary insurer then pays 80% of $2,000, which is $1,600, leaving $600 unpaid—the $200 deductible plus $400, which is Basil’s share of the other $2,000.

Kendra’s company also covers Basil. For Basil’s claim (since he is covered as a dependent of Kendra’s), her company is called the *secondary* or *excess* insurer. The secondary company will pay whatever the primary company will not pay, up to its own limits.

Therefore, assuming the remaining $600 is within the limits, Kendra’s company pays the full additional $600, which is Basil’s percentage participation (20% of $2,000 or $400) plus his deductible ($200). Because double coverage existed, Basil’s expenses were fully covered. However, he did not receive more than his actual expenses.

To restate the Coordination of Benefits “rule”: The primary company pays the claim as if there were no double coverage, and the secondary company pays whatever the primary company will not pay, within its policy limits.

When a working couple is doubly covered by group insurance, any children they support will also be doubly covered. Before June of 1985, the usual way to coordinate benefits for children was to make the father’s group plan primary, and the mother’s plan secondary.
This sex-based procedure is being phased out. Instead, the birth months and days of the parents are often used to decide which plan is primary. The plan of the parent whose birthday comes first during the year is primary. The other parent’s plan is secondary. That is, if Sue’s birthday is March 4th and her husband John’s is March 8th, Sue’s plan is primary.

Or, if Juan’s birthday is April 25th and his wife Elena’s is July 22, Juan’s plan is primary since his birthday falls first in the year.

If parents are separated or divorced, the plan of the parent with custody is primary, barring any other legal arrangements.

**Records And Recordkeeping**

This provision contains information as to whether the insurer or the policyholder will maintain records on the insureds. It provides for the policyholder to furnish the insurance company with necessary information to determine premiums and administer coverage.

**Clerical Error**

A clerical error provision provides that if there is an error or omission in the administration of a group policy, the person’s insurance is considered to be what it would be if there had been no error or omission.

For example, an employer has the responsibility to send group enrollment forms for newly hired employees to the insurer. Sean is a new employee and through an administrative error, his enrollment form is never forwarded to the insurance company. A few months later he submits a medical expense claim to the insurer and is told that they have no record of his coverage.

This recordkeeping and clerical error provision protects the new employee in this type of situation. Usually, the insurer would accept an enrollment form and all of the past due premium and proceed to pay the medical claim.

**Exercise**

A. The conversion privilege allows the insured to continue group coverage without

( ) 1. paying individual premiums.
( ) 2. filling out an application.
( ) 3. providing proof of termination of employment.
( ) 4. providing evidence of insurability.

B. All of the following could be considered dependents except the insured’s

( ) 1. adopted children.
( ) 2. parents.
( ) 3. 25-year old child who became physically disabled at 24.
( ) 4. 21-year-old child who is attending college full-time.
C. The coordination of benefits provision provides that when a person is covered under more than one plan, the total benefits cannot exceed

- the greater of the benefits provided.
- the lesser of the benefits provided.
- both of the benefits combined.
- the total medical expenses or loss of wages.

Answer: A. 4. providing evidence of insurability; B. 3. 25-year-old child who became physically disabled at 24; C. 4. the total medical expenses or loss of wages

**FEDERAL AND STATE REGULATIONS AFFECTING GROUP POLICIES**

A number of federal regulations enacted over the past 20 years affect group life and health insurance policies. These are known by the acronyms COBRA, OBRA, TEFRA, and ERISA. Also, the health reform package (HIPAA) passed in 1996 has major implications for group health insurance policies.

**Health Insurance Portability And Accountability Act**

Legislation which took effect July 1, 1997, ensures “portability” of group insurance coverage, and includes various mandated benefits that affect small employers, the self-employed, pregnant women, and the mentally ill.

**Portability**

The new law makes it easier for individuals to change jobs and still maintain continuous health coverage. Employers now must make full health care coverage available immediately to newly hired employees who were previously covered at another job (the individual must have had coverage for at least 18 months). Prior to this change, coverage for preexisting conditions could be delayed for six months to one year, and new hires were subject to a waiting period before being eligible for health insurance. If the worker goes without health insurance for more than 63 days between jobs, the waiting period can be reinstated.

Also, an individual with group health insurance who leaves to become self-employed cannot be denied coverage (although the premium charged may be higher).

Group plans cannot impose more than a 12 month preexisting conditions exclusion for a person who sought medical advice, diagnosis, or treatment within the previous six months. However, this exclusion cannot be applied in the case of newborns, adopted children, or pregnancies existing on the effective date of coverage.

**Mandated Benefits**

The new law guarantees coverage for a 48-hour hospital stay for new mothers and their babies after a regular delivery (96 hours for a cesarean section birth). Also, it expands coverage for mental illness by requiring similar coverage for
treatment of mental and physical conditions. The law eliminates the special limitations included in many policies such as lifetime spending limits and annual limits applied only to mental health coverage.

Small employers (those with 2–50 employees) now cannot be denied group health insurance coverage because one or more employees are in poor health.

**Continuation Of Benefits (COBRA)**

The Consolidated Omnibus Budget Reconciliation Act (COBRA) is a federal law that requires employers with 20 or more employees to provide for a continuation of benefits under the employer's group health insurance plan, for former employees and their families. Coverage may be continued for 18 to 36 months. Employees and other qualified family members, who would otherwise lose their coverage because of a qualifying event are allowed by COBRA to continue their coverage at their own expense at specified group rates. COBRA specifies the rates, coverage, qualifying events, qualifying beneficiaries, notification of eligibility procedures, and time of payment requirements for the continuation of insurance. Below are the terms and concepts most important to the understanding of COBRA and its limitations.

**Qualifying Event**

A qualifying event is an occurrence that triggers an insured's protection under COBRA. Qualifying events include: the death of a covered employee, termination or reduction of work hours of a covered employee, Medicare eligibility for the covered employee, divorce or legal separation of the covered employee from the covered employee’s spouse, the termination of a child's dependent status under the terms of the group insurance plan, and the bankruptcy of the employer. Termination of employment is not a qualifying event if it is the result of gross misconduct by the covered employee. In short, a qualifying event occurs when the employee, spouse, or dependent child becomes ineligible for coverage under the group insurance contract.

**Qualified Beneficiary**

A qualified beneficiary is any individual covered under an employer-maintained group health plan on the day before a qualifying event. Usually this includes the covered employee, the spouse of the covered employee and/or dependent children of the employee. Changes made in 1996 amend the definition of “qualified beneficiary” to include children born or adopted during the 18 month coverage period.

**Notification Statements**

Employers are obligated to provide notification statements to individuals eligible for COBRA continuation. This notification must be provided under the following circumstances:

- When a plan becomes subject to COBRA
- When an employee is covered by a plan subject to COBRA
- When a qualifying event occurs
In addition to notifying current employees, the company must also notify new employees when they are informed of other employee benefits. Initial notification made to the spouse of an employee, or to his or her dependents must be made in writing and sent to the last known address of the spouse or dependent.

Following the notification of eligibility for continuation of benefits an individual has 60 days in which to elect such continuation. If continued coverage is not elected within 60 days the option to do so is forfeited.

**Duration Of Coverage**

An employer is not required to make continuation coverage available indefinitely. The rationale behind COBRA is to provide transitional health care coverage until the employee or family member can obtain coverage or employment elsewhere. The maximum period of coverage continuation for termination of employment or a reduction in hours of employment is **18 months**. For all other qualifying events the maximum period of coverage continuation is **36 months**. There are also certain **disqualifying events** that can result in a termination of coverage before the time periods specified above. The dates of these events are as follows:

- The first day for which timely payment is not made
- The date the employer ceases to maintain any group health plan
- The first date on which the individual is covered by another group plan (even if coverage is less)
- The date the individual becomes eligible for Medicare

It should be remembered that COBRA deals with continuation of the exact same group coverage that the employee had as a covered employee. This distinction is important so as not to confuse this provision with the conversion of group coverage to a lesser amount of insurance as part of an individual plan.

Not only is the type of coverage the same that the insured had while employed, the premium is also the same except now the terminated employee will pay the entire premium to the employer for the privilege of continuing the group benefits. To cover any administrative expense that the employer may incur, the terminated individual may also pay an additional amount each month not to exceed 2% of the premium. It should also be noted that only the health benefits can be continued under COBRA. Any group life insurance under the plan may not be continued. It can of course be converted.

Recent amendments to COBRA require the continuation of coverage if a pre-existing condition limitation is included in the new group health coverage. However, the new group health coverage is primary and the continuation coverage is secondary.

**Plan Termination**

In most states, if an employer discontinues its group insurance plan, employees must have the opportunity to convert to individual insurance without a medical exam or other evidence of insurability.
Suppose Giovanni has been employed by the same company for 15 years. He is now 53 years of age and has battled with a number of skin cancers during the past four years. Giovanni’s employer terminates its group health plan, but offers employees the opportunity to convert to individual coverage. In order to get this coverage, it is likely that Giovanni will not be required to have a physical examination or otherwise show that he is insurable. Giovanni is fortunate since he otherwise might not be able to get health insurance at standard rates.

**OBRA**

The Omnibus Budget Reconciliation Act of 1989 (OBRA) extended the minimum COBRA continuation of coverage period from 18 to 29 months for qualified beneficiaries disabled at the time of termination or reduction in hours. The disability must meet the Social Security definition of disability, and the covered employee’s termination must not have been for gross misconduct. Changes to COBRA in 1996 permit individuals who become disabled during the first 60 days of the 18-month coverage period to extend their coverage to 29 months, to extend coverage until the person would become eligible for Medicare (the five month waiting period plus 24 months of eligibility for Social Security disability benefits).

Under OBRA ’89, an employer may terminate COBRA coverage because of coverage under another health plan provided the other plan does not limit or exclude benefits for a beneficiary’s preexisting conditions.

OBRA ’89 also clarifies that COBRA coverage may be terminated only because of Medicare entitlement, not merely eligibility. Before terminating COBRA coverage for beneficiaries at age 65, an employer must first be certain that the individual has actually enrolled under Medicare. Also, 36 months of COBRA coverage must be provided for the spouse and dependent children of a covered employee whose group insurance terminates because of entitlement to Medicare.

**TEFRA**

TEFRA (the Tax Equity and Fiscal Responsibility Act of 1982) is intended to prevent group term life insurance plans (usually always part of group health insurance programs) from discriminating in favor of “key employees.” Key employees include officers, the top 10 interest-holders in the employer, individuals owning 5% or more of the employer, or owning more than 1% who are compensated annually at $150,000 or more.

TEFRA amends the Social Security Act to make Medicare secondary to group health plans. TEFRA applies to employers of 20 or more employees, and to active employees and their spouses between ages 65 and 69. TEFRA also amends the Age Discrimination in Employment Act (ADEA) to require employers to offer these employees and their dependents the same coverage available to younger employees.
ERISA
The Employee Retirement Income Security Act of 1974 (ERISA) was intended to accomplish pension equality, but it also protects group insurance plan participants. ERISA includes stringent reporting and disclosure requirements for establishing and maintaining group health insurance and other qualified plans. Summary plan descriptions must be filed with the Department of Labor and an annual financial report must be filed with the IRS. For other qualified plans, legal documentation of the trust agreement, plan instrument, plan description, plan amendments, claim and benefit denials, enrollment forms, certificates of participation, annual statements, plan funding, and administrative records must all be maintained.

Age Discrimination In Employment Act
This act applies to employers with 20 or more employees and is directed toward employees who are age 40 or older. Generally speaking, this act prohibits compulsory retirement, except for those in executive or high policymaking positions. Employee benefits, which in the past usually ceased or were severely limited when an employee turned 65, must be continued for older workers, although some reductions in benefits may be allowed. Some states have laws that are even stricter with regard to retirement and benefits.

The Americans With Disabilities Act (ADA)
This act has a widespread impact on almost all facets of American life. With respect to group insurance, it makes it unlawful for employers with 15 or more employees to discriminate on the basis of disability against a qualified individual with respect to any term, condition or privilege of employment. Employees with disabilities must be given equal access to whatever health insurance coverage the employer provides to other employees, although certain coverage limitations may be acceptable for mental and nervous conditions as opposed to physical conditions as long as such limitations apply to employees without disabilities as well those with disabilities.

Among other things, the law forbids exclusion or limitation of benefits for

- specific disabilities such as deafness or AIDS;
- individually distinct groups of afflictions, such as cancer, muscular dystrophy or kidney disease; and
- disability in general.

Pregnancy Discrimination
In the past, pregnancy was treated differently from other medical conditions under both individual and group health policies. However, an amendment to the Civil Rights Act requires that women affected by pregnancy, childbirth or related medical conditions be treated the same for employment-related purposes as other persons who are not affected in the same way but are in similar positions. This includes receiving benefits under an employee benefit plan, such as group health insurance. While the federal law only applies to employers who have 15 or more employees, various state laws may affect employers with fewer than 15 employees.
State Regulation

Many states have some form of mandated group health benefits. These commonly include required coverage for adopted or newborn children, continued coverage for handicapped dependents, coverage for treatment of alcoholism or drug abuse, and coverage for mammograms and pap smears.

Some state statutes mandate continuation of coverage for individuals whose group insurance has terminated. Most often, COBRA satisfies the state continuation of coverage requirements. In instances where the state requirements are more generous than COBRA, the employer must follow the more generous plan.

