PREPARING PEOPLE TO PASS

XCEL TESTING SOLUTIONS

ACCIDENT, HEALTH INSURANCE & LAWS

Pre-licensing Education – Accident and Health Insurance

Basic Principles of Life and Health Insurance and Annuities

➢ TYPES OF INSURANCE COMPANIES

Commercial Insurers (also known as **private insurance companies**) are in the business of selling insurance for a profit. Commercial insurers offer many lines of insurance. Some sell primarily life insurance and annuities, while other sell accident and health insurance, or property and casualty insurance. An insurance company selling more than one line of insurance is known as a **Multi-line insurer.** Commercial insurance is divided into two main groups: stock and mutual insurers.

Stock Companies are organized and incorporated under state laws for the purpose of making a profit for its stockholders (shareholders). Traditionally, stock insurers are called **nonparticipating insurers** because policyholders do not participate in receiving dividends or electing the board of directors, unless they are also a stockholder of the company. When declared, stock dividends are paid to stockholders. In a stock company, the directors and officers are responsible to the stockholders. Transformation of a stock insurer into a mutual insurer is termed mutualization, and the reverse is termed demutualization. Dividends from a stock insurer subject to taxation because they are considered profit.

Mutual Companies are owned by their policyholders. Mutual insurers are known as **Participating Insurers** because policyholders PARTICIPATE in receiving dividends and electing the board of directors. When declared, mutual company dividends are paid to the policyholders**.** Dividends from a mutual insurer are not subject to taxation because the dividends are considered to be a return of premium. The only exception is if the policyowner chooses to let the dividends sit and collect interest. In this case, only the accumulated interest would be taxable.

If a company operates as both a **PARTICIPATING** and **NONPARTICIPATING** insurer they are known as a **MIXED insurer.** DIVIDENDS can NEVER be guaranteed regardless of the type of company offering them.

Strong Assessment Mutual Companies are classified by the way the charge premium.

1. **A pure assessment mutual company**, operates based on loss-sharing by group members. No premium is payable in advance. Instead, each member is assessed an individual portion of losses that occur.
2. **An advance premium assessment mutual**, charges a premium at the beginning of the policy period. If the original premiums exceed the operating expenses and losses, the surplus is returned to the policyholders as dividends. However, if total premiums are not enough to meet losses, additional assessments are levied against the members. Normally, the amount of assessment that may be levied is limited either by state law or simply as a provision in the insurer's by-laws.

Fraternal benefit societies are special types of mutual companies, nonprofit religious, ethnic or charitable organizations that provide insurance solely to their members. Fraternal must be formed for reasons other than obtaining insurance. *An example of fraternal societies is Knights of Columbus.*

Risk retention groups are mutual companies formed by a group of people in the same industry or profession. *Examples would be pharmacists, dentists, and engineers.*

Service Providers offer benefits to subscribers in return for the payment of a premium. These services are packaged into various plans, and those who purchase the plans are known as subscribers. *Examples of service providers are Health Maintenance Organizations (HMO) and Preferred Provider Organizations (PPO).*

Reciprocal insurers are unincorporated groups of individual members that provide insurance for other members through indemnity contracts. Each member acts as both insurer and insured and are managed by Attorney in Fact.

Reinsurers make arrangements with other insurance companies to transfer a portion of their risk to the reinsurer. The company transferring the risk is called the **Ceding Company** and the company assuming the risk is the **Reinsurer.**

Captive Insurer is an insurer established and owned by the parent company to insure the parent company's loss exposure.

Home Service Insurers (also known as **industrial insurance**), is sold by home service or **debit** life insurance companies. Face amounts are small; usually $1,000 to $2,000 and premiums are paid weekly.

Government Insurance: Federal and state government are also insurers. They provide social insurance programs, to protect against universal risks by redistributing income to help people who cannot afford the cost of incurring such losses themselves. These programs have far reaching effects and millions of people depend on them. Types of Government Insurance include:

- **Social Security** (**O**ld **A**ge **S**urvivor **D**isability **I**nsurance **OASDI** – Provides income benefits for the elderly (retirement), survivors of those who died young (young child of a deceased parent), and those qualifying for federal disability.
- **Medicare -** Health insurance to CARE for the elderly
- **Medicaid -** Health insurance to AID the financially needy.
- **S.G.L.I.** and **V.G.L.I** (Serviceman's or Veteran's Group Life Insurance: life insurance for active and retired members of the military)
- **Tri-Care** (health insurance for members of the military and their family)

Self-Insurers retain risks and must have a large number of similar risks and enough capital to pay claims. However, they may save money if the loss experience is lower than the expected costs. Self-insurers are not a method of transferring risk, rather self-insurers establish their own self-funded plan to cover potential losses. A **Self-funded plan** is a plan in which an employer pays insurance benefits from a fund derived from the employer's current revenues

Lloyd's of London is not an insurance company. Members of the association form syndicates to underwrite and issue insurance- like coverage. This is a group of investors who share in unusual risk.

➢ HOW INSURANCE IS SOLD

Distribution Systems are the ways insurance products are marketed and sold to the public. Insurance can be purchased through licensed insurance producers, who are either agents or brokers, or through a number of other ways. Agents are either captive/career agents or independent agents. Captive agents work for only one insurer. Independent agents work for themselves or for several insurers non- exclusively.

Career Agency System: With the career agency system commercial insurers establish offices in certain locations. Career agents are recruited to work at these locations. A general agent hires and trains new producers and supervises a number of other producers. All producers under the career agency system are captive agents and employees of the insurer.

Personal Producing General Agency System: With the personal producing general agency (PPGA) system, agents work for an independent agency selling policies from several insurance companies. Unlike the career agency system, agents are not employees of the insurance company. Instead, they work for the PPGA. Furthermore, personal producing general agents primarily sell insurance, instead of recruiting and training new agents as in the career agency system.

Independent Agency System (American Agency System): Independent agents represent a number of insurance companies under separate contractual agreements. They may also work for themselves or under other insurance agents. Independent insurance agents have control and ownership over their clients' accounts. This means they may place clients' business with

a different insurer when policies are up for renewal. Independent insurance agents earn commissions on the sales they make and overrides on sales made by agents they manage.

Managerial System: With the managerial system, branch offices are established in several locations.
Instead of a general agent running the agency, a salaried branch manager is employed by the insurer. The branch manager supervises agents working out of that branch office. The insurer pays the branch manager's salary and pays him a bonus based on the amount and type of insurance sold and number of new agents hired.

Mass Marketing: Another way to sell insurance is through mass marketing methods. Direct selling (or direct mail) is a mass marketing method where agents are not used. Instead, policies are marketed and sold through television and radio advertisements, print sources found in newspapers and magazines, by mail, in vending machines, and over the internet.

- **INDUSTRY OVERSIGHT AND REGULATION**

The insurance industry is primarily regulated on a state-by-state basis with minimal federal oversight. The primary purpose of this regulation is to promote public welfare and provide consumer protection and ensure fair trade practices, contracts and prices. Key historical events that have shaped the current regulation include:

- **1869 Paul v. Virginia:** the U.S. Supreme Court ruled that insurance transactions crossing state lines are not interstate commerce.

- **1905 The Armstrong Investigation Act** gave the authority to the states to regulate insurance.

- **1944 United States v. South-Eastern Underwriters Association** ruled that insurance transactions crossing state lines are interstate commerce and are subject to federal regulation. Thus, many federal laws were conflicting with existing state laws. However, this decision did not affect the power of states to regulate insurance.

- **1945 The McCarran Ferguson Act** states that while the federal government has authority to regulate the insurance industry, it would not exercise its right if the insurance industry was regulated effectively and adequately on the state level. Under the McCarran-Ferguson Act, the minimum penalty of a producer who has obtained personal information about a client without having a legitimate reason to do so is a fine of $10,000.

- **1970 Fair Credit Reporting Act:** provides individuals privacy protection and fair and accurate credit reporting. Insurance companies are required to notify applicants if a credit check will be made on them. Under the Fair Credit Reporting Act, the maximum penalty of a producer who has obtained Consumer Information Reports under false pretenses is a fine of $5,000.

- **1999 Gramm-Leach-Bliley Act (Financial Services Modernization Act)**: This law repealed the Glass-Steagall Act; this allows Banks, Retail Brokerages and Insurance companies to enter each other's line of business.

- **2001 USA PATRIOT ACT (U**niting and **S**trengthening **A**merica by **P**roviding **A**ppropriate **T**ools **R**equired to **I**ntercept and **O**bstruct **T**errorism Act**):** as it relates to the insurance industry, is designed to detect and deter terrorists and their funding by imposing anti-money laundering requirements on brokerage firms and financial institutions.

- **2003 National Do Not Call Registry:** Insurance calls are not exempt from the no not call registry.

- **2010 Patient Protection and Affordable Care Act (PPACA):** often shortened to the **Affordable Care Act** (**ACA**), represents one of the most significant regulatory overhauls and expansions of coverage in U.S. history.

The **National Association of Insurance Commissioners (NAIC)** is an organization composed of insurance commissioners from all 50 states, the District of Columbia and the 4 US territories. They are responsible for recommending appropriate laws and regulations. They are responsible for the creation of the **Advertising Code** and the **Unfair Trade Practices Act,** and the Medicare Supplement Insurance Minimum Standards Model Act. The NAIC has four broad objectives:

1. To encourage uniformity in state insurance laws and regulations
2. To assist in the administration of those laws and regulations by promoting efficiency
3. To protect the interest of policyowners and consumers
4. To preserve state regulation of the insurance business

Advertising Code: the code specifies certain words and phrases that are considered misleading and are not to be used in advertising of any kind.

Unfair Trade Practices Act: gives chief financial officer the power to investigate insurance companies and producers to impose penalties. In addition to that, the act gives officers the authority to seek a court injunction to restrain insurers from using any methods believed to be unfair.

NAIFA (National Association of Insurance and Financial Advisors) **and NAHU** (National Association of Health Underwriters): Members of these organizations are life and health agents dedicated to supporting the industry and advancing the quality of service provided by insurance professionals. *These organizations created a Code of Ethics detailing the expectations of agents in their duties toward clients.*

To sell insurance, each state requires high level of professionalism and ethics. Some of these standards and ethics are:

- Selling to needs: agents must first determine the consumers' needs then determine which policy fits their needs best.
- Suitability of recommended products: an ethical agent must be able to assess the correlation between a recommended product and the consumer's needs.
- Full and accurate disclosure: an ethical agent must inform consumers of the benefits and limitations of recommended products. Recommendations must be accurate, complete and clear.
- Documentation: an ethical agent must document each client's meeting and transaction.
- Client Services: an ethical agent must know that a sale does not mark the end of the relationship, but rather the beginning of the relationship. Therefore, routine follow-up calls are recommended.
- **Buyer's Guide:** each state requires agents to deliver a buyer's guide to consumers that explain various types of life insurance products and other information on the recommended policy, such as premiums, dividends, and benefit amounts.
- **Policy Summary:** help consumers evaluate the suitability of the recommended product.