Extension of benefits is similar to continuation of coverage. In this case, benefits which began to be paid while a health insurance policy was in force continue, or are extended, after the insurance contract is terminated. Some states require group policies to provide for extension of benefits for a covered member who is totally disabled at the time of policy discontinuance.

States often regulate the marketing and advertising of accident and health insurance policies to assure truthful and full disclosure of pertinent information when selling these policies. As a rule, the insurer is held responsible for the content of advertisements of its policies. Advertisements cannot be misleading or obscure, or use deceptive illustrations, and must clearly outline all policy coverages as well as exclusions or limitations on coverage (such as pre-existing condition limitations).

INDIVIDUAL VS. GROUP INSURANCE

The chart that follows summarizes how individual and group plans differ.

<table>
<thead>
<tr>
<th>Comparison of Individual &amp; Group Plans</th>
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<td><strong>Individual</strong></td>
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| Anyone can apply for coverage.         | Only group members are covered.  
                                          | Group must meet size and purpose definitions. |
| Each person has a policy.              | There is one master contract.                 |
| Individual selects coverage options.   | Benefits are essentially the same for all group members. |
| Individual's health is evaluated.      | Group as a whole is evaluated; no individual underwriting. |
| Coverage renewable at option of the insured, sometimes insurer. | Coverage stops when insured leaves the group. |
| All accidents are covered.             | Only off-the-job accidents are generally covered. |
NOTES

1. An individual is not eligible for the conversion privilege if
   ( ) A. the insured's employment is terminated.
   ( ) B. the insured becomes ineligible for coverage because the class he or she was insured under is no longer eligible for coverage.
   ( ) C. the insured fails to make the conversion within 31 days.
   ( ) D. the insured's dependent child reaches the age specified in the policy as the age of terminating dependent coverage.

2. Which of the following is not part of the qualification process for legal dependency?
   ( ) A. Relationship to the insured
   ( ) B. Residency in the home
   ( ) C. Eligibility for insurance
   ( ) D. Listing on the insured's tax return as a dependent

3. When both parents have employer-provided group coverage, the children are covered under
   ( ) A. the father's plan.
   ( ) B. the mother's plan.
   ( ) C. the plan of the parent whose birthday falls closest to the child's birthday.
   ( ) D. the plan of the parent whose birthday falls closest to the start of the calendar year.

4. Under the coordination of benefits rule, the primary company pays
   ( ) A. if there is no other coverage.
   ( ) B. as if there is no other coverage.
   ( ) C. whatever the other coverage does not pay, up to the policy limits.
   ( ) D. only if the other coverage refuses the claim.

5. Under the coordination of benefits rule, the secondary company pays
   ( ) A. if there is no other coverage.
   ( ) B. as if there is no other coverage.
   ( ) C. whatever the other coverage does not pay, up to the policy limits.
   ( ) D. only if the other coverage refuses the claim.

6. Carla enrolls in group insurance when she is eligible under her employer's plan. Because of an administrative error, her enrollment form is never sent to the company. When she later has a claim, the insurer will
   ( ) A. deny the claim, because it has no record of her policy.
   ( ) B. force the employer to pay the claim, because it was the employer's error.
   ( ) C. pay the claim only if the insurer is proven to have made an error.
   ( ) D. accept the enrollment form and all of the past due premium and pay the medical claim.
7. A federal law that requires employers with more than 20 employees to include in their group insurance plan a continuation of benefits provision for all eligible employees.

( ) A. COBRA
( ) B. OBRA
( ) C. ERISA
( ) D. TEFRA

8. A federal law intended to prevent group term life plans from discriminating in favor of key employees.

( ) A. COBRA
( ) B. OBRA
( ) C. ERISA
( ) D. TEFRA

9. A federal law that extends the minimum continuation of coverage period from 18 to 29 months for qualified beneficiaries disabled at the time of termination or reduction in hours.

( ) A. COBRA
( ) B. OBRA
( ) C. ERISA
( ) D. TEFRA

10. A federal law intended to accomplish pension equity, but also protects group insurance plan participants.

( ) A. COBRA
( ) B. OBRA
( ) C. ERISA
( ) D. TEFRA

11. Which of the following provisions is not a part of HIPPA?

( ) A. Employers must make full health care coverage available immediately to newly hired employees who were previously covered for at least 18 months.
( ) B. New mothers and their babies must be allowed to stay in the hospital for at least 48 hours following a regular delivery.
( ) C. Small employers may not be denied group health insurance coverage because one or more employees is in poor health.
( ) D. Annual limits and lifetime spending limits may no longer apply to mental health coverage.

12. Which of the following is considered a disqualifying event under COBRA?

( ) A. The employer ceases to maintain any group health plan
( ) B. The employee is no longer eligible for the group health plan due to a change in the covered classes.
( ) C. The employee voluntarily leaves employment with the employer.
( ) D. The employee's employment is terminated by the employer.
13. Under OBRA, an employer may terminate COBRA coverage because of coverage under another health plan
   ( ) A. as soon as the coverage is in force.
   ( ) B. as long as the other health plan does not limit benefits for the insured’s preexisting conditions.
   ( ) C. as long as the other health plan limits benefits for the insured’s preexisting conditions.
   ( ) D. only if the premiums for the new plan are paid entirely by the insured’s new employer.

14. The Age Discrimination in Employment Act applies to employees who are
   ( ) A. 40 or older.
   ( ) B. 45 or older.
   ( ) C. 50 or older.
   ( ) D. 55 or older.

15. The Americans with Disabilities Act
   ( ) A. does not apply to acquired diseases such as AIDS.
   ( ) B. permits exclusion of benefits for individual distinct groups of afflictions, such as cancer, muscular dystrophy or kidney disease.
   ( ) C. applies to all employers with 25 or more employees.
   ( ) D. requires that employees with disabilities be given equal access to whatever health insurance is provided to other employees.

Answers:
1. C. the insured fails to make the conversion within 31 days.
2. C. Eligibility for insurance
3. D. the plan of the parent whose birthday falls closest to the start of the calendar year.
4. B. as if there is no other coverage.
5. C. whatever the other coverage does not pay, up to the policy limits.
6. D. accept the enrollment form and all of the past due premium and pay the medical claim.
7. A. COBRA
8. D. TEFRA
9. B. OBRA
10. C. ERISA
11. D. Annual limits and lifetime spending limits may no longer apply to mental health coverage.
12. A. The employer ceases to maintain any group health plan
13. B. as long as the other health plan does not limit benefits for the insured’s preexisting conditions.
14. A. 40 or older.
15. D. requires that employees with disabilities be given equal access to whatever health insurance is provided to other employees.
UNIT 8
SOCIAL HEALTH INSURANCE

LEARNING OBJECTIVES

After completing Unit 8—Social Health Insurance, you will be able to:

1. List the four main types of social health insurance provided in the United States.
2. Describe the Medicare system, its purpose and administration.
3. Explain who is eligible for Medicare, and how individuals can enroll.
4. List and explain the benefits provided under Medicare parts A and B.
5. Explain the purpose of Medicare supplement insurance.
6. List and describe the core benefits available in all Medicare supplement policies.
7. List and describe the optional benefits available under Medicare supplement policies.
8. List and describe the 10 Medicare supplement plans that may be offered.
9. Describe the Medicare Select and Medicare+Choice programs, explaining how they differ from standard Medicare supplement plans.
10. Explain how Medicare benefits coordinate with employer-provided benefits.
11. Describe the Medicaid program, its purpose and administration.
12. Explain who is eligible for Medicaid and how individuals can enroll.
13. Explain the spousal impoverishment rule.
14. List and describe the costs Medicaid is required to pay.
15. Describe the Social Security program, its purpose and administration.
16. Explain the purpose of TRICARE and who is eligible.
17. Describe Workers Compensation, its purpose and administration.
18. List the four categories of benefits incorporate by all states.
19. Explain what injuries and illnesses are compensable under Workers Compensation.

(continued)
20. List and explain the four types of disability defined under Workers Compensation law.

21. Describe an Extraterritorial provision under Workers Compensation.
SOCIAL HEALTH INSURANCE

INTRODUCTION

The term **social health insurance** refers to health coverages subsidized and implemented through government administration of tax money and social programs. We will look at four areas:

- Medicare and associated private coverages
- Medicaid
- Social Security
- Workers Compensation

MEDICARE

Medicare is the U.S. version of national health insurance, at least as far as the elderly and disabled are concerned. It was originally enacted by Congress in 1965 and has been modified many times since. Medicare is a federal program. It is administered by the Center for Medicare Services (CMS), a division within the U.S. cabinet level Department of Health and Human Services. At the local level, district offices of the Social Security Administration accept Medicare enrollment applications, process claims and provide general information to the public about the Medicare program. However, Social Security does not make Medicare policy; it simply handles the paperwork.

To make Medicare benefit payments, the U.S. Government enters into contracts with selected private insurance companies. The insurance companies that make coverage and payment decisions with respect to services provided by hospitals, skilled nursing facilities, home health agencies and hospices are called “intermediaries.” The insurance companies that handle claims with respect to services provided by physicians and other providers are called “carriers.”
**Eligibility**

The following chart shows who may be covered by Medicare and under what conditions.

![Medicare Eligibility Diagram]

Survivors and dependents of these individuals may also qualify for Medicare coverage under certain circumstances. A common example is the surviving spouse of an individual who qualified for Social Security before his or her death. If the survivor is at least age 65, he or she can qualify for Medicare after the spouse’s death. Other restrictions apply in other situations.

Here are just a few examples of people who would be eligible for Medicare:

- Chris, age 65, the surviving spouse of Stacy, who was age 68 and eligible for Social Security at the time of death.
- Orlando, age 49, who is suffering from kidney failure
- Hester, age 70, who is not eligible for Social Security, but is willing to pay for Medicare coverage

**Enrollment**

Medicare benefits are divided into two parts:

- Part A, Hospital Insurance, and
- Part B, Supplementary Medical Insurance

Enrollment in Part A is automatic for individuals entitled to Social Security benefits. These persons are eligible for Part A benefits as of the first day of the month in which they reach age 65.
Enrollment in Part B, on the other hand, is voluntary and requires payment of a monthly premium. When individuals become eligible for the hospital insurance coverage under Part A, they will be enrolled and their premium payment established for Part B coverage also unless they sign a form indicating they do not want the Part B coverage.

If individuals enroll before the month in which they reach age 65, Part B coverage begins as of the first day of the month when they are 65, just as it does for Part A. If enrollment takes place later, coverage also begins later.

### Part B Initial Enrollment

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Begins on the first day of the third month before...

The month in which age 65 is attained.

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The initial enrollment period for Part B is a seven month period that...

The initial enrollment period for Part B is a seven month period that...

People who choose not to enroll in Part B during their initial enrollment period may do so later. A general enrollment period occurs each year from January 1 through March 31. When enrollment occurs during this period, coverage always begins on the following July 1.

### Benefits Under Medicare Part A

Part A provides coverage for four different kinds of care:

- Inpatient hospital care
- Skilled nursing facility care
- Home health care
- Hospice care

The services covered under each of these arrangements are subject to certain limitations that we will discuss in the following sections.
Examples of the four types of care follow.

- An individual who is hospitalized with pneumonia is receiving inpatient hospital care.
- An individual receives skilled nursing services in a facility designed for that purpose. This is skilled nursing facility care.
- An individual receives assistance several days a week at home following major surgery. This is home health care.
- An individual with a terminal illness who will spend the remainder of his life in a hospice receives hospice care.

Inpatient Hospital Care

Medicare's inpatient hospital care benefit helps pay the reasonable charges that result from hospitalization in a semiprivate room for medically necessary care. This includes meals, regular nursing services, special care units, drugs taken in the hospital, tests, medical supplies, operating room, and many other supplies and services.

For each benefit period, Medicare will pay the full cost of up to 60 days of inpatient hospital care, after the patient pays a deductible, which changes annually. From the 61st through 90th days of hospitalization, Medicare pays all but a specified coinsurance amount per day. This figure also changes annually. For a stay over 90 days, the patient may draw upon 60 lifetime reserve days, which may be used only once in a lifetime. The patient's daily co-payment amount increases substantially when these reserve days are used.

A benefit period begins upon admission and ends 60 days after hospital discharge. A readmission during this 60 days is considered part of the same benefit period; a readmission after the 60 days run out is the beginning of a new benefit period.

Skilled Nursing Facility Care

Medicare will share the cost of skilled nursing facility (SNF) care for up to 100 days in each benefit period.

The patient must pay a specified dollar amount (coinsurance) for the 21st through 100th days of confinement. This amount changes annually. Medicare pays all reasonable charges for the first 20 days.

Medicare defines the skilled nursing facility benefit quite narrowly. The patient must be receiving medically necessary services provided by a highly skilled staff in a Medicare-approved facility, following a prior hospital stay of at least three days. The care must be of a type that can be performed only by or under the supervision of licensed nursing personnel, and only as the result of a doctor's orders.

Any type of intermediate or custodial, as opposed to skilled, nursing care is not covered.
**Home Health Care**

If a patient is confined at home, the *home health care benefit* provides for certain services performed by a participating home health agency. This is a public or private agency that provides skilled nursing or therapeutic services in the home. Eligible expenses include:

- Intermittent part-time nursing care
- Physical, occupational or speech therapy
- Home health aides
- Medical social services
- Medical supplies
- 80% of certain durable medical equipment, such as wheelchairs or hospital beds

No benefits will be paid for housekeeping services, meal preparation or delivery, shopping, full-time nursing care, blood transfusions, drugs, or biologicals.

The home health care benefit pays for an unlimited number of home visits as medically necessary, provided they are *intermittent*, rather than constant or full-time. Note that this is *not* the same benefit that is found in long-term care policies.

**Hospice Care**

A hospice is organized primarily for the purpose of providing support services to terminally ill patients and their families. For terminally ill patients, the *hospice care benefit* provides inpatient and outpatient hospice care. Payments are made for pain relief and symptom management, but not for curative or other types of treatment.

It is possible for Medicare to cover hospice care for an unlimited period of time as long as a physician certifies need.

Medicare pays virtually all costs for hospice treatment, with no deductible. Only two services require co-payments:

- Prescription drugs, for which patients must pay 5% or $5 per prescription, whichever is less.
- Respite care, for which patients must pay 5% of the Medicare-approved rate up to a specified dollar amount, which changes annually.

The *respite care* benefit covers temporary care in a hospice for a patient who is normally cared for in the home. The respite is for the usual caregivers, and may last no more than five consecutive days.

Let’s look at how the hospice care benefit might apply to a specific situation. Ellis is admitted to a hospice in March. Medicare begins paying covered charges immediately, with no deductible required from Ellis.

In July and again in October, Ellis is recertified as being terminally ill. Medicare continues to pay hospice benefits for Ellis.
During this time, Ellis receives experimental medical treatments that could conceivably halt the progress of his illness. Medicare will not cover these treatments, so Ellis must find other funding to pay for them.

Now let’s suppose that Ellis is instead being cared for at home by his brother, Bradley, who needs some time off from the responsibility of caring for Ellis. If Bradley wants to take Ellis to a hospice for several days, Medicare will pay for five consecutive days of respite care.

**What Part A Does Not Cover**

Hospital insurance under Medicare does not cover:

- Private duty nursing
- Charges for a private room, unless medically necessary
- Conveniences, such as a telephone or television in an insured’s room
- The first three pints of blood received during a calendar year (unless replaced by a blood plan)

**Benefits Under Medicare Part B**

Medicare Part B provides coverage for three general kinds of medical services:

- Doctors’ services
- Home health care (if not covered by Part A)
- Outpatient medical services and supplies.

Part B is an optional program of medical insurance designed to supplement Part A. Persons who enroll in Part A are automatically enrolled in Part B unless they request otherwise. Part B requires payment of a monthly premium, which many people simply have deducted from their Social Security or Railroad Retirement checks.

**Common Deductible And Co-Payment**

Medicare Part B requires cost-sharing by the patient. There is an annual deductible and a coinsurance percentage that applies to all Part B covered services, across-the-board. This contrasts with Part A, where each benefit provided has its own unique co-payment requirements for the patient.

Under Part B, a patient is always responsible for these co-payments:

- An annual deductible amount
- 20% of all “reasonable charges” for covered, medically necessary services
- The first three pints of blood

The deductible can be met by any combination of expenses covered under Part B. The patient does not have to meet a separate deductible for each type of covered service.

Medicare determines what is a reasonable charge for a particular service. If the actual charge is more than that, the patient must pay the difference, unless the doctor or supplier agrees to accept assignment. Assignment means
that the doctor or supplier will accept Medicare’s approved amounts as full payment and cannot legally bill the patient for anything above that amount. Doctors and suppliers are not required to accept assignment, but many will.

If Medicare decides that an expense is medically unnecessary, the patient must pay the entire cost. Neither Medicare nor most private insurance policies will provide benefits.

**Doctors’ Services**

Part B covers most physicians’, surgeons’ and osteopaths’ services and supplies furnished as part of such services. It does not matter where such services are provided—in a hospital, in a skilled nursing facility, in a clinic, at the doctor’s office, at the patient’s home, or anywhere else in the U.S.

Some of the specific services covered are:

- Medical and surgical services, including anesthesia
- Office visits, house calls and hospital calls
- Radiological and pathological services provided by a physician
- Medical supplies furnished as part of a physician’s professional services
- Second opinions before surgery
- Diagnostic tests that are part of the patient’s treatment
- X-rays
- Services of the doctor’s office nurse
- Physical, occupational and speech therapy services
- Blood transfusions
- Drugs and biologicals that cannot be self-administered.

Specifically excluded from Part B coverage are physicians’ services for:

- Routine physical exams
- Routine foot care, treatment of flat feet, and treatment for subluxations of the foot
- Eye exams, fitting of eyeglasses or contact lenses
- Hearing exams, fitting of hearing aids
- Most types of dental care
- Most immunizations
- Cosmetic surgery (unless needed to repair an accidental injury or to correct a malformed body part).

**Home Health Care Services**

Recall that Medicare Part A covers home health care services. For persons who participate in Part B but not Part A, Part B pays the full cost of medically necessary home health visits for patients requiring home nursing care. The patient pays no deductible or coinsurance, except for 20% of the cost of durable medical equipment, provided under the home health care benefit (e.g., wheelchairs, hospital beds).

Persons covered by Part A will have their home health care expenses paid for under Part A.
Unit 8—Social Health Insurance

NOTES

**Outpatient Medical Services And Supplies**

Medicare Part B will help pay for certain services received as an outpatient from a Medicare-certified hospital for the diagnosis or treatment of an illness or injury.

Here is a relatively comprehensive list of some of the outpatient medical services and supplies covered under Medicare Part B:

- Outpatient clinic services
- Emergency room services
- X-rays, whether for therapy or diagnosis billed by the hospital
- Medically necessary ambulance services
- Purchase or rental of durable medical equipment used in the patient’s home
- Artificial limbs and eyes
- Artificial replacements for internal organs (e.g., colostomy bags and supplies)
- Braces for neck, back or limbs
- Casts, splints and surgical dressings
- Blood transfusions (after the first three pints) furnished to an outpatient
- Outpatient physical, occupational and speech therapy provided in a therapist’s office, as an outpatient, or in the patient’s home
- Drugs and biologicals that cannot be self-administered
- Mammograms, Pap smears and colonrectal screenings
- Diabetes glucose monitoring and education
- Flu shots

Outpatient services not covered by Part B are:

- Routine physical exams
- Eye exams, fitting of eyeglasses or contact lenses
- Hearing exams, fitting of hearing aids
- Most immunizations
- Routine foot care

**What Part B Does Not Cover**

Medical insurance under Medicare does not cover:

- Private duty nursing
- Skilled nursing home care costs over 100 days per benefit period
- Intermediate nursing home care
- Physician charges above Medicare’s approved amount
- Most outpatient prescription drugs
- Care received outside the United States (limited coverage for Canada and Mexico)
- Custodial care received in the home
- Dental care, routine physicals and immunizations, cosmetic surgery, eyeglasses, hearing aids, orthopedic shoes, acupuncture expenses
- Expenses incurred due to war or act of war
Claims And Appeals

If a doctor has not accepted a Medicare assignment, the doctor sends the bill directly to the patient. The patient fills out a Medicare claim form, and attaches itemized bills from the doctor including date of treatment, place of treatment, description of treatment, doctor's name, and charge for service. The form and accompanying documents are sent to the Medicare “carrier” (also known as a “fiscal intermediary”—a private insurance company) in the patient’s area. Upon receiving the claim, the carrier will send a form called Explanation of Medicare Benefits. This form shows which services are covered and the amounts approved for each service.

If Medicare claims are denied, there is an appeal process a patient can go through. Within six months of the receipt of the Explanation of Medicare Benefits notice, the patient must file a written request for review. The carrier will check for miscalculations or other clerical errors. If the carrier, after review, declines to make a change, an appeal can be made (if the amount disputed is $100 or more) to the Social Security office. The patient must appear in person to attend a hearing and present evidence, such as a doctor's letter, to support his or her point. A written notice of the decision will be sent after the hearing.

Exercise

A. Which of the following individuals is least likely to be eligible for Medicare?

( ) 1. Mannie, who is 65 and just registered for his Social Security benefits.
( ) 2. Margaret, who is not eligible for Social Security, but is willing to pay a fee for her insurance.
( ) 3. Karl, who has been diagnosed with end stage liver disease.
( ) 4. Genevieve, who has been receiving disability benefits from Social Security for three years.

B. Michelle is 65 and starting to receive Social Security benefits. To receive Medicare Part A, she needs to

( ) 1. fill out an enrollment form at her local Social Security office.
( ) 2. pay a monthly premium.
( ) 3. prove eligibility.
( ) 4. do nothing.

C. The annual general enrollment period for Medicare Part B begins on

( ) 1. January 1.
( ) 2. March 1.
( ) 3. March 31.
( ) 4. July 1.

Answer: A. 3. Karl, who has been diagnosed with end stage liver disease; B. 4. do nothing; C. 1. January 1
MEDICARE SUPPLEMENT INSURANCE

As we have seen, the Medicare program provides substantial hospital and other medical benefits for beneficiaries of the program. However, even after Medicare pays its share, the patient may still owe large amounts due to:

- deductibles
- coinsurance
- noncovered services, and
- actual charges by service providers in excess of the approved amount that Medicare will pay.

Several methods are available to supplement Medicare and cover most of the remaining expenses.

1. Medicaid, discussed in the next section of this unit, covers expenses not paid by Medicare for eligible low-income people. In other words, these people do not need supplemental insurance.

2. Many employers offer their retiring employees an opportunity to continue their group insurance coverage or to convert it to Medicare supplement coverage. For those who continue to work after age 65, Medicare may become the secondary payer to an employer group health care plan. This means that the employer plan will pay first on hospital and medical bills. If the employer plan does not pay all expenses, then Medicare may pay secondary benefits for Medicare-covered services to supplement the amount paid by the employer group health care plan. Medicare is also the secondary payer to employer plans for beneficiaries who have Medicare because of disability or permanent kidney failure.

3. Associations and groups may offer supplemental Medicare coverage to their members who are age 65 and over.

4. Members of certain HMOs can sign up for a Medicare Replacement Plan which eliminates Medicare’s deductibles and co-payments and provides additional benefits.

5. More often, a Medicare supplement policy is purchased from an insurer to help cover the costs not paid by Medicare. This may also be referred to as a Medigap policy.

This section concentrates on the last option above—Medicare supplement policies purchased from private insurers.

Some kind of supplement to Medicare is needed by almost everyone covered by Medicare except those whose income is low enough to qualify for help from Medicaid.

STANDARDIZED MEDICARE SUPPLEMENT BENEFITS

Under federal law, states are required to standardize the types of Medicare supplement policies that may be sold in their jurisdictions, limiting policies to 10 standard designs. To meet these requirements, the National Association of Insurance Commissioners (NAIC) has revised its Medicare supplement model act and regulation, which must be adopted by all states.
The model regulation describes a basic “core” of benefits which all Medicare supplement policies must provide. It also describes a number of additional benefits that may be included in a Medicare supplement policy. A Medicare supplement policy may contain only the benefits described in this model regulation. They are as follows:

**Core Benefits**

These must be included in any Medicare supplement policy.

- Part A co-payments for the 61st through 90th day of hospitalizing
- Part A co-payments for the 60 lifetime reserve days
- All charges for 365 days of hospitalization after all Part A inpatient hospital and lifetime reserve days are used up
- Blood deductible (Medigap pays first three pints)
- Part B co-payments on Medicare-approved charges for physicians’ and medical services

**Optional Benefits**

These may be included in a Medicare supplement policy in addition to the core benefits.

**Part A Deductible**—pays the inpatient hospital deductible for each benefit period.

**Skilled Nursing Facility Care**—covers the Part A co-payments for the 21st through the 100th day of skilled nursing facility care.

**Foreign Travel Emergency**—pays 80% of the charges for emergency care given in a foreign hospital that would have been covered by Medicare had the treatment been given in the U.S.

**Part B Deductible**—covers the calendar-year deductible for physicians’ and medical services regardless of hospitalization.

**Part B Excess Charges**—Pays charges for physicians’ and medical services which exceed the Medicare-approved amount. Coverage may be obtained for 80% or for 100% of these charges.

**At-Home Recovery**—pays for a care provider to give assistance with ADLs while a beneficiary qualifies for Medicare home health care benefits and for up to eight weeks following the last Medicare-approved home health care visit.

**Preventive Care**—pays for an annual flu shot, an annual physical and any screening tests or preventive measures deemed appropriate by a physician.

**Prescription Drugs**—pays 50% of an outpatient’s prescription drug charges after a $250 deductible. The basic drug benefit has a yearly limit of $1,250; the extended drug benefit has a yearly limit of $3,000.
### Standard Medigap Plans

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Standardized Policy Forms

Insurance companies are not free to offer these benefits in any combination they wish. The NAIC model regulation outlines 10 Medicare supplement plans, designated by the letters A through J, containing various combinations of the benefits just described. These 10 are the only plans that may be offered by an insurer.

As the chart shows, Plan A offers only the core benefits, with no additional benefits included. Companies that wish to sell any of the plans must offer at least Plan A. The offer of any other plan is optional and subject to a state's authorization to sell that plan in its jurisdiction. States need not approve all 10 plans for sale in their jurisdictions.