Reserves: are the accounting measurement of an insurer's future obligations to its policyholders. They are classified as liabilities on the insurance company's accounting statements since they must be settled at a future date. Reserves are set aside by an insurance company and designated for the payment of future claims.

Liquidity: An insurer's ability to make unpredictable payouts to policyowners

Guaranty Associations are established by all states to support insurers and protect consumers in case an insurer becomes insolvent. State life and health guaranty associations provide a safety net for all member life, health and annuities insurers in a particular state. Guaranty associations protect insureds in the event of insurer insolvency, or inability to pay claims up to a certain limit.

Independent Rating Services are credit rating agencies that rate or "grade" the financial strength and stability of insurers based on claims, reserves, and company profits. The nationally recognized statistical rating organizations that rate insurers are **A. M. Best, Moody's, Standard and Poor's, and Fitch Ratings.** Each rating service has its own rating system, but most use an A to F letter grading scheme.

Nature of Insurance

➢ HAZARDS, PERILS, and RISK

Hazard: A condition or situation that creates or increases a chance of loss. For example, icy roads, driving while intoxicated, improperly stored toxic waste. Types of Hazards include:

- **Physical** – Poor health, overweight, blind.
- **Moral** – Dishonesty, drugs, alcohol abuse.
- **Morale** – Careless attitude – reckless driving, jumping off a cliff, stealing, racing motorcycles, carefree, careless lifestyle. This attitude causes an indifference to loss.

Loss: is the unintentional decrease in the value of an asset due to a peril.

Peril: an immediate, specific event which causes loss, such as an earthquake or tornado. Perils can also be referred to as the accident itself.

Risk: the potential for loss

Speculative Risk: is a risk that presents both the chance for loss or gain. Gambling is an example. Speculative risks are not insurable.

Pure Risk: is the only insurable risk and present a potential for loss only, such as injury, illness, and death.

ELEMENTS OF INSURABLE RISK

- **Loss must be due to chance** – Causeless, outside the insured's control.
- **Loss must be definite and measurable** – Time, place, amount, and when payable.
- **Loss must be predictable** – Statistically able to estimate the average frequency and severity.
- **Loss cannot be catastrophic** – Must be reasonable, 1 trillion-dollar policy is not reasonable.
- **Loss exposure to be insured must be large** – Ideally, common enough that the insurer can pool many homogeneous, or similar, exposure units (**law of large numbers**).
- **Loss must be randomly selected** – Fair proportion of good and poor risks (**adverse selection**).

Law of Large Numbers: The larger the amount of exposures that are combined into a group, the more certainty there is to the amount of loss incurred in any given period. The Law of Large Numbers allows:

- Prediction of individual and group losses based on past experience
- An increased degree of accuracy in predicting losses in large groups

Homogeneous exposure units: are similar objects of insurance that are exposed to the same group of perils. For example, insuring a large number of homes in the same geographical area against hail damage.

Adverse Selection: Insurers must minimize adverse selection, which is defined as the tendency for poorer than average risks to seek out insurance. **For example,** a person who takes 12 prescriptions is a poor risk. If an insurer cannot compensate poor risks with better than average risks, then its loss experience will increase and its ability to pay claims may be compromised.

Risk Management: is the process of analyzing exposures that create risk and designing programs to handle them.

Treatment of Risk – how people deal with risk

- **Avoidance** – Avoid the risk all together. For example, you can avoid the risk of getting injured in a car accident by never leaving the house.
- **Reduction** – Take precautions; minimizing severity of a potential loss. For example, you can reduce the risk of getting injured in a car accident by taking public transportation.
- **Retention (Self Insure**) – accepting a risk and confronting it if it occurs. For example, you would retain the risk of getting injured in a car accident by driving without insurance.
- **Transfer (Transference)** – Make someone else responsible for a loss. For example, buying auto insurance transfers the cost associated with a car accident from the driver to the insurance company. Buying Insurance is the best way to transfer risk.
- **Risk Pooling (Loss sharing):** When a large group of people spread a risk for a small certain cost. It transfers risk from an individual to a group. An example of **Risk sharing** would be, doctors pooling their money to cover malpractice exposures

Reinsurance: Insurers deal with catastrophic loss through reinsurance, which is defined as a contractual arrangement that transfers exposure from one insurer to another insurer.

Principle of Indemnity: involves making an insured whole by restoring them to the same condition as before a loss.

➢ ECONOMIC BASIS OF INSURANCE

Human Life Value Approach: A method of determining the financial value of a person's life based on computing the current value of a person's future earnings for a certain period of time. For example, if the main income earner of the family makes $50,000 a year and the family would like to make sure they are protected for 10 years in the event something happens to the main income earner. $50,000 (current income) X 10 years (protection) = $500,000 insurance policy.

Needs Based Value Approach: A method of determining a person's financial value based on the amount of money needed for current and future expenses. These expenses include final expenses, spouse's income, mortgage, college education, retirement, charity donations, etc. For example, a family would like to ensure they can take care of 5 years of annual expenses if something were to happen to the main income earner, and they have an average of $60,000 worth of expenses per year. $60,000 (expenses) X 5 years (protection) = $300,000 insurance policy.

Legal Concepts of the Insurance Contract

Insurance policies are legal contracts where a promise of benefits is exchanged for valuable consideration (Premiums). Contracts of insurance are binding and enforceable. All parties are subject to specific legal requirements.

- **Life insurance:** the insurance company agrees to pay a predetermined amount – the **face amount (**or **benefit),** in exchange for the insured's consideration **(premium)**.
- **Health insurance:** the insurance company agrees to pay a percentage of the insured's medical bills **(**or **benefit)** in exchange for consideration **(premiums**).

➢ ELEMENTS OF THE CONTRACT

Four elements must be present in every contract to be valid and legally enforceable. These elements include:

1. Consideration: Consideration is something of value that each interested party gives to each other. The insured provides **consideration** with **payment of premium**. The insurer provides consideration by **promising to pay** the insurance benefit. The applicant says, "PLEASE CONSIDER me for insurance. Here's my initial premium, my completed application, as well as how much and how often I agree to pay."

2. Legal Purpose: An insurance contract must be legal and not in opposition of public policy. If an insurance contract has **insurable interest** and the insured has provided written consent, it has **legal purpose**. Without legal effect, the contract would be null and void. Said differently, the contract cannot be for an illegal purpose.

3. Offer and Acceptance: An **offer** is made when the applicant submits an **application and initial premium** for insurance to the insurance company. The **offer** is accepted by the insurer after it has been **approved** by the insurance company's **underwriter** and a policy is issued. If no money is given, the applicant is making an invitation. On the other hand, if an offer is answered by a counteroffer, the first offer is void.

4. Competent Parties: All parties must be of legal competence, meaning they must be of legal age, mentally capable of understanding the terms, and not influenced by drugs or alcohol**.**

➢ SPECIAL FEATURES OF INSURANCE CONTRACTS

Contract of Adhesion: Because an insurance contract has been prepared by an insurance company with no negotiation, it is considered a contract of adhesion. In a contract of adhesion there is only one author – the insurance company. Insurance carriers are also responsible for assembling the policy forms for insureds. If there is an ambiguity in the contract, the courts always favor the insured over the insurer. Under a contract of adhesion, the terms must be accepted or rejected in full. The customer must adhere to the insurer's contract without any input of their own.

Aleatory Contract: Insurance contracts are aleatory, which means there is an unequal exchange. The premiums paid by the applicant is small in relation to the amount that will be paid by the insurance company in the event of a loss. For example, Tory paid one month's premium of $50, when she died one month later, her beneficiary received the whole $50,000 face value of Tory's policy.

- Consideration may be unequal
- The outcome depends on chance or uncertain event
- A legal bet is considered an aleatory contract

Unilateral Contract: One sided agreement, where only the insurer is legally bound. In an insurance contract, only the insurance company is legally bound to do anything (pay claims). Uni=one lateral=side, one side - the insurance company is legally bound. The insured does not make a promise to pay premiums, however, if premiums are not paid the insurer has the right to cancel the contract.

Personal Contract: Most insurance contracts are personal contracts between the insurance company and the insured individual, and are not transferable to another person without the insurer's consent. Life insurance is an exception to this standard as the owner of the policy has no bearing on the insurer's assumed risk. Therefore, people who own life insurance are called policyowners rather than policyholders and may transfer or assign ownership by notifying the company.

Conditional Contract: Insurance contracts are conditional because certain conditions must be met by all parties in the contract. Hence, benefits depend on the occurrence of an event covered by contract. This is needed when a loss occurs for the contract to be legally enforceable.

Valued vs. Indemnity: Life insurance contracts are **valued** contracts, which means it will pay a stated amount. **Health insurance** contracts are **indemnity** contracts and will only reimburse the actual cost of the loss (pay medical bills, etc.). The **Principle of Indemnity** is to restore the insured to the same financial condition as that which existed prior to the loss. You cannot profit from an indemnity contract.

Utmost Good Faith: Implies that there will be no attempt by either party to misrepresent, conceal or commit fraud as it pertains to insurance policies. Insurance applicants are required to make full, fair, and honest disclosure of the risk to the agent and insurer. Agents and insurers are required to accurately explain the policy's features, benefits, advantages, and possible disadvantages to an applicant.

Warranties: Statements made by the applicant guaranteed to be true (name, DOB) becomes part of the contract and if found to be untrue, can be ground for revoking the contract.

Representations: Statements made by the applicant believed to be true (height, weight) are not part of the contract and need to be true only to the extent that they are material and related to the risk.

Concealment: Withholding of information or facts by the applicant (smoker, diabetes).

Insurable Interest: Requires that an individual have a valid concern for the continuation of the life or well-being of the person insured. Without insurable interest, an insurance contract is not legally enforceable and would be considered a wagering contract. Insurable interest only needs to exist at the time of the application (the inception of the contract)**.** *For example, spouses would typically have insurable interest on each other's life childhood friends typically would not have insurable interest on each other's life. An employer may have insurable interest on a key employee's life.*

Reasonable Expectations: A concept which states that the insured is entitled to coverage under a policy that a sensible and prudent person would expect it to provide**.** Reinforces the rule that ambiguities in insurance contracts should be interpreted in favor of the policyholder.