Other Standard Provisions

• No Medigap policy may duplicate benefits provided by Medicare.
• Benefits under Medigap policies must automatically change to coincide with changes in Medicare deductibles and co-payments. Premiums may be modified accordingly.
• Once a Medigap policy has been in force for six months, benefits may not be denied or limited on the basis of preexisting conditions. “Preexisting condition” may not be defined more restrictively than a condition for which medical advice or treatment was given by a physician within six months before the policy was in force.
• Except for an exclusion regarding preexisting conditions (just described), no Medigap policy may contain limitations or exclusions on coverage which are more restrictive than those of Medicare.
• Losses resulting from sickness may not be treated differently than losses resulting from accidents.
• The definition of “accident” may not employ an accidental means test.
• Medigap policies must be at least guaranteed renewable. Issuers may not cancel or nonrenew a policy solely on the ground of an individual's health status. Issuers may not cancel or nonrenew a policy for any reason other than nonpayment of premium or material misrepresentation.
• Except for nonpayment of premium, coverage may not be terminated on a spouse solely because the issuer has reason to terminate coverage on an insured.
• If a Medigap policy is terminated while a loss is continuing, benefits must still be paid for that loss, subject to the continuing total disability of the insured and the policy's limits on the benefit period and maximum amount.
• If a group Medigap policy is replaced by another group Medigap policy, the new policy must cover all persons covered by the old policy. The new policy may not deny or limit any benefits on the basis of preexisting conditions that would not have been denied or limited under the old policy.
• If a group Medigap policy is terminated and not replaced, insureds must be given the choice of converting to an individual policy that offers the same benefits as the group policy or another standardized plan.
• If a person insured under a group Medigap policy terminates membership in the group, the person must be given the choice of converting to an individual standardized plan unless the group policyholder offers the person continuation of benefits under the group plan.
If a Medigap insured begins receiving Medicaid, the insured may, within 90 days, request a suspension of premiums and benefits under the policy for up to two years and get an appropriate refund of premium. Coverage must be automatically reinstated if the insured loses Medicaid and notifies the issuer within 90 days.

**Medicare SELECT**

Medicare SELECT is another version of the standard Medigap policies we have been discussing. It offers the same 10 plans with the same coverages. The only difference between Medicare SELECT and standard Medigap insurance is that Medicare SELECT is operated on a preferred provider basis. Each insurer has a list of doctors and hospitals from which the insured must make his or her choice for treatment in order to receive benefits. As a result of this requirement, Medicare SELECT policies generally have lower premiums than standard Medigap policies.

**MEDICARE+CHOICE**

A number of options to the traditional Medicare program have been introduced under the heading of Medicare+Choice which is sometimes referred to as Medicare Part C. We'll look at each of the following with respect to Medicare coverage:

- Original fee-for-service
- Private fee-for-service
- Health maintenance organizations (HMOs)
- Preferred provider organizations (PPOs)
- Provider-sponsored organizations (PSOs)
- Medical savings accounts (MSAs)

All of these options are designed to fill Medicare “gaps” that must be paid by the Medicare beneficiary.

As we have seen, under the traditional Medicare system, beneficiaries can use any hospital and see any doctor who accepts Medicare patients and receive Medicare coverage for any Medicare-approved service. A Medicare Supplement policy can be used to fill the gaps—the A through J plans, with each plan covering a different grouping of Medicare gaps. Under Medicare+Choice two new Medicare Supplement policies are included as a part of this original fee-for-service coverage. These two new policies match the standardized F and J policies, but have higher deductibles. These higher deductibles may be offset by lower premiums. So an individual may choose—with these two plans at least—to pay lower premiums but at the same time run the risk of a larger deductible.

An additional new fee-for-service system under Medicare+Choice, called private fee-for-service plans, combines some of the advantages of regular Medicare coverage with those of private insurance. Under this option, Medicare beneficiaries can buy plans from insurance companies that cover both Medicare-covered services and other Medicare Supplement coverage. The insurance companies are paid by Medicare to cover the individuals using this
option. Beneficiaries continue to pay Medicare Part B premiums directly to Medicare, but an additional premium is paid to the insurance company. Premiums are not limited by the government and Medicare’s payment to the insurance company for individuals participating in this option probably will not meet the total cost of the coverage. In effect, the individual and Medicare share the cost of coverage under the Medicare+Choice fee-for-service option. In return, this option will provide all Medicare-covered care from any provider. There may be additional benefits to cover Medicare gaps such as prescription costs and preventive services.

Medicare beneficiaries can receive health care through a Medicare-contracting health maintenance organization (HMO), if one is available in their geographic area. This can be a health center staffed with the HMO’s own employees, or the HMO may contract with a group of physicians who treat the HMO participants as well as private patients. But always, the HMO oversees decisions made about care as a means of holding down costs.

Medicare prepays a monthly amount for each beneficiary. This is called capitation. In return, the HMO must deliver all medically necessary Medicare-covered treatment. In addition, a number of extras may be included, such as preventive or routine care not normally provided by Medicare. Depending on the plan, beneficiaries may or may not pay the HMO a fixed monthly premium. Beneficiaries continue to pay the Medicare Part B premium directly to Medicare. Co-payments may be required for some services, but there are no Medicare deductibles or coinsurance. Like many HMOs, this Medicare+Choice option may not pay for services delivered by physicians outside the HMO’s network.

Like the HMO option, the Medicare+Choice preferred provider organization (PPO) option is a type of managed care. However, the two options differ from each other in two significant ways.

1. A PPO is administered by an insurance company.
2. A PPO allows more freedom than an HMO to seek care outside the network—but at a cost.

A PPO is a network of providers who contract to provide services at pre-negotiated rates. Participants in this option may go outside the network for services if they’re willing to pay more. This option pays a higher percentage of costs when participants use its “preferred providers,” less if they go outside the network to a non-preferred provider.

Medicare prepays a monthly amount to the PPO on behalf of each participant. Participants may also pay a fixed monthly premium. Medicare Part B premiums must continue to be paid directly to Medicare. While participants do not pay Medicare deductibles or coinsurance, the PPO may have its own deductibles and/or coinsurance. For example, the PPO may pay 90% of the approved amount for service from a preferred provider, but only 60% for that of non-preferred providers. It may also begin paying its share of costs after the first $100 of medical expenses have been paid on an annual basis. Whatever the arrangements, in return the PPO delivers all medically necessary Medicare-covered care to participants.
Under Medicare+Choice, physicians and hospitals are allowed to create their own organizations to contract with Medicare the same way HMOs and PPOs do. These provider-sponsored organizations (PSOs) are owned and operated by the providers themselves: the doctors and other practitioners who deliver care. As such, PSOs are likely to be as restrictive as HMOs regarding the necessity of receiving care from network members. In fact, PSOs work much like HMOs except that decisions about the care of participants are free from oversight by a separate managed care organization.

Medicare plans, such as HMOs and PSOs that are strong managed care plans may be either risk plans or cost plans. Plans with risk contracts have “lock-in” requirements. This means that plan participants generally are locked into receiving all covered care from the doctors, hospitals and other health care providers that are affiliated with the plan. If plan participants go outside the plan for services, neither the plan nor Medicare will pay and participants will have to foot the entire bill—with the possible exception of emergency services. Some risk plans will allow an option in which the plan permits participants to receive certain services outside the plan’s established provider network and the plan will pay a percentage of the charges. In return for such flexibility, participants must pay a portion of the costs—generally around 20%.

Plans with cost contracts do not have lock-in requirements. Plan participants can go to health providers affiliated with the plan or go outside the plan. If they go outside the plan, the plan will not pay but Medicare will. Medicare will pay its share of charges it approves. Participants are responsible for Medicare’s coinsurance, deductible and other charges, just as if they were receiving care under the fee-for-service system.

Medical savings accounts (MSAs) are tax-free bank accounts that hold money earmarked for health care. Under Medicare+Choice, the government has created Medicare medical savings accounts on a limited demonstration basis. These Medicare MSAs offer two sources of coverage for health care expenses:

- The account itself
- A high deductible (maximum $6,000) insurance policy that backs up the account

Here’s how it works. The account is funded by an annual contribution by Medicare minus the amount Medicare pays monthly toward the MSA’s insurance premiums. Account funds are available on a tax-free basis—but only for qualified medical expenses. If the high deductible of the insurance policy is reached, the policy covers 100% of allowed charges for Medicare-approved care plus Medicare deductibles and coinsurance. Note that the money in the account may not equal the high deductible and that the account holder may have to pay medical expenses above those provided for by the account until the deductible is reached. On the other hand, any money left in the account at the end of a year can either be kept by the account holder and used for any purpose or rolled over to an MSA in the following year.

**MEDICARE AND EMPLOYER COVERAGE**

Many individuals continue working beyond the age of 65 or have spouses who are working. In such cases, Medicare beneficiaries may be covered by their own or their spouse’s employer group health plan. When this occurs, Medicare may be the secondary payer to any group health plan provided by an employer with 20 or more employees. This means that the group health plan pays first
on hospital and medical bills. If the plan does not pay all of the expenses incurred, then Medicare may pay secondary benefits for Medicare-covered services to supplement the amount paid by the group health plan.

Note that employers with 20 or more employees must offer the same health benefits to employees who are age 65 or older as well as to their spouses who are age 65 or older as they offer to younger employees and spouses. The older employee has the option of rejecting such group health coverage in which case Medicare becomes the primary payer for Medicare-covered health services.

Medicare may also be a secondary payer to employer-provided group health coverage for certain individuals under age 65 who are entitled to Medicare based on their disability. To be the primary payer, the group health plan must generally be that of an employer or employee organization that covers the employees of at least one employer with 100 or more employees. Such plans are known as large group health plans (LGHPs). An LGHP may not treat disabled employees differently from other employees because of their disability.

**Exercise**

A. Medicare supplement policies are also known as

( ) 1. Medicare policies.
( ) 2. Medigap policies.
( ) 3. Medicaid policies.
( ) 4. Medichoice policies.

B. Which of the following statements is **false** regarding Medicare supplement policies?

( ) 1. Once a Medicare supplement policy has been in force for three months, benefits may not be denied or limited on the basis of preexisting conditions.
( ) 2. Medicare supplement policies may not duplicate benefits provided by Medicare.
( ) 3. Losses resulting from sickness may not be treated differently from losses resulting from accidents.
( ) 4. Except for nonpayment of premium, coverage may not be terminated on a spouse solely because the insurer has reason to terminate coverage on an insured.

C. Which of the following benefits are not required in any Medicare supplement policy?

( ) 1. Skilled nursing care benefit that covers the Part A copayments for the 21st through the 100th day of skilled nursing facility care
( ) 2. Part A copayments for the 61st through the 90th day of hospitalization
( ) 3. Part B copayments on Medicare-approved charges for physician’s and medical services
( ) 4. All charges for 365 days of hospitalization after all Part A inpatient hospital and lifetime reserve days are used up

Answer:  
A. 2. Medigap policies; B. 1. Once a Medicare supplement policy has been in force for three months, benefits may not be denied or limited on the basis of preexisting conditions; C. 1. Skilled nursing care benefit that covers the Part A copayments for the 21st through the 100th day of skilled nursing facility care
Medicaid is a welfare health care program for indigent persons. It was established by the federal government but is administered by the states. The eligibility requirements for Medicaid vary somewhat state-by-state. Generally speaking, to be eligible for Medicaid, a person must either qualify for (1) Aid for Families with Dependent Children (also known as public assistance or welfare), or (2) Supplemental Security Income, an assistance program under Social Security for indigent persons who are age 65 or over, blind, or disabled. For those who do qualify, Medicaid covers most health care costs including hospital and doctor bills and nursing home care.

Financial Tests

Each state establishes its own limit on the income and financial resources that a Medicaid recipient may have and still qualify for Medicaid. The recipient must “spend down” or exhaust his or her income and resources to a minimal amount before Medicaid becomes available.

The recipient—an individual, a couple, or a family—is permitted to retain a small amount of monthly income plus certain assets (or what the law refers to as “resources”). The recipient is allowed to keep his or her home. Within important limits, the recipient may also be able to keep some personal property.

Spousal Impoverishment Rule

In the case of a married couple, suppose that only one spouse requires nursing home care. Without some relief in the law, the institutionalized spouse would have to impoverish the other spouse in order to qualify for Medicaid. But the law now provides that the spouse who is not institutionalized is permitted to keep a portion of the couple’s resources, as determined by state and federal guidelines.

The law also allows the noninstitutionalized spouse to retain some of the couple’s assets or to receive a transfer of assets from the institutionalized spouse, in order to bring his or her assets up to a specified minimum level that is adjusted annually.

If the institutionalized spouse has any resources remaining after making a transfer to the spouse, they are applied toward the nursing home bill. Medicaid then pays only the difference between the actual bill from the nursing home and the institutionalized spouse’s contribution toward that bill out of his or her own income and resources.

Medicare Cost Assistance

Medicaid is required by law to pay certain Medicare costs of indigent Medicare patients:

- Medicare deductibles
- Part B premium
- Medicare co-payments
- Part A premiums (when required)
SOCIAL SECURITY DISABILITY

The Social Security program in the United States provides death benefits, survivor benefits, retirement benefits and disability benefits, the last of which is a type of social health insurance. Social Security disability benefits are available to people who meet these requirements:

- Totally and permanently disabled for at least five months
- Expected to be disabled for 12 months or longer or the disability will end in death
- “Fully insured” and “disability insured” as defined under Social Security regulations

*Fully insured* means the individual has been credited with the appropriate number of quarters of coverage required by Social Security laws.

*Disability insured* means the individual is fully insured, has the required quarters of coverage, and meets the first two qualifications in the list above.

Based on these definitions, here are examples of two people who could qualify for Social Security disability benefits. Bill, who was totally and permanently disabled in an auto accident, is fully and disability insured. Mary, who was totally and permanently disabled for six months and is not expected to live.

On the other hand, here are examples of two people who do not qualify for Social Security benefits: Lionel is 50% disabled from a military wound. Iona is fully and disability insured and disabled, but she expects to return to work after a nine-month recuperation period.

Benefits available are equal to 100% of the individual's primary insurance amount (PIA), which is the amount the person would normally receive as a retirement benefit. After being entitled to disability benefits for two years, an individual may also receive Medicare benefits.

Social Security disability benefits are based on the level of a worker’s earnings up to the time of disability. However, they are not designed to replace the entire amount of a worker’s earnings. A worker’s average earnings are reduced by a formula to calculate his or her Primary Insurance Amount (PIA). Benefit amounts are based on the PIA as follows:

- A disabled worker receives a benefit equal to 100% of his or her PIA.
- A spouse caring for an unmarried child of the worker who is under age 16 or was disabled before age 22 also receives a benefit, equal to 50% of the worker’s PIA.
- Each unmarried child under age 18 (19 if in high school) or disabled before age 22 receives a benefit equal to 50% of the worker’s PIA.

The total dollar amount a family may receive is capped by a Maximum Family Benefit amount that is also based on the worker’s average earnings. If the total amount a family is eligible for would exceed the Maximum Family Benefit, the disabled worker receives the full amount he or she is eligible for, but dependents’ benefits are scaled back proportionately until the total amount equals the Maximum Family Benefit.
Social Security disability payments will generally continue as long as the recipient cannot engage in *any substantial gainful activity*. This is essentially the same as the any occupation definition discussed in a previous unit.

Suppose that Lavonia, formerly a professional dance instructor, was disabled for 34 months. At the end of that period she was well enough to work at a telephone answering service to pay her bills and fixed expenses. However, she will never again be able to teach dance. Even if Lavonia had qualified for Social Security disability payments previously, it is unlikely she will continue to qualify since she is able to engage in a substantial gainful activity. Whether or not she can resume her former occupation is not an issue in making this determination.

**TRICARE**

TRICARE is a regionally managed health care program for active duty and retired members of the military uniformed services and their families, as well as survivors who are not eligible for Medicare. Participants choose among three health care options: TRICARE Standard, a fee-for-service plan; TRICARE Extra, a preferred provider plan; and TRICARE Prime, for those who seek care at Military Treatment Facilities (MTFs).

**Exercise**

A. Which of the following individuals is **not** likely to be eligible for Medicaid?

   ( ) 1. Pam, a single mom who relies on Aid to Families with Dependent Children to help feed her family
   ( ) 2. Darrell, who has been unable to work since becoming blind two years ago
   ( ) 3. Carmen, who has not been able to work since losing both legs in an accident
   ( ) 4. Ginny, who is over 65 and working as a manager of a retail outlet

B. Fully insured and disability insured are defined by

   ( ) 1. state legislatures.
   ( ) 2. Social Security regulations.
   ( ) 3. individual insurers.
   ( ) 4. state Departments of Insurance.

C. Under Social Security disability benefits, a disabled worker receives a benefit equal to

   ( ) 1. his or her earnings at the time of the disability.
   ( ) 2. 66% of his or her earnings at the time of the disability.
   ( ) 3. his or her preferred insurance amount.
   ( ) 4. his or her primary insurance amount.

Answer:  A. 4. Ginny, who is over 65 and working as a manager of a retail outlet; B. 2. Social Security regulations; C. 4. his or her primary insurance amount
Types Of Benefits

All state Workers Compensation laws incorporate four categories of benefits:

- Disability (loss of income) benefits
- Medical benefits
- Survivor (death) benefits
- Rehabilitation benefits

Disability benefits compensate for loss of income or earning capacity suffered by an individual injured in his or her occupation. How and in what amounts benefits are paid depend upon the severity and permanency of the injury.

Payments may be made on a weekly basis, a lump-sum basis, or some combination. For example, an employee temporarily off work with a broken leg will probably receive a weekly payment based on a percentage of regular wages, subject to an upper limit.

On the other hand, an employee who suffers a permanent loss, such as amputation of a limb, will probably receive a flat lump-sum payment based on a predetermined schedule in the state’s Workers Compensation law.

Some state laws prescribe both methods of payment for permanent injuries. It is important to be aware of your own state’s Workers Compensation provisions.

Medical benefits compensate for the cost of medical treatment resulting from job-related injury. In most cases, Workers Compensation will pay for the full cost of this treatment.

Suppose an employee of Spaulding Mattress Manufacturers breaks a leg while on the job and is taken to a hospital to have it casted. The resulting hospital bills will be payable under Workers Compensation medical benefits since the employee was injured on the job.

If this same employee had broken a leg in an accident while driving home from work, Workers Compensation medical benefits would not apply because the injury was not job-related.

Survivor benefits attempt to compensate the widowed spouse or other survivor of an employee whose death results from a job-related injury. The amount of the benefit depends upon:

- The deceased’s earnings, subject to fixed minimums and maximums, and
- The number of surviving dependents

A fixed amount is also available for burial expenses. Benefits normally extend until the spouse remarries or until the children become adults.
NOTES

Rehabilitation benefits are not specifically named in some state Workers Compensation acts. However, rehabilitation is provided in every state, since all states accept the provisions of the Federal Vocational Rehabilitation Act, which provides federal aid toward the costs incurred.

Diligent rehabilitation and determination on the part of the disabled employee can make the difference between a partial disability and a total one. Rehabilitation for gainful employment serves to reduce insurance losses while restoring the injured worker's dignity. Therefore, rehabilitation is considered worthy of federal help.

Compensable Injuries

In order to be considered compensable as interpreted in Workers Compensation law, an injury must meet three basic criteria:

- It must be accidental.
- It must arise out of the individual's employment.
- It must arise in the course of the individual's employment.

Accidental means that the injury was not intended to happen as far as the injured person is concerned. For example, injury resulting from falling from a loading dock would meet the criteria, while injury resulting from deliberately jumping from the loading dock would not.

The second requirement for a compensable injury is that it must arise out of employment. This means the employment must be the source of the accident. If Bud is a welder and is injured welding on the job, the injury is compensable—provided the third criterion is also met.

The third criterion is that the injury must arise in the course of employment. The time, place, and circumstances of the accident are important in determining whether it results from the employment or not. If Bud from the previous paragraph were injured while welding at his place of employment, but the injury occurred after hours while Bud was welding for his personal use, the injury would not be compensable.

Occupational Diseases

In order to be classified as an occupational disease under a Workers Compensation law, the disease must meet these requirements:

- Arise out of employment and
- Be due to causes or conditions characteristic of and peculiar to the particular trade, occupation, process or employment

The requirement of peculiarity to a particular employment means Workers Compensation coverage does not apply for any ordinary diseases to which the general public is exposed.

It is possible that an employee might contract a disease that arises out of and in the course of employment but is not an occupational disease. Consider a heart attack, ulcers, or even alcoholism. These are not deemed occupational
diseases, yet employment could have played a part in inducing any of them. States treat this type of situation differently; some states may award compensation and others may not.

If a chemical engineer develops a throat disease due to working with toxic materials in his employer's laboratory, this would likely qualify as an occupational disease. However, if a school teacher develops bronchitis in the classroom, this probably is not an occupational disease, even if the teacher was exposed to students with bronchitis, since bronchitis is a condition to which the general public is exposed.

All states mandate coverage for most occupational diseases as part of the Workers Compensation system. In most states, occupational diseases are eligible for the same compensation that applies to occupational injuries.

Types Of Disability

Four types of disability are defined under Workers Compensation law:

- Permanent total
- Permanent partial
- Temporary total
- Temporary partial

The difference between permanent and temporary is as simple as it appears—it will last forever or it will not last forever.

The difference between total and partial depends upon the disabled person's ability to work. If a worker is disabled to the extent that he or she cannot perform any job, this is considered a total disability.

On the other hand, if a worker is disabled but able to perform some job (even if it is not the same as the previous employment), then this is considered to be a partial disability. You'll recognize the parallels between these definitions and those of "own occupation" and "any occupation" discussed in the unit covering disability income insurance.

Now let's look individually at each of the four types.

A permanent total disability usually results in a complete and permanent loss of earning power, with no ability to perform gainful employment. Many state compensation laws specify that certain injuries, such as total loss of sight, loss of both hands or both feet, constitute permanent total disability regardless of the insured's ability to do some type of work.

Tanika, a research physicist, permanently loses her eyesight when a batch of chemicals in the laboratory explodes in her face. She suffers a permanent total disability.

A permanent partial disability usually refers to a permanent physical impairment that leaves the individual incapable of performing the previous regular job, yet results in only partial loss of earning power since other jobs may be performed. In other words, the employee may be able to perform some other type of work.
Simon, a machinist, severs his leg when it is caught in a machine. Simon can no longer perform his former job, but he has had experience as a dispatcher and has been transferred to that position within his company. This is a permanent partial disability.

A temporary total disability usually refers to a total disability that lasts a short period, after which the employee is fully able to return to work. For example, Andre strains his back while lifting heavy boxes at work. He is in traction and off work for five months before he is able to resume his former job.

A temporary partial disability usually refers to a temporary disablement which allows the employee to continue the same job, but with a diminished capability. Francesca, who is a photographer/artist, twists her ankle and is unable to shoot on location. However, she can complete a graphic illustration for her client, so she is only partially disabled and will be only temporarily disabled until her ankle heals.

Compulsory And Elective Compensation Laws

State Workers Compensation laws are either compulsory or elective, with the majority being compulsory. This means the employer must accept and comply with all the provisions of the law.

If the state law is elective, however, the employer and employee both have the option of accepting or rejecting the law.

Some state Workers Compensation laws are deemed compulsory for specific types of work, and elective for still other types. However, if an employer chooses not to be subject to a state's elective Workers Compensation law, the employer is denied any rights provided under its law, and loses use of most pro-employer law defenses as well.

In compulsory states, employers with fewer employees than a minimum established by law do not have to purchase compensation coverage. Most states do allow the employer to voluntarily provide protection by electing to be subject to the law. Once an employer volunteers, then the state Workers Compensation law applies as if it were mandatory.

In states where the Workers Compensation law is elective, the option is usually available only to private employers, since public (governmental) employers are required to provide compensation benefits to their employees.

Both compulsory and elective states often exclude two classifications of employees from required coverage:

- Farm workers
- Domestic servants

The direction of changes to Workers Compensation law is to require coverage for farm workers. Presently, slightly more than 70% of the jurisdictions cover agricultural workers to greater or lesser extent. Fewer jurisdictions require domestic employees to be covered. In both cases, where coverage is required, the details of the law vary widely by jurisdiction.
Extraterritorial Provisions

Most state Workers Compensation laws contain an extraterritorial provision. This means that a worker who is employed in a particular state is covered under that state’s Workers Compensation law, even while temporarily working in another state.

For example, Earl is employed by Stockhausen Sporting Goods Manufacturing Company in a state where the Workers Compensation law includes an extraterritorial provision. If Earl travels to Texas for a Sporting Goods Distributors convention and injures his back while working at the convention, he is entitled to Workers Compensation benefits under the laws of his own state.

While most states have extraterritorial provisions, there is a distinct lack of uniformity among them. This results from the fact that each state law is different and is written broadly in order to protect all types of workers within the state.

Second Injury Funds

Second injury funds have been established in almost every state to promote the hiring of previously injured or physically handicapped workers. These funds provide that if a handicapped employee is injured a second time, the employer will be charged only for the loss accrued by that specific second injury, not for the total disability. The employee will collect total disability benefits as the law provides, the difference being paid out of the second injury fund.

The financing of second injury funds differs among the states. Some states directly assess all of the insurance companies writing Workers Compensation insurance in the state. Others insist that the insurance companies make a special contribution to the second injury fund whenever certain claims are processed. These funds serve to spread the cost of benefits among the insurers, encouraging the employment of handicapped persons.

REVIEW

1. Carla is 67 and eligible for Social Security and Medicare. When she comes out of retirement to work at a large corporation which provides health benefits
   ( ) A. her private benefits become secondary to Medicare benefits.
   ( ) B. her Medicare benefits become secondary to her private benefits.
   ( ) C. the employer is not required to offer her private benefits.
   ( ) D. she will cease to be eligible for Medicare benefits.

2. Medicare is administered by the
   ( ) A. Social Security Administration.
   ( ) B. individual state governments.
   ( ) C. Health Care Financing Administration.
   ( ) D. Health Care Focus Association.
3. Medicare Part A covers all of the following except
   ( ) A. charges for a private room.
   ( ) B. skilled nursing facility care.
   ( ) C. home health care.
   ( ) D. hospice care.

4. For each benefit period, Medicare will pay the full cost of up to
   ( ) A. 30 days of hospital care.
   ( ) B. 60 days of hospital care.
   ( ) C. 90 days of hospital care.
   ( ) D. 365 days of hospital care.

5. Medicare will pay the entire cost for skilled nursing facility care for the first
   ( ) A. 20 days.
   ( ) B. 80 days.
   ( ) C. 100 days.
   ( ) D. 0 days.