Stranger-Originated Life Insurance: In Stranger-Originated Life Insurance, or **STOLI**, a consumer purchases a life insurance policy with the agreement that a third-party agent/broker or investor will purchase the consumer's policy and receive the proceeds as a profit upon the consumer's death. This differs from a standard insurance policy because a 3rd party OWNER will be the one benefiting from the death of the insured. **STOLI** policies are typically illegal as they violate insurable interest requirements.

- **AGENT AUTHORITY**

A relationship in which one person is authorized to represent and act for another person or company is established through the law of agency**.** In applying the law of agency, the insurance company (insurer) is the principal. An agent or producer will always be deemed to represent the insurance company and not the applicant. Regarding the insurance contract, any knowledge of the agent is considered to be the knowledge of the insurance company (insurer). If the agent is working within the conditions of his/her contract, the insurance company is fully responsible.

Authorized agent: a person who acts for another person or entity and has the power to bind the principal to contracts.

Agents are granted **authority** by the insurer through the agency contract to transact insurance or adjust claims on their behalf. Some common tasks agents are authorized to perform include solicit applications, collect premiums, render services to prospects, and describes the company's insurance policies.

Types of agent authority:

- **Express:** Express authority is the explicit authority granted to the agent by the insurer as written in the agency contract. *For example, solicit applications and collect premiums.*
- **Implied:** The unwritten authority of a producer to perform incidental acts necessary to fulfill the purpose of the agency agreement (otherwise unwritten in the contract). *For example, since you are authorized to solicit applications and collect premiums, it is implied that you are authorized to set appointments.*
- **Apparent**: Apparent authority deals with the relationship between the insurer, the agent, and the customer. It is the appearance of authority based on the agent-insurer relationship. Apparent authority is a situation in which the insurer gives the customer reasonable belief that an agent has the power and authority to bind the principal. *For example, since you have all of the insurance application forms and business cards it is apparent to the customer that you are able to help them apply for insurance.*

➢ OTHER LEGAL CONCEPTS

Fiduciary Responsibility – Because the agent handles money of the insured and insurer, he/she has a fiduciary responsibility. A fiduciary is someone in a position of trust and confidence. *With insurance, for example, it is illegal for agents to mix premiums collected from applicants with their own personal funds.* This is called **commingling**.

Fraud: Fraud is an intentional misrepresentation or concealment of material fact made by one party in order to cheat another party out of something that has economic value. An insurer may void an insurance policy if a misrepresentation on the application is proven to be material.

Waiver: Waiver is the voluntarily giving up of a known right. *For example, if an insurer chose to approve an application and issue a policy without requesting a medical exam they cannot later request a medical exam to for that policy in the future.*

Estoppel: The legal process of preventing one party from reclaiming a right that was waived.

Parol Evidence Rule: Rule that prevents parties in a contract from changing the meaning of a written contract by introducing oral or written evidence made prior to the formation of the contract, but are not part of the contract.

Subrogation is the right for an insurer to pursue a third party that caused an insurance loss to the insured. This is done as a means of recovering the amount of the claim paid to the insured for the loss. *For example, if an insured driver's car is totaled through the fault of another driver; the insurance carrier will reimburse the covered driver as described in the policy and take legal action against the driver-at-fault in an attempt to recuperate the cost of that claim.*

Void and Voidable Contracts: A void contract is an agreement that does not have legal effect, and therefore is not a contract. Void contracts are not enforceable by either party. Unlike a void contract, a voidable contract is a valid, binding contract which can be voided at the request of a party with the right to reject.

Cancellation: the voluntary act of terminating an insurance contract.

Endorsement: a written form attached to an insurance policy that alters the policy's coverage, terms, or conditions.

Brokers: a broker or independent agent may represent a number of insurance companies under separate contractual agreements.

Professional Liability Insurance (Errors and omissions): A professional liability for which producers can be sued for mistakes of putting a policy into effect. under the insurance, the insurer agrees to pay sums that the agent legally is obligated to pay for injuries resulting from professional services that he rendered or failed to render.

Health and Accident Insurance

➢ USES OF HEALTH INSURANCE

Health insurance: refers to the broad field of insurance plans that provide protection against the financial consequences of illness, accidents, injury, and disability.

The two perils that are covered in health insurance are accident and sickness.

Distinct categories of health coverage include:

1. **Medical expense insurance** provides financial protection against the cost of medical care by reimbursing the insured, fully or in part, for these costs, called **reimbursement plans.** Examples of medical expense insurance are Medicare supplement insurance and long-term care insurance.
2. **Disability income insurance** provide a replacement income when wages are lost due to a disability.
3. **Accidental Death and Dismemberment Insurance (AD&D):** provides the insured with a lump-sum benefit amount in the event of accidental death or dismemberment under accidental circumstances.
4. **Interim Coverage:** short-term policies that can be purchased on an interim basis when in between jobs or waiting for a new policy to start.

Health insurance policies are paid for on a year-to-year basis and are subject to periodic increases in premium. Health insurance premium is calculated based on interest, expense, types of benefits, and **morbidity**, or the expected incidence of sickness or disability within a given age group during a given period of time.

Health insurance benefits are not fixed rather they depend on the amount of loss.

Subrogation: the right for an insurer to pursue a third party that caused an insurance loss to the insured. This is done as a means of recovering the amount of the claim paid by the insurance carrier to the insured for the loss. *For example, the right of an insurance company to sue the at-fault drive of an accident to recuperate the loss suffered from paying related medical bills.*

➢ BUSINESS NEEDS FOR HEALTH INSURANCE

Business uses of health insurance can be broadly divided into two categories:

1. **Business Continuation Plans** to continue the operation of a business in the event of a disabling sickness or injury to a business owner or key employee.
2. **Employee Benefit Plans** to help an employee in the event of a disabling sickness or injury.

Business Continuation Plans

- **Business Overhead Expense Insurance**
    - Sold on an individual basis to professionals in private practice, self-employed business owners, partners, and occasionally close corporations.
    - Business overhead expense insurance is designed to reimburse a business for overhead expenses in the event a business owner becomes **disabled**
    - Designed to help the day to day operation of businesses to continue during the period of disability.
    - Overhead expenses include such things as rent or mortgage payments, utilities, telephones, leased equipment, employees' salaries etc.
    - Does not include any compensation for the disabled owner
    - The premium for business overhead insurance is a tax-deductible business expense

- The benefits when paid are treated as taxable income
- *For example, an attorney may take out a business overhead expense policy to cover the expense of keeping is practice open if we were in an accident and couldn't work for 3 months. However, this would not provide him any income.*

- **Disability Buy-Sell Plan also known as Disability Buy-Outs**

  - A Business Disability Buy-Sell policy is designed to assist in the sale of a business in the event of the **disability** of a business owner.
  - The plan sets forth the terms for selling and buying a partner's or stock owner's share of a business in the event she becomes disabled and is no longer able to participate in the business.
  - It is a legal, binding arrangement funded with a disability income policy.
  - Unlike typical disability income insurance plans that pay benefits in the form of periodic payments, the buy-out plan usually contains a provision allowing for a lump-sum payment of the benefit.
  - Benefits are received **tax-free** because the **premiums paid are not tax deductible**.
  - Characterized by lengthy elimination periods, often as long as two years.
  - *For example, three partners of a law firm may take out a disability buy-sell plan on each other with an agreement if one becomes disability they will sell the business to the other two partners who will use the proceeds from the policy to purchase the business.*

  - **Key Person Disability Insurance**

  - 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's economic value to the business is determined in terms of the potential loss of business income that could occur, as well as the expense of hiring and training a replacement for the key person.
  - 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**.
  - *These policies are typically reserved for "hard-to-replace" employees like executives or key sales members and would not be used on lower-level employees like secretaries or assistants.*

Employee Benefit Plans

While the term employee benefit plan can encompass a wide variety of benefit offerings (life insurance, pension or profit-sharing plans, vacation pay, deferred compensation arrangements, funeral leave, sick time) it is rare when it does not include some kind of provision for health insurance or health benefits. By providing its employees with a plan for health insurance, an employer derives many benefits:

- The plan contributes to employee morale and productivity
- The plan enables the employer to provide a needed benefit that employees would otherwise have to pay for with personal after-tax dollars (this helps hold down demands for wage increases)
- The plan places the employer in a competitive position for hiring and retaining employees
- The employer can obtain a tax deduction for the cost of contributing to the plan
- The plan enhances the employer's image in both public and employee relations

➢ NATURE OF GROUP HEALTH INSURANCE

The contract for a group health insurance policy is between the insurance company and the group (usually employer). Health insurance is provided through group master contracts. In this case, the employer or the association is the

policyowner and is responsible for premium payments. The employer may pay the entire premium or require some contribution from each member to cover the insurance cost.

- A **master policy** is issued to the employer.
- Insureds (employees or group members) receive **certificates of insurance** and an **outline** that describes their benefits.
- The benefits provided under a group health plan are more extensive than those provided under an individual health plan.
- Group health plans typically have higher benefit maximums and lower deductibles.
- Benefits provided to individual insureds are predetermined by the employer in conjunction with the insurer's benefit schedules and coverage limits. For example, group disability benefits can be tied to a position or earnings schedule
- **Probationary period:** the period of time during which a new employee is ineligible for group health insurance coverage. *Think the probation period when you start a new job.*
- **Enrollment period:** the limited period of time during which all members may sign up for a group plan.
- **T**o qualify for group health coverage, the group must be a natural group) formed for some reason other than to obtain insurance). *For example, employers, labor unions, trade associations, creditor-debtor groups, multiple employer trusts, lodges etc.*
- State laws specify the minimum number of persons to be covered under a group policy
- Like group life, group health plans commonly impose a set of eligibility requirements that must be met before an individual member is eligible to participate in the group plan.

Coordination of Benefits

The purpose of the coordination of benefits (COB) provision, found only in group health plans, is to avoid duplication of benefit payments and over insurance when an individual is covered under more than one group health plan.

- The provision limits the total amount of claims paid from all insurers covering the patient to no more than the total allowable medical expenses
- The COB provision establishes which plan is the **primary carrier** (provider), or the plan that is responsible for providing the full benefit amounts as it specifies.
- Once the primary plan has paid its full promised benefit, the insured may submit the claim to the **secondary carrier**(provider) for any additional benefits payable
- In no case will the total amount the insured receives exceed the costs incurred or the total maximum benefits available under all plans
- Are more appropriate for married couples when each is covered by an employer group plan
- Coordinating benefits are needed for workers with Medicare
- **Overutilization** of a plan occurs when health benefits are too high.