6. Individuals who are eligible for Social Security benefits become eligible for Medicare Part A benefits as of
   ( ) A. the day they become eligible for Social Security benefits.
   ( ) B. the first day of the month they become eligible for Social Security benefits.
   ( ) C. the day they turn 65.
   ( ) D. the first day of the month they turn 65.

7. Medicare Part A provides coverage for all of the following kinds of care except:
   ( ) A. private duty nursing.
   ( ) B. skilled nursing facility care.
   ( ) C. home health care.
   ( ) D. hospice care.

8. Medicare Part B provides coverage for all of the following kinds of care except:
   ( ) A. skilled nursing facility care not covered by Part A.
   ( ) B. doctor's services.
   ( ) C. home health care not covered by Part A.
   ( ) D. outpatient medical services and supplies.

9. Which of the following Medicare supplement plans covers the Part A and Part B deductible?
   ( ) A. B
   ( ) B. C
   ( ) C. D
   ( ) D. E
10. Which of the following Medicare supplement plans covers the Part B excess at 80%?
   ( ) A. E
   ( ) B. F
   ( ) C. G
   ( ) D. H

11. Which of the following statements about Medicare Supplement plans is false?
   ( ) A. Benefits must automatically change to coincide with changes in Medicare deductibles and co-payments.
   ( ) B. Losses resulting from sickness may not be treated differently than losses resulting from accidents.
   ( ) C. The definition of “accident” may employ an accidental means test.
   ( ) D. Policies must be at least guaranteed renewable.

12. In order to be compensable as interpreted in Workers Compensation law, an injury must meet all of the following criteria except
   ( ) A. it must be accidental.
   ( ) B. it must arise out of the individual’s employment.
   ( ) C. it must arise in the course of the individual’s employment.
   ( ) D. it must be unforeseeable.

13. Juanita is employed in California. She takes a business trip to Colorado to demonstrate some techniques to workers in another facility, and is injured in the process. Her worker’s compensation benefits will be paid according to the laws of
   ( ) A. California.
   ( ) B. Colorado.
   ( ) C. whichever state would provide the greater benefit.
   ( ) D. whichever state would provide the lesser benefit.

Answers:
1. B. her Medicare benefits become secondary to her private benefits.
2. C. Health Care Financing Administration.
3. A. charges for a private room.
4. B. 60 days of hospital care.
5. A. 20 days.
6. D. the first day of the month they turn 65.
7. A. private duty nursing.
8. A. skilled nursing facility care not covered by Part A.
9. B. C
10. C. G
11. C. The definition of “accident” may employ an accidental means test.
12. D. it must be unforeseeable.
13. A. California.
UNIT 9

LONG-TERM CARE

LEARNING OBJECTIVES

After completing Unit 9—Long-Term Care, you will be able to:

1. Explain the purpose of long-term care insurance.
2. Describe candidates for whom LTC insurance would be a suitable purchase.
3. Explain the likelihood of an individual needing long-term care.
4. List and describe options other than LTC insurance for taking care of long-term care costs, and explain the drawbacks to each.
5. Explain who is eligible for LTC insurance.
6. Explain how premiums for LTC insurance are set, and the rating factors that affect them.
7. List and describe the different care levels covered under LTC policies.
8. Explain how benefit amounts are generally defined in an LTC policy.
9. Explain other provisions that affect LTC policies, including waiver or premium, benefit periods, preexisting conditions, and elimination periods.
10. Define Activities of Daily Living, and explain how they affect LTC policies.
11. Describe the standards required of qualified LTC plans.
LONG-TERM CARE

Better and better medical care means many individuals are living into their 80s, 90s, and beyond. Unfortunately, although life expectancy has increased, many older individuals have serious health problems that keep them from living on their own or completely caring for themselves. Long-term care pays for the kind of care needed by individuals who have chronic illnesses or disabilities. It often covers the cost of nursing home care, and also provides coverage for home-based care—visiting nurses, chore services, and respite care for daily caregivers who need time away from these difficult duties. Such coverage becomes important when one considers the annual cost for nursing home confinement can reach $40,000.

Many people believe Medicare or Medicare supplement policies will pay for this care if they need it. Medicare will cover nursing home care if it is part of the treatment for a covered injury or illness, but care needed because of aging is not covered by Medicare or Medicare supplements. Medicare and supplementary insurance pay for skilled nursing care, but the coverage is extremely limited (the care must immediately follow a period of hospital confinement, and no benefits are provided after the 100th day). Medicaid does pay for nursing home care, but provides coverage only for needy families. Sadly, many people must pay for their own nursing home care, and eventually turn to Medicaid when their life savings are gone.

HISTORY OF LTC COVERAGE

The earliest long-term care (LTC) policies were relatively more restrictive than the current generation of plans, often requiring prior hospitalization and a level of service greater than mere custodial care. Many covered care in a nursing facility only, rather than also providing coverage for services in the home of the individual or in an adult day care center. Most excluded Alzheimer’s and dementia—two common illnesses of the elderly, and the reason many older persons require such care.

Some long-term care policies were so closely tied to Medicare’s restrictions that they paid little that Medicare did not already pay. During the early development period, policies often had so many restrictions that few insureds qualified for payment of benefits.
LTC policies are still evolving. However, with attention to the problem of long-term care firmly focused, legislators and the insurance industry have begun to come to grips with the far-reaching ramifications of health services for an older population. With the federal government responding to consumer interests in long-term care coverages, the National Association of Insurance Commissioners (NAIC) developed a model to help state legislatures in an effort to keep regulation on a state level. More than half of the states currently use the NAIC or a similar model. Key issues include:

- A benefit period of at least one year
- Strict restrictions on cancellation, specifically prohibiting cancellation due to the insured’s aging; most policies now guarantee renewability
- Standards for covering preexisting conditions
- A free-look period
- Prohibition of exclusions for Alzheimer’s disease

Another factor in the evolution and increasing availability of LTC policies is that consumers, too, are more aware that:

- Medicare does not cover long-term care (much to the surprise of most of the population, who at one time believed Medicare did cover most nursing home care).
- One in four people are likely to spend at least some time in a nursing home after age 65, increasing to about a third if they live to age 85.
- The average cost for nursing home confinement is currently about $3,300 per month and can be as high as $5,000 per month, depending on location and level of care. These costs that are likely to continue growing.

The increased knowledgeability of insurance buyers has played a part in the development and refinement of LTC policies. In addition, law changes have clarified the tax status of long-term care policies which are now treated like accident and health policies taxwise. Proceeds of qualified long-term care policies are generally received income tax-free and premiums may be deductible as a medical expense, within certain limitations. Federal law now determines what constitutes a “qualified” long-term care policy eligible for these tax advantages. The law spells out when benefits must be paid and what options must be offered to prospects for long-term care insurance.

Note, however, that insurers are not required to offer and consumers are not required to purchase qualified long-term care policies. Nonqualified policies may offer benefits that are more attractive or easier to obtain than qualified policies and may be more desirable to certain consumers even if the nonqualified policies do not offer the tax advantages of qualified policies.

**SUITABLE PURCHASERS**

LTC insurance enables the senior citizen to maintain his or her independence. With adequate coverage, the individual does not have to rely on friends or family to provide custodial needs or necessary funds to help defray the costs of a nursing home stay.
Protection of personal assets may well be the most important reason for purchasing LTC insurance. Possibly, the question isn’t “Can I afford to buy LTC insurance?,” but rather, “Can I afford not to purchase LTC insurance?”

When an individual has substantial financial assets (and retirement income), the possibility that LTC expenses could mean a significant reduction in the person's assets and standard of living is a real threat. Thus, the purchase of LTC insurance to protect one's personal financial resources may well be a wise financial decision.

Paying periodic premiums is a more efficient and manageable way to provide for future LTC costs than having to rely on personal savings. LTC insurance provides that a person's financial resources need not be liquidated either to pay for nursing home expenses or to “spend down” to satisfy Medicaid eligibility.

For example, an individual with no dependents and few financial responsibilities may not have a very big need for life insurance. Likewise, a person without substantial assets at risk may have little need to purchase LTC insurance.

If a senior citizen’s sole source of income is a relatively small pension and his or her financial assets are very minimal, then this person may already be “eligible” for Medicaid reimbursement of LTC expenses. Also, because of the individual’s low income and limited financial resources, LTC insurance premiums may be unaffordable.

**Example:** Joe and Irene Brown are both 67 years old. Their only source of income is Social Security and a small pension ($200 monthly). They rent an apartment in a senior citizen complex, have a very small amount of life insurance (enough for burial) and usually maintain a savings account balance of no more than $1,000. They have no other assets other than personal possessions and an automobile. Are Mr. and Mrs. Brown prospects for LTC insurance? Probably not. First of all, it’s doubtful that they could afford the premiums based on their relatively small retirement income. Secondly, they have no assets of any consequence to protect. They do not own a home, a large savings account or have other investments. In essence, they probably are already eligible for Medicaid benefits should they be forced into a nursing home.

**PROBABILITY OF NEEDING CARE**

In 1980, there were 25 million Americans 65 and older. It is estimated that by the turn of the century, the over 65 population will exceed 35 million, and by the year 2030 there will be more than 64 million Americans age 65 and over.

In addition, life expectancy is increasing in the United States. In 1980, life expectancy for males, 65 years old, was about 78, and for females, 81. It is estimated that by the year 2000, life expectancy for males will be age 81 and 86 for females. These retirees will face a greater potential need for long term medical care, simply due to longer life expectancy.
At age 65, the likelihood of a nursing home confinement is about 1 in 3. The odds increase as age increases. An individual 75 years of age has a 2 to 1 chance of confinement in a nursing home. In 1990, there were approximately 7 million Americans, 65 or older, who needed long-term care. This figure is expected to increase to more than 9 million by the year 2000 and will exceed 20 million by 2050.

**OPTIONS OTHER THAN INSURANCE**

What are the available options for the senior citizen facing a stay in a nursing home? Following are some of the alternatives:

- Using personal assets
- Dependency on relatives
- Dependency on government programs

Dependency on friends and relatives for custodial type care may not be practical due to changing socioeconomic trends in today's society. Today's family is no longer a cohesive unit but rather a fragmented group whereby family members live great distances from each other.

The Medicare program is not designed to provide custodial care. It will cover a limited amount of rehabilitative care in a skilled nursing facility approved by Medicare. Since Medicare will only pay for rehabilitative services, it requires prior hospitalization before admission to the skilled nursing facility. Another avenue is Medicaid, which requires the individual to prove financial need. This normally requires that the individual “gets rid of” financial resources and “spends down” to a poverty level to obtain Medicaid eligibility. The Health Care Financing Administration reports that about one-half of all Medicaid spending goes to people who had financial resources when they entered a nursing home but reached the poverty level while in the nursing home.

**RATING FACTORS**

One way LTC policies differ from other health plans concerns how risks are rated. Whereas people afflicted with heart disease or diabetes, for example, would be rated as substandard risks under most health insurance plans, LTC policies, because of their focus on aging people, use a different means of classification. The key for LTC policies is whether or not an individual can perform the *activities of daily living (ADLs)*, and if so, with what degree of proficiency. ADLs include such things as dressing, bathing, eating, walking, and similar activities to care for oneself. Thus, an individual who has a heart disease, but is still able to perform ADLs, is a standard risk under LTC policies.

For example, Corey, who is age 60, has had several strokes during the past five years but is completely capable of performing the activities of daily living. Under a major medical policy, it is likely that Corey would be classed as a substandard risk. But under an LTC policy, Corey would be classified as a standard risk.
TYPES OF BENEFITS

Three terms regarding the type of long-term care an individual requires are important to understand in order to determine what an LTC policy covers.

- **Skilled nursing care** is nursing and rehabilitative care that is required daily and can be performed only by skilled medical practitioners on a doctor's orders.
- **Intermediate care** is nursing and rehabilitative care that is required occasionally and can be performed only by skilled medical practitioners on a doctor's orders.
- **Custodial or residential care** is help in performing ADLs and can be performed by someone without medical skills or training, but still must be based on a doctor's orders.

Of these, *custodial or residential care* is the type most elderly people will require at some time in their later years, and is also the type that is not covered by Medicare.

Other important terms are:

- **Home health care**, which refers to services performed from time to time in the individual's home. It may include skilled nursing, various types of therapy, help with ADLs, and help with housework.
- **Adult day care** provides company, supervision, social, and recreational support during the day for people who live at home and need assistance. This service is especially useful for those who are being cared for by relatives who work during the day.

**Exercise**

A. Nursing home care is generally covered by

   ( ) 1. Medicare.
   ( ) 2. Medicare supplements.
   ( ) 3. Long-term care policies.
   ( ) 4. All of the above.

B. Which of the following individuals would be least likely to be a good candidate for a LTC policy?

   ( ) 1. George, whose law practice has allowed him to fund a generous retirement fund for himself and his wife
   ( ) 2. Nina, a single mother whose financial struggles raising her children have left her with few assets and no independent retirement savings
   ( ) 3. Carla, whose 25 years of civil service have provided a generous retirement, but who worries about the legacy she will leave her children
   ( ) 4. Darrell, whose inherited estate runs has provided him with over $6 million in net worth
C. An individual 75 years of age or older has this chance of being confined to a nursing home?