➢ **FUNDING OF GROUP INSURANCE**

Group coverage plans have a significantly less out of pocket costs. The cost of insuring an individual under a group health plan is **less** than the cost of insurance under an individual plan mostly because administrative and selling expenses involved with group plans are far less. Factors that help determine group health insurance premiums are: the size of the group, the claims experience with previous insurers, and the ages of group members

Contributory Versus Noncontributory

- If the employer pays the entire premium, the plan is noncontributory. *The employee does not contribute in paying the bill.*
    - Most noncontributory group health plans require **100% participation by eligible members**, whereas contributory group health plans often require participation by 75% of eligible members
    - The reason for these minimum participation requirements is to protect the insurer against **adverse selection** and to keep administrative expenses in line with coverage units

- If the employees share a portion of the premium, it is contributory. *The employee does contribute in paying the bill.*

Other group funding options include:

- **Shared funding arrangement:** this allows the employer to self-fund health care expenses up to a certain limit.
- **Minimum premium arrangement:** allows the employer to self-insure the normal and expected claims up to a given amount and the insurer funds only the excess amounts.
- **Retrospective premium arrangement:** the insurer agrees to collect a provisional premium but may collect additional premium or make refund at the end of the year based on the actual incurred losses.
- **Self-funding arrangement:** large employers may elect to fully self-fund, or may self-fun a plan, but contract for administrative services only.

➢ UNDERWRITING GROUP INSURANCE

The insurer evaluates the group as a whole rather than individuals within the group. The underwriter's objective is to reduce the risk of adverse selection. In order to achieve this the underwriter reviews a number of factors to determine whether or not the group should be accepted. Rarely is an entire group rejected on the basis of one bad risk, unless the group is very small. Based on the group's risk profile, the group is **either accepted or rejected**. In spite of the many differences between types of groups, there are certain general groups of underwriting considerations. General groups of underwriting considerations are applicable to all or most types of groups, such as:

- Reason for the group's existence *(purchasing group insurance must be incidental to the group's formation, not the reason for it)*
- Stability of the group *(underwriters want to see a group of stable workers without an excessive amount of "turnover")*
- Persistency of the group *(groups that change insurers every year do not represent a good risk)*
- Method of determining benefits *(it must be by a schedule or method that prevents individual selection of benefits)*
- How eligibility is determined *(insurers want to see a sickness-related probationary period, for example, to reduce adverse selection)*
- Source of premium payments, whether contributory or noncontributory *(noncontributory plans are preferred because they usually require 100% participation, which helps spread the risk and reduces adverse selection)*
- Prior claims experience of the group
- Size and composition of the group
- Industry or business with which the group is associated *(hazardous industries are typified by higher-than-standard mortality and morbidity rates)*

Preexisting Conditions, Conversion and HIPPA Requirements

- Beginning July 1, 1997, HIPAA limited the ability of employer- sponsored groups and insurers to exclude individuals on the basis of preexisting medical conditions.
    - The exclusion for preexisting conditions is now limited to conditions for which medical advice or treatment was recommended or received within the **six-month** period ending on the enrollment date and the exclusion can extend for no more than **12 months**
    - When determining whether preexisting conditions apply, new employees enrolling in a new group health plan cannot have a gap of more than 63 days without health insurance for preexisting conditions
    - **Creditable coverage** is prior group health insurance that reduces the maximum preexisting condition exclusion period that a new group health plan can apply to that individual

- HIPAA provides the ability to transfer and continue health insurance coverage for millions of American workers and their families when they change or lose their jobs.

- HIPAA portability rules allow individuals who change from one group medical plan to another to reduce or eliminate any pre-existing conditions excluded under the new plan
- Under HIPAA, when an insured individual leaves an employer and immediately begins working for a new company that offers group health insurance, the individual is eligible for coverage upon hire
- **The Conversion Privilege** allows an insured to convert their group certificate to an individual medical expense policy with the same insurer, if and when they leave their employment, or the group plan is being eliminated
  - Insurers are permitted to evaluate the individual and charge the appropriate premium, be it a standard rate or substandard rate
  - An individual cannot be denied coverage even if he/she has become uninsurable
  - The conversion must be exercised within a given period of time (usually 30 or 31 days) depending on the state. (the employee must make application for a converted policy within this timeframe)

- The HIPAA Privacy Rule provides federal protection for an individual's health information and gives patients an array of rights with respect to that individually identifiable health information.
  - HIPAA considers a person's health claim information as individually identifiable health information
  - HIPAA imposes requirements on health care providers with respect to disclosure of protected health information
  - Notice of information practices must be given to a policyholder at least every three years
  - The HIPAA Security Rule provides technical safeguards to assure the confidentiality, integrity, and availability of electronic protected health information.

- HIPPA rules apply to most **group health plans** like HMO's, PPO's, and Major medical plans. It **excludes coverage such as workers compensation and disability income plans.**
  - HIPAA requires employers with 20 or more employees to allow former employees to continue benefits under the employer's group health insurance
  - HIPAA states that a group health policy renewal can be denied when participation or contribution rules have been violated
  - HIPAA provides that the 10% excise tax for early withdrawal from IRAs will not apply to the extent a withdrawal is used for medical expenses that exceed 7.5% of the individual's adjusted gross income

COBRA Continuation of Benefits

COBRA is a federal law that guarantees a continuation of their group coverage if their employment is terminated for reasons other than gross misconduct. It stands for the Consolidated Omnibus Budget Reconciliation Act of 1985.

- Protects employees who are laid-off, but not those who are fired "for cause"
- Requires employers with **20 or more employees** to continue group medical expense coverage for terminated workers for up to **18 months** following termination
- The law does not require the employer to pay the cost of the continued group coverage
- After expiration of group benefits under COBRA, a fully insured group policy can be converted to an individual health insurance policy
- The terminated employee can be required to pay the premium, which may be up to 102% of the premium that would otherwise be charged
- The benefits under COBRA continuation coverage will end if the employer terminates all group health plans
  - The following events would qualify for extended medical expense coverage under COBRA for a terminated employee:
    - Employment is terminated (for other than gross misconduct): 18 months of continued coverage (or up to 29 months if disabled)
    - Employee's hours are reduced (resulting in termination from the plan): 18 months of continued coverage (or up to 29 months if disabled)
    - Employee dies: 36 months of continued coverage for dependents

- Dependent child no longer qualifies as "dependent child" under the plan: 36 months of continued coverage
- Employee becomes eligible for Medicare: 36 months of continued coverage
- Employee divorces or legally separates: 36 months of continued coverage for former spouse

Pregnancy Discrimination Act

- The Pregnancy Discrimination Act of 1978 is an amendment to the Civil Rights Act of 1964 designed to prohibit sex discrimination on the basis of pregnancy.
- Requires employers to treat pregnancy in the same manner as a disability for any other medical reason
- Requires group plans covering 15 or more people to treat pregnancy related claims no differently than any other allowable medical expense

➢ GROUP HEALTH INSURANCE COVERAGES

Health insurance group plans are predetermined by the employer in conjunction with the insurer's benefit schedules and coverage limits. Group health insurance contracts providing coverage for employees in more than one state are usually controlled by the laws of the state where the master contract is issued. Working people age 65 or over generally must be offered the same accident and health benefits offered to younger employees.

Group Basic Medical Expense

- The three standard forms of basic medical expense insurance; hospital, surgical, and physicians' expenses- are available for group insurance
- A group basic medical expense plan can combine two or more of these coverages or it may consist of only one type of coverage, such as hospital expense only

Group Major Medical Plans

- Like individual major medical plans, group major medical plans may be offered as a single, extensive plan (comprehensive major medical) or superimposed over a group basic plan (supplemental major medical)
- Participants are usually required to satisfy an initial deductible with comprehensive plans and either a corridor or an integrated deductible with supplemental plans
- Benefits provided by group major medical plans are usually more extensive than those of individual plans
- For most group health plans the coverage begins on the policy's effective date. However, some plans may also impose a waiting period which gives an insurance company the right to delay coverage for a covered sickness for a specified number of days after the effective date of the policy
- No health plan coverage will begin until the application is completed and approved, the policy is issued, and the initial premium is paid.

Dental care and vision care

- Dental care coverage is designed to cover the costs associated with normal dental maintenance as well as oral surgery, root canal therapy, and orthodontia
- The coverage may be on a "reasonable and customary charge" basis or on a dollar-per-service schedule approach
- Deductible and coinsurance features are typical as are maximum yearly benefit amounts
- Vision care coverage usually pays for reasonable and customary charges incurred during eye exams by ophthalmologists and optometrists.
- A common exclusion with Vision plans is Lasik surgery

Cafeteria Plans (Section 125 plan)

- Section 125 is part of the IRS Code that allows employees to convert a taxable cash benefit (salary) into non-taxable benefits. Under a Section 125 program you may choose to pay for qualified benefit premiums before any taxes are deducted from employee paychecks. An S-Corp Owner with a greater than 2% share is ineligible to participate in a Section 125 Plan.
- Cafeteria plans are benefit arrangements in which employees can pick and choose from a menu of benefits, thus tailoring their benefits package to their specific needs
- Employees can select the benefits they value or need and forgo those of lesser importance to them
- The employer allocates a certain amount of money to each employee to "buy" the benefits he/she desires
- If the cost of the benefits exceeds the allocation, the employee may contribute the balance
- Without a Section 125 Plan in place an employee's payroll contribution would not be allowed to an HAS
- Church employee welfare plans are specifically exempt from regulation under ERISA

Wellness Programs:

- Employers offer at least some wellness programs in an effort to promote employee health and productivity and reduce health related costs.
- Wellness programs focus on drug abuse and stress
- Can also be offered by insurance plans directly to their enrollees

Group Disability Income Plans

- Group disability plans usually specify benefits in terms of a percentage of the individual's earnings
- Most group disability plans require the employee to have a minimum period of service, such as 30 to 90 days, before being eligible for coverage
- A group Disability Income plan that pays tax-free benefits to covered employees is considered fully contributory
- Group short-term disability plans are characterized by maximum benefit periods of rather short duration, such as 13 or 26 weeks.
- Group long-term disability plans provide for maximum benefit periods of more than two years, occasionally extending to the insured's retirement age.

Group AD&D

- Frequently offered in conjunction with group life insurance plans.
- May be provided as a separate policy, such as employee-pay-all plans, which are called **voluntary group AD&D**
- May be provided for both occupational and nonoccupationally losses or for nonoccupationally losses only
- Normally, does not include a conversion privilege

Blanket Health Plans

- Blanket health insurance is issued to cover a group who may be exposed to the same risks, but the composition of the group (the individuals within the group) are constantly changing.
- A blanket health plan may be issued to an airline or a bus company to cover its passengers or to a school to cover its students
- No certificates of coverage are issued in a blanket health plan, as compared to group insurance.