( ) 1. 25% chance
( ) 2. 50% chance
( ) 3. 75% chance
( ) 4. 90% chance

Answer: A. 3. Long-term care policies; B. 2. Nina, a single mother whose financial struggles raising her children have left her with few assets and no independent retirement savings; C. 2. 50% chance

COMMON PROVISIONS

Now that you understand some of the terms and concepts involved in long-term care policies, let’s look at provisions that are commonly included in these coverages. You might also want to glance back at the NAIC model requirements for comparison purposes.

Currently, most LTC policies include provisions or options to include those described in the following paragraphs.

Eligibility

Youngest and oldest ages at which LTC policies may be purchased. Most minimum ages are in the 50–60 years range, but more recent policies may include a much lower minimum age, including some as low as age 18. Upper age limits at which policies may be purchased range from age 69 to 89.

Renewability

Virtually all of the current generation of LTC policies are guaranteed renewable and cannot be cancelled except for nonpayment of premium. The insurer cannot cancel the policy but does reserve the right to increase premiums in accordance with the policy provisions. If the premiums are to be increased, they will be changed on the policy anniversary and the increased premium will be for an entire class of insureds, not just a single individual.

Some LTC policies are noncancellable, which means the insured has the right to continue the coverage by timely payment of premiums, and the insurer has no right to make any change in policy provisions, cannot decline to renew, and cannot change the premium rate at renewal for any reason.

Premiums

Similar to life insurance, premiums are generally based on when an individual purchases this insurance. The younger the individual is at the time of purchase, the lower the premium. In addition, premiums will fluctuate according to the elimination and benefit periods selected—the longer the elimination period, the lower the premium; the longer the benefit period, the higher the premium. Finally, premium variations may result from underwriting considerations. Underwriters consider risk factors, including an applicant’s current ability to perform activities or daily living (ADLs). The premium will be higher if an applicant needs assistance with an ADL at the time of application than it would if the applicant did not need such assistance.
**Waiver Of Premium**

Nearly all LTC policies include a waiver of premium provision that takes effect after the insured has been confined for a specified period of time. Ninety days is the usual period, but it is as long as 180 days in some policies. A few policies have no such provision, which means the insured will be required to continue premium payments no matter how long he or she is receiving care. When waiver of premium applies, premium payment generally resumes when the care ceases.

**Prior Hospitalization**

Formerly, most nursing home policies required a hospital stay prior to confinement to a nursing home in order for benefits to be paid. This is no longer the case.

**Care Level**

This refers to whether the policy pays only if skilled nursing, intermediate, or custodial care, as specified in the policy, is required at the time the individual enters the nursing home. This is extremely important, since some policies pay only if intermediate or skilled care is involved, whereas custodial care, which is the most common type required by elders, may not be included. The best policies are those that will pay regardless of the level of care.

**Hospice Care**

Hospice care is often offered as an optional benefit under LTC policies. The primary focus of hospice care is pain control, comfort and counseling for the terminally ill patient and the patient’s family. A hospice is simply a facility whose purpose is to help terminally ill patients die with dignity and with as little suffering as possible. Typically, the expenses incurred in a hospice will be room and board and medication for pain.

**Respite Care**

Respite care is normally associated with hospice care. With this benefit, the patient is admitted to a nursing home for needed care for a short period of time, or the LTC policy will cover the cost of replacing for a short period (a day or weekend perhaps) the primary care giver, usually a family member, who is looking after an elderly person in the home.

**Home Health Care**

Most LTC policies now cover home health care as an alternative to nursing home care. Home health care is provided in the individual’s home and must begin within a prescribed period of time following a nursing home stay. Usually, the home health care benefit under the policy will be 60% of the regular daily nursing home benefit. Home health care is an extension of intermediate custodial care. The patient is in need of some health care, but is able to generally function without the need to be confined to a nursing home. Home health care might include physical therapy and some custodial care, such as meal preparations.
Unit 9—Long-Term Care

**NOTES**

**Adult Day Care**

LTC policies also increasingly make provision for adult day care to allow the primary care giver who works the opportunity to tend to his or her employment responsibilities. The day care may be provided in the home or in an adult day care facility. Adult day care is basically social and health care services for functionally impaired adults. This benefit provides reimbursement for expenses pertaining to an adult day care center such as a neighborhood recreational center, a community center, etc. Typically adult day care includes transportation to and from a day care center, and a variety of health, social, and related activities. This care usually also includes meals and certain medical services. Specialized care for Alzheimers victims is usually included in adult day care benefits.

**Professional Care Advisor**

Coverage may be provided for the services of a care coordinator to help design the most appropriate plan of treatment.

**Benefit Amount**

The prospective insured may be offered a choice of the maximum daily benefit amount for a nursing home stay or covered home health care. Naturally, higher daily benefits mean higher annual premiums.

Most LTC policies provide a daily benefit during confinement. Traditionally, this benefit has been provided as a maximum daily amount (reimbursement for charges up to the stated limit, but not more than the daily limit). Benefit amounts range from $50 per day up to $150 or $200 per day. However, some insurers provide coverage on an expense incurred basis (full reimbursement for the actual charges incurred). The maximum policy benefit may be calculated by multiplying the daily benefit by the number of days in the benefit period.

To illustrate these points, let's use the example of Kim who has a LTC policy with a 30-day elimination period, a daily benefit of $75 per day and a two-year benefit period. Her maximum policy benefit would be $54,750 ($75 a day times 730 days). If Kim is confined to a nursing home for a total of seven months, her benefit calculation would be as follows:

- First 30 days: No benefit paid (elimination period)
- Next six months: $75 per day (assumes 30-day month)
- $75 x 180 = $13,500

If Kim's actual charges were more than $75 per day, the additional amount would have to be paid by her.

Most policies specify the dollar amount per day that will be paid for skilled nursing care. Some policies may include sublimits for special types of care or services (such as home health care or adult day care). The benefit for home health care or adult day care is usually a fixed percentage of the specified daily benefit, usually 50%. In addition, there may be a deductible amount that must be satisfied before the policy begins to pay.
Benefit Periods

LTC policies vary as to the maximum period for which benefits will be paid, usually from three to five years. Some policies offer unlimited benefit periods. Some policies may contain both a benefit period per stay plus a lifetime maximum benefit period. The benefit period may also end when a maximum amount has been paid out.

Exclusions

Each policy should be read carefully to determine what is excluded. A major stride in current policies is that most now cover Alzheimer's disease and organic-based mental illness, both of which formerly were often excluded. However, some exclusions remain. Among these are war and acts of war, alcohol or drug dependency, self-inflicted injuries, mental illness and nervous disorders without a demonstrable organic cause and treatment provided without cost to the insured (such as that received in a veteran's hospital).

Preexisting Conditions

Most—but not all—LTC policies do not cover conditions that existed during the six months before the policy effective date. A few policies have no such exclusion.

Elimination Period

Similar to a disability income policy, no LTC benefits will be paid until the elimination period is satisfied. Most long-term care policies provide for a period of time, usually expressed in days or months, at the beginning of a confinement in a long-term care facility, during which no benefits are payable. The elimination period could be defined as a “time deductible.” The elimination period could be 30 days or longer. Thus, after the insured is confined to a nursing home for a period of 30 days, LTC benefits would begin.

The longer the waiting period, the lower the premium, all other facts being equal. The waiting period can be viewed as the “deductible” in an LTC policy.

BENEFIT TRIGGERS

Activities of Daily Living (ADLs)

ADLs are functions or activities which are performed by individuals without assistance, thus allowing personal independence in everyday living. These functions are used as measurement standards to determine the level of personal functioning capacity. Examples of ADLs would include:

- Mobility (or Transferring)—the ability to walk
- Dressing—being able to adequately clothe one's self
- Personal Hygiene—being able to go to and from the toilet, and remain continent
- Eating—being able to take in food
- Bathing
An individual who can not accommodate these needs will need some type of care.

Some LTC policies base eligibility for nursing home benefits on the inability to perform some of the activities of daily living in lieu of sickness or injury. These contracts do not require prior hospitalization nor that the insured be admitted to a nursing facility as a result of sickness or injury. Federal standards which determine whether an LTC policy is “tax qualified” also base eligibility on ADLs.

**Cognitive Impairment**

This means a deficiency in the ability to think, perceive, reason or remember which results in the inability of individuals to take care of themselves without the assistance or supervision of another person. LTC policies may base eligibility for nursing home benefits on cognitive impairment.

**Medical Necessity**

An LTC policy by definition provides coverage only for *medically necessary* diagnostic, therapeutic, rehabilitative, maintenance or personal care services.

**QUALIFIED PLANS**

A qualified long-term care policy must stipulate that the insured be incapable of performing at least two of the ADLs without assistance for at least 90 days in order to qualify for benefits. The cognitively impaired must require substantial supervision. A physician must certify that the insured is chronically ill and provide a plan of care. A long-term care policy will not be “qualified” if it does not conform to these standards.

Remember, however, that *nonqualified* long-term care policies do not have to conform to these federal standards. A nonqualified policy, for example, might require that the insured need assistance with only one ADL with no stipulated time period in order to be eligible for policy benefits. The prospective insured’s concern over qualification for benefits must be weighed against tax consequences when considering qualified vs. nonqualified long-term care policies.

**REGULATION**

Just as with Medicare supplement insurance, long-term care policies are heavily regulated by the state Insurance Departments. States frequently regulate minimum standards, renewability, the insured’s right to return the policy, replacement, marketing standards, and the appropriateness of recommending the purchase of LTC insurance. As with Medicare supplement insurance, frequently the delivery of a buyers guide and outline of coverage is mandatory.

Federal law allows the sale of long-term care coverage that “substantially” duplicates that provided under Medicare or Medicaid (but not multiple policies) to Medicare beneficiaries, provided the company discloses the duplication and the policy pays without regard to other benefits.
EMERGING LTC ISSUES

Long term care insurance is still in an evolutionary state. There are literally hundreds of individual contracts, which have not been standardized like Medicare supplement policies. Some emerging issues in the LTC field include inflation protection and nonforfeiture provisions. New federal standards which determine whether an LTC policy is tax qualified require consumer protections such as the offer of inflation protection and nonforfeiture provisions, as well as imposing additional disclosure requirements.

Inflation Protection

Many states require that insurers offer optional inflation protection at the time of policy purchase. The feature must either increase benefit levels annually or cover a specific percentage of actual or reasonable charges, or allow the insured to periodically increase benefit levels without needing to provide evidence of continued insurability.

Nonforfeiture Provisions

These protect the policyholder from forfeiting all policy values or benefits when the policyowner stops paying premiums and lapses the policy for any reason. Standard nonforfeiture options may include cash surrender value (a lump sum payable upon policy surrender), reduced paid up insurance (a reduced daily benefit payable for the policy’s benefit period with no further premium payments required), or extended term insurance (a limited extension of coverage for the full amount of policy benefits, without further premium payments required). Nonforfeiture provisions are not commonly included in LTC policies but are beginning to appear in some contracts.

MARKETING LTC COVERAGE

In addition to individual LTC policies, a growing number of insurers offer group LTC plans with provisions similar to those mentioned previously. Still a third marketing device involves attaching an LTC rider to a life insurance policy called an “accelerated benefits rider” or a “living benefits rider.”

Accelerated benefits may be available to insureds who are chronically ill and need money for long-term care. Such riders are subject to the same rules as individual long-term care policies, especially with respect to benefit triggers. They may also be designed to cover home health care as well as nursing home care. Adding an accelerated benefits rider to a life policy costs money in the form of additional premium.

How much may be paid by such a rider varies from policy to policy. Some limit benefits to 50 percent or 75 percent of the policy’s face value. Others place an absolute ceiling on the amount paid out, say $250,000. All, however, take into consideration any outstanding loans against the policy. Payments are ordinarily made to the insured on some kind of periodic basis. Naturally, any accelerated benefits paid out are subtracted from the death benefit paid to the beneficiary when the insured dies.
1. Early long-term care policies were
   ( ) A. more restrictive than current policies.
   ( ) B. less restrictive than current policies.
   ( ) C. the same as current policies.
   ( ) D. prohibited by law.

2. Which of the following individuals is most likely to be rated a substandard risk under a LTC policy?
   ( ) A. Gerald, who lives alone and has no trouble taking care of himself, but who has been diagnosed with an inoperable brain aneurism that, if it bursts, would almost certainly kill him immediately
   ( ) B. Ken, who is on medication to bring down his blood pressure, but who gets around and takes care of himself easily
   ( ) C. Brenda, whose diabetes is under control
   ( ) D. Garrison, who has been diagnosed with early-stage Alzheimer’s disease

3. Which of the following is the type of care most people will require at some time during their later years?
   ( ) A. Inpatient hospital care
   ( ) B. Skilled nursing care
   ( ) C. Custodial care
   ( ) D. Intermediate care

4. Virtually all of the current LTC policies are guaranteed renewable. This means that
   ( ) A. the insurer cannot cancel the policy but does reserve the right to increase policy premiums on specified classes of policies.
   ( ) B. the insurer cannot cancel the policy but does reserve the right to increase policy premiums on individual policies.
   ( ) C. the insurer cannot cancel the policy or increase policy premiums on specified classes of policies.
   ( ) D. the insurer cannot cancel the policy or increase policy premiums on individual policies.

5. When waiver of premium applies
   ( ) A. the premium is waived immediately upon disability.
   ( ) B. the premium payment is suspended permanently once it is invoked.
   ( ) C. the premium payment generally resumes when care ceases.
   ( ) D. the premium payment is only waived if disability is considered permanent and total.