Franchise Health Plans (Wholesale Plans)

- Provide health insurance coverage to members of an association or professional society

- Individual policies are issued to individual members and the association or society simply serves as the sponsor for the plan
- Premium rates are usually discounted for franchise plans

Credit Accident and Health Plans

- Credit accident and health plans are designed to help the insured pay off a loan in the event she is disabled due to an accident or sickness
- If the insured becomes disabled, the policy provides for monthly benefit payments equal to the monthly loan payments due

Health Savings Accounts (HSAs)

- An HSA is a tax-favored vehicle for accumulating funds to cover medical expenses
- Individuals under age 65 are eligible to establish and contribute to HSAs if they have a qualified high- deductible health plan
- Annual contributions of up to 100% of an individual's health plan deductible can be made to an HSA
- Individuals who are 55 to 65 years old can make an additional catch-up contribution
- Earnings in HSAs grow tax-free, and account beneficiaries can make tax-free withdrawals to cover current and future qualified health care costs.
- Qualified health care expenses include amounts paid for:
    - Doctors' fees
    - Prescription and nonprescription medicines
    - Necessary hospital services not paid for by insurance
    - Retiree health insurance premiums
    - Medicare expenses (but not Medigap)
    - Qualified long-term care services
    - COBRA coverage

Non-occupational Health Plans

- A policy that does not cover injuries sustained while at work because those injuries are covered by workers compensation.

➢ TAX TREATMENT OF GROUP HEALTH PLANS

- Employers are entitled to take a **tax deduction for premium contributions** they make to a group health plan, as long as the contributions represent an "ordinary and necessary business expense."
- As a general rule, **individual** premium contributions to a group health plan are **NOT** tax deductible
- Individual participants do not include employer contributions made on their behalf as part of their taxable income
- Any benefits an individual receives under a medical expense plan are **NOT** considered taxable income because they are provided to cover losses the individual incurred
- Disability benefit payments that are **attributed to employee contributions are not taxable,** but benefit payments that are **attributed to employer contributions are taxable**.
- Sole proprietors are permitted tax deductions for health costs paid from their earnings in the amount of 100% of costs
- Federal income taxes will not likely be applied to death benefits paid to the named beneficiary of an insured under a health insurance policy. However, the proceeds may still be included as part of the insured's taxable estate for estate tax purposes.

- **Accidental Death and Dismemberment Insurance:**
  - Pays benefits in the event of a fatal accident or if dismemberment results from an accidental injury.
  - Primary form of pure accident coverage
  - Provides a stated lump-sum benefit in the event of accidental death or in the event of loss of body members due to accidental injury
  - **Principal Sum**
    - The principal sum under an AD&D policy is the amount payable as a death benefit. It is the amount of insurance purchased- $10,000, $25,000, $50,000, $100,000, or more. The principal sum represents the maximum amount the policy will pay.
  - **Capital Sum**
    - Another form of payment payable under an AD&D policy is the amount payable for the accidental loss of sight or accidental dismemberment. It is a specified amount, usually expressed as a percentage of the principal sum, which varies according to the severity of the injury. For example, the benefit for the loss of one foot or one hand is typically of the principal sum. The benefit for the loss of one arm or one leg is usually two-thirds of the principal sum. The most extreme losses (such as both feet or sight in both eyes) generally qualify for payment of the full benefit, which is 100% of the principal sum
  - Policies that base their benefit payments on accidental means require that both the cause and the result of an accident must be unintentional.
  - AD&D can be purchased by individuals as a single policy or as part of an individual disability income policy.
  - AD&D provide benefits only in the event of death or dismemberment due to an accident
  - **Limited Risk Policies** Set forth specific risk and provide benefits to cover death or dismemberment due to that risk
  - **Special Risk Policies** Covers unusual hazards normally not covered under ordinary accident and health insurance.

Health Insurance Providers

➢ COMMERCIAL INSURANCE PROVIDERS

Health insurance may be written by a number of commercial insurers. The list includes**: life insurance companies, casualty insurance companies, and monoline companies** which specialize in one or more types of medical expense and disability income insurance.

- Commercial insurance companies function on the reimbursement approach
- The right of assignment built into most commercial health policies lets policyowners assign benefit payments from the insurer directly to the health care provider, thus relieving the policyowner of first having to pay the medical care provider

➢ SERVICE PROVIDERS

Service providers offer benefits to subscribers in return for the payment of a premium. Benefits are in the form of services provided by hospitals and physicians in the plan.

Blue Cross and Blue Shield

Blue Cross and Blue Shield are the dominant health insurers of the United States. The nation's Blue Cross and Blue Shield plans are loosely affiliated through the national Blue Cross and Blue Shield Association but are independently managed. 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 to the subscriber, instead of reimbursing the insured.

- As participating providers, the doctors and hospitals contractually agree to specific costs for the medical services provided to subscribers
- Members of Blue Cross and Blue Shield are known as subscribers
- Blue Cross and Blue Shield plans are called prepaid plans because the subscribers pay a set fee (usually each month) for medical services covered under the plan
- Most Blue Cross and Blue Shield organizations operate as nonprofits

Health Maintenance Organizations

A health maintenance organization, or HMO, is another type of organization offering comprehensive prepaid health care services to its subscribing members. HMOs are distinguished by the fact that they not only finance health care services for their subscribers on a prepayment basis, but **they also organize and deliver these health services at its own local health care facilities.**

- Subscribers pay a fixed periodic fee to the HMO (as opposed to paying for services only when needed) and are provided with a broad range of health services, from routine doctor visits to emergency and hospital care
- Health care services are normally rendered only by physicians and hospitals (providers) who participate in the HMO
- The payment given to a physician for each member of an HMO assigned to them is called **capitation**
- When the HMO is represented by a group of physicians who are salaried employees and work out of the HMO's facility, this is known as a closed panel (sometimes called a staff model HMO)
- For non-emergency situations in a closed network plan, a subscriber may be required to pay up to 100% of the billed amount if a health provider is chosen outside of the network

- An HMO which is characterized by a network of physicians who work out of their own facilities and participate in the HMO on a part-time basis is known as an open panel.
- **HMOs are known for stressing preventive care**
- Health maintenance organizations may be self-contained and self-funded based on dues or fees from their subscribers. They may also contract for excess insurance or administrative services provided by insurance companies. In fact, some HMOs are sponsored by insurance companies.
- Employers with **25 or more employees** to offer enrollment in an HMO if they provide health care benefits for their workers
- Hospital care under a typical HMO plan includes services such as hospitalization, in-hospital lab work and X-rays, inpatient laboratory services, and inpatient mental health care
- HMO's often require subscribers to select a primary care physician, which is a doctor who provides all care for a particular member and controls all referrals for specialized care, and in some cases, hospital care
- If a need for emergency health services arises for an enrollee of a health maintenance organization (HMO) using a gatekeeper system, the enrollee should proceed directly to the nearest emergency room
- With HMO prescription drug plans, drugs are usually dispensed through participating pharmacies
- An in-house pharmacy is typically available to enrollees in a staff model

Preferred Provider Organizations

Another type of health insurance provider is the preferred provider organization, or PPO. A preferred provider organization is a collection of health care providers such as physicians, hospitals, and clinics who offer their services to certain groups at **prearranged discount prices**. In return, the group refers its members to the preferred providers for health care services.

- Unlike HMOs, preferred provider organizations usually operate on a fee for-service-rendered basis, not on a prepaid basis
- Members of the PPO select from among the preferred providers for needed services. In contrast to HMOs, PPO's provide a wider choice of physicians. PPO health care providers are normally in private practice. They have agreed to offer their services to the group and its members at fees that are typically less than what they normally charge. In return, the group refers its members to the PPO and the providers broaden their patient/service base
- Groups that contract with PPOs are often **employers, insurance companies, or other health insurance benefit providers**
- While these groups do not mandate that individual members must use the PPO, **a reduced benefit is typical if they do not**
- **If a patient with a preferred provider organization (PPO) chooses to use a non-PPO, the patient usually can expect to have higher out-of-pocket expenses**

Ambulatory Care

Ambulatory care is a personal health care consultation, treatment, or intervention using advanced medical technology or procedures delivered on an outpatient basis. Designed to handle:

- Outpatient surgery
- Routine physicals
- Immunizations

➢ **GOVERNMENT INSURANCE PROGRAMS**

Government provides insurance for many reasons. The primary reasons include:

- To meet social needs
- To make insurance available for certain groups
- To encourage economic development

Medicare

The federally administered Medicare program took effect in 1966. Its purpose is to provide hospital and medical expense insurance protection to those aged 65 and older. It also provides insurance protection to any individual who suffers from chronic kidney disease or to those who have been receiving Social Security Disability benefits for at least 24 months.

- Medicare Part A (Hospital Insurance) covers inpatient care in hospitals and skilled nursing facilities, and it covers care provided in a hospice and some care provided at home
- Part A covers drugs administered as part of inpatient treatment
- Social Security Administration enrollment for the Medicare program and provides information about Medicare to the public
- All parts of the Medicare program (except for public information and enrollment) are administered by The Centers for Medicare and Medicaid Services
- The day the insured enters a hospital is the first day of a Medicare Part A benefit period
- Skilled nursing facility expenses are sometimes covered by Medicare Part A, but ONLY if the insured was hospitalized shortly before entering the facility
- Medicare Part A will cover a maximum of 100 days per benefit period in a skilled nursing facility (days 1-20 will pay 100%, days 21-100 will pay a flat dollar amount per day)
- The lifetime maximum for inpatient psychiatric care under Part A Medicare is 190 days
- The primary source of financing for Part A is Federal payroll and self-employment taxes
- Physicians who agree to accept assignment on ALL Medicare claims are called **participating providers**
- Dental care is not covered under Medicare
- Medicare Part B (Medical Insurance) provides medical insurance for required doctors' services, outpatient services and medical supplies, and many services not covered by Part A
- The difference between the physician's actual charges and Medicare's approved amount is called "excess charge"
- Falling below the federal poverty level is not a qualifying event for Medicare
- Open enrollment period for Medicare Part B is January 1 through March 31
- When becoming eligible for Medicare an individual can enroll in a Part C Medicare Advantage Plan
- Medicare Part B is funded by General tax revenue and user premiums
- Medicare Part A covers inpatient hospital stay
- To become eligible for Part D: Prescription Drug coverage, one must have Medicare coverage

Social Security Disability Income

Social Security provides services other than survivorship and retirement benefits. In addition to Medicare, the federal government also provides disability related benefits through the Social Security OASDI program.

- To be eligible for Social Security Disability benefits, you need to be fully insured, in which you need at least one quarter of coverage for each calendar year after turning 21 years old. The minimum number of credits needed is 6.
- To be fully insured on a permanent basis, 40 quarter credits are required – at this point you are fully insured for Social Security Disability benefits whether you continue to work or not.

- The maximum Social Security Disability benefit an insured may receive is equal to 100% of the insured's Primary Insurance Amount (PIA)
  - Disability income benefits are available to covered workers who qualify under Social Security requirements
  - One of the requirements is that the individual must be so mentally or physically disabled that he cannot perform any substantial gainful work
  - The impairment must be expected to last at least **12 months** or result in an earlier death
  - A **five-month waiting period** is required before an individual will qualify for benefits, during which time he/she must remain disabled
  - The worker's spouse and dependent children are entitled to an income benefit which is a percentage of the worker's primary insurance amount

Medicaid

Medicaid is Title XIX of the Social Security Act, added to the Social Security program in 1965. Its purpose is to provide matching federal funds to states for their medical public assistance plans to help needy persons, regardless of age.

- Medicaid benefits are generally payable to low income individuals who are blind, disabled, or under 21 years of age
- The benefits may be applied to **Medicare deductibles** and co-payment requirements
- Medicaid is financed by both federal and state governments
- Under Medicaid, **financial need** is an eligibility requirement for the payment of **nursing home expenses**

TRI-CARE

TRI-CARE is a federal government accident and health plan which provides accident and health coverage to military families.

Federal Employees Health Benefits Program

The Federal Employees Health Benefits (FEHB) Program is a system of "managed competition" through which employee health benefits are provided to civilian government employees and annuitants of the United States government. There are two types of plans that participate in the FEHB program: fee-for-service plans and health maintenance organizations (prepaid).

State Workers' Compensation Programs

- Workers compensation benefits generally compensate employees for **lost wages and medical expenses due to occupational accidents.**
- All states have workers' compensation laws, which were enacted to provide mandatory benefits to employees for work-related injuries, illness, or death
- Employers are responsible for providing workers' compensation benefits to their employees and do so by purchasing coverage through state programs, private insurers, or by self-insuring
- There is no time limit on how long Workers' Compensation medical expense benefits continue for disabled workers
- The benefits arising from a worker's compensation claim could be inadequate to replace the loss of income
- Under medical expense insurance policies, losses that are covered by workers' compensation are generally excluded from coverage

➢ **ALTERNATIVE METHODS OF PROVIDING HEALTH INSURANCE**

Self-Insurance

- Many self-insured plans are administered by insurance companies or other organizations that are paid a fee for handling the paperwork and processing the claims. When an outside organization provides these functions, it is called an administrative-services-only (ASO) or third-party administrator (TPA) arrangement.
- To bolster a self-insured plan, some groups adopt a minimum premium plan (MPP). These plans are designed to insure against a certain level of large, unpredictable losses, above and beyond the self-insured level. As the name implies, MPPs are available for a fraction of the insurer's normal premium.

Multiple Employer Trusts

- A method of marketing group benefits to employers who have **a small number of employees** is the multiple employer trust (MET). They are usually in the same industry group
- METs can provide a single type of insurance (e.g., health insurance) or a wide range of coverages (e.g., life, medical expense, and disability income insurance)
- An employer who wants to get coverage for employees from a MET must first become a member of the trust by subscribing to it
- A MET may either provide benefits on a self-funded basis or fund benefits with a contract purchased from an insurance company
- In the latter case, the trust (rather than the subscribing employers) is the master insurance contract holder
- Participants are issued a joinder agreement (document which an individual is admitted as a member and bound to the terms of membership)
- The employer's premium payments are directed into a trust from which the plan's benefits and claims are paid. These trusts are also called **501(c)(9)** trusts after the relevant section of the Internal Revenue Code.
- Self-insured plans are common to multiple employer trusts (METs) or multiple employer welfare arrangements (MEWAs). They are also common in cases where the insured group is small, with relatively healthy members and few claims.
- Self-funded plans commonly use the services of an insurance company to act as a third-party administrator of the plan. Insurers may provide such services without responsibility for claims payment under an **Administrative Services Only** (ASO) contract.

Multiple Employer Welfare Arrangements

- A multiple employer welfare arrangement (MEWA) is a type of MET
- It consists of small employers who have joined to provide health benefits for their employees, often on a self-insured basis
- They are tax-exempt entities
- Employees covered by a MEWA are required by law to have an employment related common bond

Disability Income Insurance

➢ PURPOSE OF DISABILITY INCOME INSURANCE

- Disability income insurance is designed to provide an individual with a stated amount of periodic income in the event of a **disabling illness or accident**
- The financial impact of total disability may be worse than the financial impact of death
- Disability income policies are available as individual plans and group plans
- They also serve a very important function for businesses and business owners
- The most common type of individual disability income policy is the guaranteed renewable policy, which typically adjusts the premium on an annual basis and provide benefits for nonoccupational illnesses and injuries

➢ DISABILITY INCOME BENEFITS

- The **insured's income** limits the amount of the monthly benefit that an insured may select in a Disability Income policy
- The benefits paid under a disability income policy are in the form of monthly income payments.
- The highest premium under the disability income policy is a 14-day waiting period with a 10-year benefit period
- Insurers typically place a ceiling on the amount of disability income protection they will issue on any one applicant, defined in terms of the insured's earnings
- Insurers use two methods to determine the amount of benefits payable under their disability income policies: percent-of-earnings approach and the flat amount method.
- The first method is called the **percent-of-earnings approach**, which determines the benefit using a percentage of the insured's pre-disability earnings and considers other sources of disability income
- The second method used to establish disability benefits is the **flat amount method.** Under this approach, the policy specifies a flat income benefit amount that will be paid if the insured becomes totally disabled. Normally, this amount is payable regardless of any other income benefits the insured may receive.
- In the event the insured dies because of the disability, any earned but unpaid benefits will be paid to the insured's estate
- Group long-term disability benefit amounts are typically limited to 60% of a participant's income

➢ Disability Defined

- With one exception (partial disability), an insured must be totally disabled before benefits under a disability income policy are payable
- What constitutes total disability varies from policy to policy
- The insured must meet the definition set forth in her policy
- In disability income insurance, the definition of total disability often considers the insured's education, training, and experience
- There are two definitions: any occupation or own occupation

Any Occupation

The "any occupation" definition of total disability requires the insured to be unable to perform **any occupation** for which he is reasonably suited by reason of education, training, or experience to qualify for disability income benefits

Own Occupation

The "own occupation" definition of total disability requires that the insured be unable to perform the insured's **current occupation** because of an accident or sickness.

- From a policyowner's point of view, an "own occupation" disability income policy is more advantageous
- It is more expensive and difficult to qualify for

Presumptive Disability

- This provision specifies certain conditions that automatically qualify the insured for the full benefit because the severity of the conditions presumes the insured is totally disabled even if he can work
- Presumptive disabilities include blindness, deafness, loss of speech, and loss of two or more limbs (*in this case it is presumed you are disabled)*
- A presumptive disability provision typically waives the usual requirements for total disability benefits

Partial Disability

- The inability of the insured to perform one or more important duties of the job or the inability to work at that job on a full-time basis. Either of which results in a decrease in income.
- Normally, partial disability benefits are payable only if the policyowner has first been totally disabled
- Permanent Partial disability would be less than total impairment and equal to permanent impairment
- This benefit is intended to encourage disabled insureds to get back to work, even on a part-time basis, without fear that they will lose all their disability income benefits
- The amount of benefit payable when a policy covers partial disabilities depends on whether the policy stipulates a flat amount or a residual amount

Flat Amount Benefit

- A flat amount benefit is a set amount stated in the policy
- This amount is usually 50% of the full disability benefit
- *For example, let's assume Helen, who has a disability income policy with an own-occupation definition, is severely injured after falling down a flight of stairs. She is unable to work for four months during which time her disability income policy pays a full benefit. After four months she can return to work, but only on a part-time basis earning substantially less than she did before her injury. If her policy did not contain a partial disability provision, her benefits would cease entirely because she no longer meets the definition of totally disabled. However, if her policy provides for partial disability benefits to be paid as a flat amount, she will be able to work on a part-time basis and continue to receive half of her disability benefits.*

Residual Amount Benefit

- Normally used after a full disability payment have been paid and the insured is back to work, however with a **reduced** workload
- A residual amount benefit is based on the proportion of income lost due to the **partial** **disability**, considering the fact that the insured is able to work and earn some income
- The benefit is usually determined by multiplying the percentage of lost income by the stated monthly benefit for total disability.

- *For example, let's say your job was to wash 10 cars a day. You broke your arm, were still able to work, but could only wash 6 cars a day because of the residual impact of the broken arm.*
- If the insured suffered a 40% loss of income because of the partial disability, the residual benefit payable would be 40% of the benefit that the policy would provide for total disability.
- A Residual Disability benefit is usually a **percentage of the total disability benefit** for when the insured is working, but unable to perform some of the duties of his/her occupation

Rehabilitation Benefit

- An insured may not be able to return normal occupation because of a disability, but still be able to work at some kind of job. The rehabilitation benefit facilitates vocational training to prepare insureds for a new occupation.
- Under the rehabilitation benefit in a disability income policy, the insurer will pay the approved cost a of a rehabilitation program to help a disabled return to work

Cause of Disability

- Policies that use the **accidental means provision** require that the **cause** of the injury must have been unexpected and accidental
- Policies that use the **accidental bodily injury provision (or results provision)** require that the result of the injury has to be unexpected and accidental
- *For example, Jim took an intentional dive off a high, rocky ledge into a lake. He struck his head on some rocks and ended up partially paralyzed. If his policy had an accidental means provision, the benefits would probably not be payable because the cause of his injury (the dive) was intentional. However, if his policy had an accidental bodily injury (or results) provision, benefits would be payable because the result of the accident (his injury) was unintentional and accidental.*
- Today, most disability income policies use the accidental bodily injury or results provision, which is far less restrictive than the accidental means provision

➢ DISABILITY INCOME POLICY PROVISIONS

Probationary Period

- The probationary period specified in a disability insurance policy is the period of time that must elapse following the effective date of the policy before benefits are payable.
- It is a one-time-only period that begins on the policy's effective date and ends 15 or 30 days after the policy has been in force.
- Purpose of the probationary period is to exclude preexisting sicknesses from coverage and provide a guidepost in borderline cases when there is a question as to whether an insured became ill before or after the effective date of the policy.
- Helps protect the insurer against **adverse selection** because those who know they are ill are more likely to try to obtain insurance coverage.
- Probationary period does not apply to accidents because you cannot anticipate an accident

Elimination Period

- The elimination period is the time immediately following the start of a disability when benefits are not payable
- Elimination periods eliminate claims for short-term disabilities
- The longer the elimination period, the lower the premium for comparable disability benefits
- The elimination period is sometimes called the waiting period

Benefit Period

- The benefit period is the maximum length of time that disability income benefits will be paid to the disabled insured
- The longer the benefit period, the higher the cost of the policy
- Individual short-term policies provide benefits for six months to two years
- Individual long-term policies are characterized by benefit periods of more than two years, such as 5, 10, or 20

Delayed Disability Provision

- In some cases, total disability does not occur immediately after an accident but develops some days or weeks later
- Most policies allow a certain amount of time during which total disability may result from an accident and the insured will still be eligible for benefits
- The amount of time allowed for a delayed disability may be 30, 60, or 90 days etc.