6. Typically, the expenses incurred in a hospice will be
   ( ) A. surgical and room and board.
   ( ) B. room and board and physical therapy.
   ( ) C. surgical and physical therapy.
   ( ) D. room and board and medication for pain.
7. The elimination period may be thought of as
   ( ) A. a dollar amount deductible.
   ( ) B. a time deductible.
   ( ) C. a dollar amount copayment.
   ( ) D. a time copayment.

8. Which of the following is not considered an activity of daily living?
   ( ) A. Transferring
   ( ) B. Dressing
   ( ) C. Bathing
   ( ) D. Working

Answers:
1. A. more restrictive than current policies.
2. D. Garrison, who has been diagnosed with early-stage Alzheimer’s disease
3. C. Custodial care
4. A. the insurer cannot cancel the policy but does reserve the right to
   increase policy premiums on specified classes of policies.
5. C. the premium payment generally resumes when care ceases.
7. B. a time deductible.
8. D. Working
UNIT 10
HEALTH INSURANCE AND TAXATION

LEARNING OBJECTIVES

After completing Unit 10—Health Insurance and Taxes, you will be able to:

1. Explain how Social Security health benefits are funded.
2. Explain how the following types of health insurance is taxed, when premiums are deductible, and when the benefits are taxed.
3. Explain how MSAs work, and the tax implications of this type of policy.
4. Explain when and how disability insurance premiums and benefits are taxed.
5. Explain when and how Medicare supplement and long-term care insurance premiums and benefits are taxed.
HEALTH INSURANCE AND TAXATION

TAXATION AND GOVERNMENT HEALTH PROGRAMS

Medicare

As a government social program, Medicare is largely paid for by federal taxes as indicated here:

Medicare Funding

<table>
<thead>
<tr>
<th>Medicare Part A Hospital Insurance</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Primarily supported by</td>
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</tr>
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</table>

Social Security Disability Benefits

Social Security disability benefits are financed through a payroll tax. The tax rate is applied to an employee's gross wages (up to the current wage base) and an appropriate amount is deducted from the employee's wages each pay period. A like amount is contributed by the employer. Self-employeds must pay 100% of the combined employee/employer tax rate.

Tax Treatment Of Social Security Contributions

While employers may take a tax deduction for contributions on behalf of their employees as a routine and necessary cost of doing business, employees are not entitled to a deduction for their share of the Social Security tax. In other words, employee Social Security taxes are paid with after-tax dollars.
NOTES

**Taxation Of Social Security Benefits**

Social Security benefits are generally received free of income tax. However, federal income taxes are imposed on some benefits if the taxpayer has a substantial amount of additional income.

The specifics of the calculations are not important at this stage of your training. However, it is important to understand that Social Security benefits may not be entirely free from federal income taxes.

**HEALTH INSURANCE**

To understand how health insurance is taxed, we need to organize coverage into the following groups:

- Individually owned
- Group
- Sole proprietors and partners
- Business

Let's begin with individual policies.

**Individual Policies**

The premiums for individually owned accident, health, disability or long-term care policies generally are not deductible to the individual taxpayer. However, if the taxpayer’s medical expenses exceed 7.5% of his or her adjusted gross income during a taxable year, any medical expenses, including premiums for accident and health insurance (but not disability insurance), incurred above the 7.5% threshold can be deducted. For long-term care insurance, there is an annual dollar limit for deductions. This limit is based on the taxpayer’s age. Benefits paid by individually owned accident, health, disability or long-term care policies generally are received income tax-free by the taxpayer provided the benefits do not exceed actual expenses.

Congress has determined that individual long-term care insurance policies be treated the same as accident and health policies taxwise, as long as such policies are qualified according to federal law. Individual premiums may be deductible if the 7.5% of adjusted gross income threshold is exceeded. All qualified long-term care policy benefits are received income-tax free so long as they do not exceed actual expenses. As for nonqualified long-term care policy premiums and benefits, it’s not clear what their precise status is. Until Congress or the IRS clarifies that status, however, it would be wise to treat nonqualified policies as if they did not have the tax advantages of qualified policies.

**Group Policies**

The premiums paid by a company for group accident, health and dental coverage for its employees are generally deductible by the company as a business expense. The premiums are not taxed to the employees. The benefits are received by the employees income tax-free to the extent the benefits do not exceed actual expenses.
The premiums paid by a company for group disability insurance for its employees are generally deductible by the company as a business expense. The premiums are not taxed to the employees, but the benefits are taxable. However, if an employee pays all or part of the premiums for group disability coverage, he or she may not deduct these premiums but the benefits will be received income tax-free to the extent that the employee paid the premiums. Let’s look at an example to see how this works.

Wanda’s company pays the entire premium for her group disability coverage. If Wanda should become disabled, all of her benefits from this coverage would be subject to tax. However, if Wanda paid 50% of the premiums then 50% of her benefits would be tax-free. And if she paid 100% of the premiums, all of her benefits would be tax-free.

Note, however, that disability benefits are subject to Social Security tax (FICA) and federal unemployment tax (FUTA) for the first six calendar months following the last month the employee was on the job.

Group accidental death and dismemberment coverage premiums may be deducted as a business expense by companies. The premiums are not taxable to the employees and the benefits are received income tax-free.

Qualified group long-term care insurance, like individually owned long-term care policies, are treated the same as other group health policies and companies offering this coverage may deduct any premiums paid as a business expense. The employee is not taxed on these premiums and the benefits are tax-exempt.

Companies offering group long-term care coverage can deduct any premiums paid as a business expense. The employee is not taxed on these premiums, and the benefits are tax-exempt. However, these tax advantages do not apply to group long-term care coverage provided through a Section 125 cafeteria plan, and expenses for long-term care services cannot be reimbursed under flexible spending arrangements.

**Sole Proprietors And Partnerships**

Self-employed persons are allowed to deduct from their gross incomes 70% of the amount they pay for health insurance (including qualified long-term care insurance). This percentage rises to 100% in 2003 and thereafter. In order to claim this deduction, however, self-employed persons (1) must show a net profit for the year and (2) cannot claim the deduction for any month in which they were eligible to participate in a health plan subsidized by their employer or by the employer of their spouse.

Payments of premiums by a partnership for a partner's health and accident insurance is generally deductible by the partnership. The amount of the premiums is included in the partner's gross income, but is deductible on the same basis as for self-employed persons—70% in 2002 and then to 100% in 2003 and thereafter.
**NOTES**

**Business Policies**

The premiums paid for business overhead expense insurance are deductible as a business expense whether the business is a sole proprietorship, partnership or corporation. The proceeds of business overhead expense insurance, however, are taxable.

The premiums paid for a disability policy that is used to fund a buy-sell agreement are not deductible, nor are the proceeds taxable.

Similarly, the premiums paid for a key employee disability policy are not deductible, nor are the proceeds taxable.

**Medical Savings Accounts (MSAs)**

Medical savings accounts (MSAs) are a pilot program that combine tax incentives with a measure of self-insurance as a means of controlling health care costs. We’ve already looked at an example with Medicare MSAs. Non-Medicare MSAs are very similar. Basically, these MSAs are limited to self-employed individuals or individuals employed by a small employer having 50 or fewer employees. The self-employed individual or the employer funds an MSA with tax deductible dollars. At the same time, the account holder is covered by a high deductible health insurance policy. Qualified medical expenses are paid for with tax-free withdrawals from the MSA. The health insurance policy kicks in only when the high deductible is met. There may or may not be enough in the MSA to cover all medical expenses until the high deductible is met. If there isn’t enough, the account holder must make up the difference out of pocket. Like Medicare MSAs, any funds left over at the end of the year in a non-Medicare MSA can be withdrawn (on a taxable basis) by the account holder or rolled over (on a nontaxable basis) into a new MSA the following year. The withdrawal feature, especially with employer-sponsored MSAs, is seen to be an incentive to employees to keep their medical expenses low so that they can collect more at the end of the year.

**DISABILITY INSURANCE**

*Premiums paid by the insured* for individually owned disability income insurance are not tax deductible. However, benefits paid in this type of situation are tax free to the insured.

In situations where the business is providing disability income coverage for its employees, the *premium paid by the business* is tax deductible as a business expense. This is true whether the coverage is provided by a group policy or individual contracts. Naturally, the benefits received by the employees would then be taxable as income.

In situations where the business is providing disability income coverage to protect itself (key person, disability buy-sell insurance), premiums paid by the business are not tax deductible as a business expense. The basic premise is that either the premium or the benefit will be taxed. If the premium is not deductible to the business, then the benefits will be received tax free. If the premium is deductible then the benefits are taxable as is the case with the BOE policy.
MEDICARE SUPPLEMENT AND
LONG-TERM CARE INSURANCE

Individual Medicare supplement insurance premiums are considered deductible medical expenses, to the extent that the combination of premiums paid plus other unreimbursed medical expenses exceeds 7.5% of adjusted gross income. Benefits are considered reimbursements for medical expenses already incurred, and are therefore received tax-free. Premiums paid by an employer for group Medicare supplement insurance is tax deductible to the employer, and benefits are received tax free.

The Health Insurance Portability and Accountability Act of 1996 provided that premiums paid for individually-owned long term care insurance are tax deductible, to the extent that combined premiums and unreimbursed medical expenses exceed 7.5 of adjusted gross income. This tax deductibility is subject to age-related limits ranging from $200 per year for taxpayers under age 40 up to $2,500 per year for taxpayers age 71 and older (these limits are subject to annual indexing after 1997).

Premiums for group LTC insurance paid by employers are deductible as a business expense, but the coverage cannot be part of a cafeteria plan or flexible spending account. Benefits are received tax free up to specified limits ($190 per day for “per diem” benefits in 1999, indexed annually).

LTC policies issued on or after January 1, 1997 must meet federal standards for “tax qualified status.” LTC policies issued before that date are grandfathered and are automatically tax qualified.

The federal standards establish new eligibility requirements. The individual must be certified by a licensed health care professional to be “chronically ill” with a condition that is expected to last at least 90 days, and must have a “plan of care.” Chronically ill means the individual:

- Is unable without substantial help from another person to perform at least two of five (or six) Activities of Daily Living (ADLs) for at least 90 days. The ADLs include bathing, dressing, toileting, transferring, eating, and continence. It is up to the state legislatures to determine whether to include five or all six of the ADLs.
- Needs substantial supervision because of a cognitive impairment (i.e., Alzheimer's disease)

The individual must be recertified as chronically ill on an annual basis.

The new federal standards also establish consumer protection standards such as guaranteed renewability and the option to add inflation protection and non-forfeiture benefits (but not in the form of cash surrender values), and impose new disclosure requirements.
NOTES

REVIEW

1. Medicare Part A hospital insurance is primarily funded by
   ( ) A. general tax revenue.
   ( ) B. premiums from beneficiaries.
   ( ) C. state government taxes.
   ( ) D. Social Security payroll taxes.

2. Social Security taxes are paid by employees with
   ( ) A. pre-tax dollars.
   ( ) B. tax-deductible dollars.
   ( ) C. after-tax dollars.
   ( ) D. tax-deferred dollars.

3. Premiums for individually owned health policies may be deductible if the taxpayer's medical expenses exceed
   ( ) A. 5% of his or her adjusted gross income during the taxable year.
   ( ) B. 5% of his or her adjusted net income during the taxable year.
   ( ) C. 7.5% of his or her adjusted gross income during the taxable year.
   ( ) D. 7.5% of his or her adjusted net income during the taxable year.

4. The premiums paid by a company for group health for its employees are
   ( ) A. not tax deductible to either the company or the business.
   ( ) B. tax deductible by the company and not considered taxable income to the employees.
   ( ) C. tax deductible by the company and considered taxable income to the employees.
   ( ) D. tax deductible to the employees and the company.

5. Benefits paid by individually owned accident, health, disability or long-term care policies generally are
   ( ) A. received income-tax free by the taxpayer provided benefits do not exceed actual expenses.
   ( ) B. received income-tax free by the taxpayer even if benefits exceed actual expenses.
   ( ) C. received partially tax-free by the taxpayer provided benefits do not exceed actual expenses.
   ( ) D. taxed upon receipt by the taxpayer.

6. Qualified group long-term care coverage
   ( ) A. is deductible by both the company and the employee.
   ( ) B. is not deductible by either the company nor the employee.
   ( ) C. is deductible by the company but not the employee.
   ( ) D. is deductible by the employee but not the company.

7. Individual disability insurance
   ( ) A. premiums are deductible to the insured, and the benefits are received tax free.
   ( ) B. premiums are not deductible to the insured, but the benefits are received tax free.
   ( ) C. premiums are deductible to the insured, but the benefits are taxed.
   ( ) D. premiums are not deductible to the insured, and the benefits are taxed.
8. An individual who is considered chronically ill must be recertified as such
   ( ) A. every month.
   ( ) B. every six months.
   ( ) C. annually.
   ( ) D. every two years.

Answers:
1. D. Social Security payroll taxes.
2. C. after-tax dollars.
3. C. 7.5% of his or her adjusted gross income during the taxable year.
4. B. tax deductible by the company and not considered taxable income to the employees.
5. A. received income-tax free by the taxpayer provided benefits do not exceed actual expenses.
6. C. is deductible by the company but not the employee.
7. B. premiums are not deductible to the insured, but the benefits are received tax free.
8. C. annually.
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