Recurrent Disability Provision

- It is not unusual for a person who experienced a total disability to recover and then, weeks or months later, undergo a recurrence of the same disability
- Most policies provide for recurrent disabilities by specifying a period of time during which the recurrence of a disability is considered a continuation of the prior disability
- The insurer will then pay benefits without a new elimination period
- If the recurrence takes place after that period, it is considered a new disability and will be subject to a new elimination period before benefits are again payable
- *For example, say you were recovering from a serious illness and missed 2 months of work. Then you went back to work and 2 weeks later the disability came back or **recurred** and you were forced to miss more work while you recovered again.*

Change of Occupation Provision

Under the change of occupation provision, if an individual covered under a disability income policy is injured while engaged in an occupation that is more hazardous than the occupation stated in the policy, the result will be the benefit level is reduced. If the insured is engaged in a less hazardous occupation than that was originally stated in the policy, the benefits will likely be increased

Nondisabling Injury

- Frequently, a person covered by a disability income policy will suffer an injury that does not qualify for income benefits
- Many such policies include a provision for a medical expense benefit that pays the actual cost of medical treatment for nondisabling injuries that result from an accident

Elective Indemnity

- Some short-term disability income policies provide for an optional lump- sum payment for certain named injuries
- The insured may sometimes select this elective indemnity option when applying for the policy

Coverage after Age 65

Disability income policies typically require the insured to be actively working for the stated number of hours per week if coverage extends past age 65.

➢ **DISABILITY INCOME POLICY RIDERS**

Waiver of Premium Rider

- A waiver of premium rider generally is included with guaranteed renewable and noncancelable individual disability income policies.
- It exempts the policyowner from paying the policy's premiums during periods of total disability.
- To qualify for the exemption, the insured must experience total disability for more than a specified period, commonly three or six months.
- The waiver of premium generally does not extend past the insured's age 60 or 65
- Premiums are waived beginning at the date of disability

Social Security Rider

The Social Security rider provides for the payment of additional income when the insured is eligible for social insurance benefits, but those benefits have not yet begun, have been denied, or have begun in an amount less than the benefit amount of the rider

Cost-of-Living Adjustment (COLA) Rider

- The cost-of-living adjustment (COLA) rider provides for indexing the monthly or weekly benefit payable under a disability policy to changes in the Consumer Price Index (CPI)
- Typically, the benefit amount is adjusted on each disability anniversary date to reflect changes in the CPI

Guaranteed Insurability Rider

This option guarantees the insured the right to purchase additional amounts of disability income coverage at predetermined times in the future without evidence of insurability

Exclusion Rider

An exclusion rider on a disability income policy means that a specified disease or body part is not afforded coverage

Medical Expense Insurance

Medical expense insurance provides financial protection against the cost of medical care for accidents and illness. Coverage may be provided for hospital care, physician services, surgical expenses, diagnostic and laboratory services, drugs, nursing,

and other medically necessary procedures. The broadness of the specific types of services and treatment are dependent upon the medical expense policy written. Medical expense insurance typically excludes coverage for care provided in a government facility. Individual medical expense insurance typically is written for a term of 1 year.

➢ BASIC MEDICAL EXPENSE PLANS

- Basic medical expense insurance is sometimes called "first dollar insurance". Unlike major medical expense insurance, it provides benefits up front without having to satisfy a deductible
- Basic medical expense policies classify their coverages according to general categories of medical care: hospital expense, surgical expense, and physicians' (nonsurgical) expense
- Basic medical expense insurance typically has lower benefit limits than major medical insurance
- The benefits provided by basic medical expense insurance are lower than the actual expenses incurred
- A particular fee charged by a physician or other health professional is called a usual, customary, and reasonable expense
- The amount of the patient's claim payment will be based on the terms of the policy

Hospital Expense policies

- **Cover hospital room and board, miscellaneous hospital expenses** (such as lab and x-ray charges), medicines, use of operating room, and supplies
- These expenses are covered while the insured is confined in a hospital
- There is no deductible and the limits on room and board are set at a specified dollar amount per day up to a maximum number of days
- Hospital room and board benefits cover expenses for occupancy of the room and bed, general nursing care, food and beverages, and personal hygiene items
- Concurrent review is a method of utilization review that takes place on-site when a patient is confined to a hospital. **A typical result of a concurrent review is that the length of stay in the hospital is monitored.**
- Preadmission testing helps control health care costs primarily by reducing **the length of hospitalization**
- These limits may not provide for the full amount of hospital room and board charges incurred by the insured.
- *For example, if the hospital expense benefit was $200 per day and the hospital actually charged $400 per day, the insured would be responsible for the additional $200 per day*

Basic Surgical Expense Coverage

- Commonly written in conjunction with hospital expense policies
- These policies pay for the costs of surgeons' services, whether the surgery is performed in or out of the hospital
- Coverage includes surgeon's fees, anesthesiologist, and the operating room
- Under the **surgical schedule approach**, every surgical procedure is assigned a dollar amount by the insurer
- Under the **reasonable and customary approach**, the surgical expense is compared to what is deemed reasonable and customary for the geographical part of the country where the surgery was performed. If the charge is within the reasonable and customary parameters, the expense is normally paid in full. If the charge is more than what is reasonable and customary, the patient must absorb the difference
- **Usual, customary, and reasonable (UCR)** charges are the maximum amount the insurer will consider eligible for reimbursement under a health insurance plan. It is based primarily on average charges within a geographic area
- The **relative value approach** is similar to the surgical schedule method. The difference is that instead of a flat dollar amount being assigned to every surgical procedure, a specified set of units is assigned. The policy will carry a stated dollar-per-units amount (known as the conversion factor) to determine the benefit

Basic Physicians' Expense Coverage

- Often referred to as Basic Physicians Nonsurgical Expense Coverage because it provides coverage for nonsurgical services a physician provides

- Basic medical expense coverage can be purchased to cover emergency accident benefits, maternity benefits, mental and nervous disorders, hospice care, home health care, outpatient care, and nurses' expenses
- Regardless of what type of plan or coverage is purchased, these policies usually offer only limited benefits that are subject to time limitations

Other Basic Plans

- **Nurses' expense benefits**
  - Usually pay only for private duty nursing care arranged according to a doctor's order while the insured is a hospital patient
  - Both registered professional and licensed practical nurses may be covered
- **Convalescent care facility benefits**
  - Provide a daily benefit for confinement in a skilled nursing facility for a limited recovery period following discharge from a hospital
- **Pharmacy benefits**
  - Patient care services are generally limited to medication dispensing and medication therapy management activities required by individual state boards of pharmacy.
  - A controlled substance list is a pharmacy benefit that covers prescription drugs

➢ **MAJOR MEDICAL EXPENSE PLANS**

Major medical expense insurance usually picks up where basic medical expense insurance leaves off in one of two ways: as a supplement to a basic plan or as a comprehensive stand-alone plan. Major medical expense plans offer broad coverage under one policy:

- Benefits for reasonable and necessary medical expenses, subject to policy limits
- Comprehensive coverage for hospital expenses (room and board and miscellaneous expenses, nursing services, physicians' services, etc.)
- Catastrophic medical expense protection
- Benefits for prolonged injury or illness
- Unlike the basic medical expense plans, these policies **usually carry deductibles, coinsurance requirements, and have large benefit maximums**
- Coverage is provided for both inpatient and outpatient hospital expenses
- Hospice benefits under a major medical plan normally includes coverage for pain management, home-based services, and counseling
- The list of prescription drugs covered by a pharmacy benefit is called a **drug formulary**

Supplementary Major Medical

- These policies are used to supplement the coverage payable under a basic medical expense policy
- After the basic policy pays, the supplemental major medical will provide coverage for expenses that were not covered by the basic policy, and expenses that exceed the maximum
- If the time limitation is used up in the basic policy, the supplemental coverage will provide coverage thereafter

Comprehensive Major Medical

- Combines the features of basic expense coverage and major medical coverage, sold as one policy
- Cover practically all medical expenses, hospital, physicians, surgical, nursing, drugs, laboratory tests, etc.
- Comprehensive major medical policies include a deductible (usually a single deductible per person and per family, but corridor deductible may also apply), coinsurance, and are generally sold on a group basis. An example of a comprehensive health policy is a major medical policy.

- Most major medical plans contain a "lifetime maximum benefit" that limits the insurer's total exposure under a contract, while few contain a "per cause maximum benefit" which limits the medical expenses covered for each cause

➢ MAJOR MEDICAL EXPENSE CHARACTERISTICS

Deductibles

A deductible is a stated initial dollar amount that the individual insured is required to pay before insurance benefits are paid. Deductibles are used primarily to help control the cost of premiums and are used most frequently with major medical policies. A policy can have multiple types of deductibles.

- **Flat (initial) deductible** is a stated dollar amount that applies to a covered loss (*for example $500*). This deductible is applied per occurrence, per insured individual.
- **Corridor deductible** covers the gap between basic coverage and major medical. When a major medical policy is supplementing basic coverage (that contains no deductible), the deductible is not applied until the basic coverage has been exhausted
- **Integrated deductible** is used when a major medical plan is supplementing basic coverages. *For example, If the major medical has a $500 deductible and the insured has basic coverage of $500 or more, then, in the event of a claim, the amount paid by the basic coverage satisfies the major medical deductible. However, if the basic does not cover the entire deductible amount of the major medical plan, the insured is required to make up the difference*
- In a **per-cause deductible**, the insured must satisfy a deductible for each accident or illness.
- In an **all-cause deductible**, the insured only has to meet the deductible amount once during the benefit period.
- With a **Calendar-year deductible,** the deductible year begins on January 1st and ends on December 31st. Calendar-year deductibles reset every January 1st. A Calendar-year deductible requires the insured to pay a specific sum out of pocket before any benefits are paid in a calendar year.

The **carryover provision** permits expenses incurred during the **last 3 months** of the calendar year to be carried over into the new year if needed to satisfy the deductible for the next year.

Coinsurance

Coinsurance is another characteristic of major medical policies. It is a sharing of expenses by the insured and the insurer. After the insured satisfies the deductible, the insurance company and the insured share in the remainder of expenses.

- The insurance company pays a high percentage of the additional expenses (usually 75% or 80%) and the insured pays the remainder.
- Typically, the percentage of payment participation required of the insured is 20% and the insurance company pays 80%
- Coinsurance requires the insured to participate in the payment of expenses

Stop-Loss (Out of Pocket Maximum/Maximum Out of Pocket)

- Stop – Loss is a feature designed to limit the amount of expense the insured may be exposed to in a policy year
- Often, the stop-loss will state that after the insured has paid a specific amount toward his covered expense, the insurer, will pay 100% of the remaining expenses for the remainder of the policy year, up to the maximum limit of the policy.

Pre-existing Conditions

- Most policies contain a benefit limitation on pre-existing conditions
- Limitations apply to all pre-existing conditions whether or not the insured declared them on the application
- Unlike the impairment rider, the exclusion for pre-existing conditions is subject to the time limit for certain defenses

- When considering the replacement of an individual accident and health insurance policy, a preexisting conditions exclusion in the new contract may reduce the insured's benefits. The new policy may not cover the same health conditions under the new policy.

Internal Limits

Certain types of expenses may have limits placed on the dollar amount of certain services or on the type of service provided. For example, the policy will only pay for a semi-private room, not for a private room; or it will pay only medical expenses that are usual and customary; or it will pay lifetime alcohol or drug rehab expenses only up to $10,000, or for 75 days, etc.

- **MEDICAL EXPENSE ACCOUNTS**

Health Savings Accounts (HSA)

- A tax-advantaged medical savings account available to individuals who are enrolled in a high-deductible health plan.
- The funds contributed to an account are not subject to federal income tax at the time of deposit and roll over and accumulate year to year if not spent.
- HSAs are owned by the individual and are an alternate tax-deductible source of funds used to pay for qualified medical expenses at any time without federal tax liability or penalty.
- Health savings accounts (HSAs) are designed to help individuals save for qualified health expenses such as deductibles, coinsurance, prescription drugs etc. that they, their spouse, or their dependents incur
- HSAs are **tax deductible**
- An individual who is covered by a **high- deductible health plan** can make a tax-deductible contribution to an HSA and use it to pay for out- of-pocket medical expenses
- Contributions to HSAs by individuals are deductible, even if the taxpayer does not itemize.
- Contributions by an employer are not included in the individual's taxable income
- To be eligible for a Health Savings Account, an individual must be covered by a **high-deductible health plan (HDHP)**, must not be covered by other health insurance (does not apply to accident insurance, disability, dental care, vision care, long-term care), must not be eligible for Medicare, and can't be claimed as a dependent on someone else's tax return
- Distributions other than for qualified medical expenses to a Health Savings Account are taxable and subject to a penalty of **10%**

Health Reimbursement Arrangements (HRA)

- Must be established by the employer
- Employer-funded, tax-advantaged health benefit plans that reimburse employees for out-of-pocket medical expenses and individual health insurance premiums.
- Unused amounts may be carried forward for reimbursement in future years.
- Reimbursements may be tax-**free** if the employee paid for qualified medical expenses or a qualified medical plan
- Employee **does NOT** contribute to an HRA

Medical Savings Accounts (MSA)

- Created to help employees of small employers, as well as self-employed individuals, pay for their medical care expenses.
- MSA's are tax-free accounts set up with financial institution such as banks and insurance companies.
- Qualified medical savings accounts are available for employers with no more than 50 employees

Flexible Savings Accounts (Flexible Spending Accounts)

- Tax-advantaged accounts that can be set up through a cafeteria plan of an employer.

- An FSA allows an employee to set aside a portion of earnings to pay for qualified medical expenses (such as prescription medication) as established in the cafeteria plan.

Private Insurance Plans for Seniors

➢ MEDICARE SUPPLEMENTS, MEDICARE SELECT, MEDICARE PART C & D

Medicare Supplement Policies (Medigap)

- Medicare Supplement (Medigap) insurance is specifically designed for individuals by the age of 65 who have enrolled in Medicare however, anyone currently receiving Medicare Parts A and B is eligible to participate in a Medigap policy
- Medicare in-hospital deductible is addressed with Medicare Supplemental Insurance
- A Medigap policy is a Medicare supplement insurance policy sold by private insurance companies to cover medical costs not covered by the government in Medicare Parts A and B.
- Medigap policies do not pay costs for Medicare Parts C and D
- As of June 2010, there are 10 standardized Medigap plans. Each of the 10 plans has a letter designation of A, B, C, D, F, G, K, L, M, or N
- These policies were standardized by the National Association of Insurance Commissioners (NAIC) to help consumers understand and compare them and make informed buying **decisions**
- These standards can be found in NAIC's Medicare Supplement Insurance Minimum Standards Model Act
- Medicare Supplement policies sometimes provide preventative medical care benefits such as annual physical exams
- A Medicare Supplement policy must NOT contain benefits which duplicate Medicare benefits
- Individuals over 65 who have just enrolled in Medicare Part B for the first time cannot be refused a Medicare Supplement policy and cannot be rated if they apply for coverage within 6 months of Part B enrollment (in other words, Medicare Supplements must be guaranteed issue during open enrollment)
- All Medicare supplement policies must be guaranteed renewable and can only be canceled by the insurer for nonpayment of premiums
- Hospice care is included in most standard Medicare Supplement insurance policies
- Hospice care typically offers a family counseling benefit
- Medicare Supplement policies typically provide foreign travel emergency health care coverage as a core benefit when you travel outside the U.S.
- Coverage for Medicare Part B excess charges is a Medicare Supplement additional benefit.
- Medicare Supplement Plan F will not pay for charges exceeding the approved amount
- In general, the following six minimum standards apply to all policies designated as Medicare Supplement Insurance.
  - The policy must supplement both Part A and Part B of Medicare
  - The policy must automatically adjust its benefits to reflect statutory changes in Medicare
  - The policy must cover all expenses not covered by Part A from the 61st to the 90th day. Furthermore, it must cover the lifetime reserve copayment and must provide full coverage for an additional 365 days after Medicare benefits are exhausted.
  - If the policy excludes coverage for preexisting conditions, the exclusion cannot exist for longer than six months. That is, no coverage can be denied as a preexisting condition after the policy has been in effect for six months.
  - Part B expenses not covered by Medicare (that is, the 20% co-payment) must be covered by the Medigap policy. However, policies may include a deductible before this benefit becomes payable.
  - The policy must include a minimum 30 day free-look provision.

Core Benefits

All Medicare Supplement plans cover coinsurance on hospital costs, up to an additional 365 days after Medicare Part A hospital benefits run out. All Medigap policies also cover at least part of these costs:

- Medicare Part A hospice coinsurance or copayment

- Medicare Part B coinsurance or copayment
- First 3 pints of blood received as a hospital inpatient

Medicare Select

Medicare Select Coverage means Medicare supplement coverage through a preferred provider organization (PPO) or any other type of restricted network whose coverage has been approved by the state. A PPO is a health care provider or an entity that contracts with health care providers that establish alternative or discounted rates of payment and offers the insureds certain advantages for selecting the member providers. Examples of Medicare Select organizations include provider groups, hospital marketing plans, and groups that are formed or operated by insurers or third-party administrators. An insured must choose providers that belong to a network (except in cases of emergencies).

- With a Medicare Select plan, the insured agrees to use preferred providers, and in exchange, pay a lower premium

Medicare and Managed Care

There are a number of Managed Care Organizations (MCOs) that have contracted with the Health Care Financing Administration to provide both Part A and Part B services to Medicare recipients. Medicare managed care plans are offered by private companies. A company can make a plan available to everyone with Medicare in a state or only be open in certain counties. A company also may choose to offer more than one plan in an area providing different benefits and costs. Each year a managed care company can decide to join or leave Medicare.

Medicare Part C (Medicare Advantage)

Medicare Advantage Plans are Medicare provided by an approved Health Maintenance Organization or Preferred Provider Organization. Some of these plans do not charge premiums beyond what is paid by Medicare and others do. These are coordinated care plans that generally offer people with Medicare additional benefits and coordinated care beyond the standard Medicare coverage (such as eye exams, hearing aids, dental care, and prescription drugs).

Another choice is a Private Fee For Service (PFFS) Plan. In this type of plan an individual may go to any Medicare-approved doctor or hospital that accepts Medicare payments. The insurance plan, rather than the Medicare Program, decides how much it will pay and what the Medicare enrollee pays for the services rendered. The plan could include extra benefits that are not covered under the original Medicare plan.

- HMO's, PPO's, and Private Fee-For-Services are all types of a Medicare Advantage Plan
- In addition to the premium, Medicare Advantage enrollees normally must pay a small copayment per visit or per service
- Medicare Part C does NOT cover long-term care

Medicare Part D

Medicare Part D is a prescription drug plan administered by one of several private insurance companies, each offering a plan with different costs and lists of drugs that are covered. Participation in Part D requires payment of a premium and a deductible.

- **LONG-TERM CARE INSURANCE**

Nursing home care is often covered by long-term care insurance. However, long-term care (LTC) refers to a broad range of medical, personal, and environmental services designed to assist individuals who have lost their ability to remain completely independent in the community.

- Although care may be provided for short periods of time while a patient is recuperating from an accident or illness, LTC refers to care provided for an extended period of time (normally more than 90 days).
- Depending on the severity of the impairment, assistance may be given at home, at an adult care center, or in a nursing home.
- It is similar to most insurance plans in that the insured receives specified benefits in the event long-term care is required
- Most LTC policies pay the insured a fixed dollar amount for each day the policy covers, regardless of what the care costs

Long-Term Care Coverages

- As individuals age, they are likely to suffer from acute and chronic illnesses or conditions. **An acute illness** is a serious condition, such as pneumonia or influenza, from which the body can fully recover with proper medical attention**.** The patient may also need some assistance with chores for short periods of time until recovery and rehabilitation from the illness are complete.
- Some people will suffer from chronic conditions, such as arthritis, heart disease, or hypertension, which are treatable but not curable illnesses
- Over time, a chronic condition frequently goes beyond being a nuisance and begins to inhibit a person's independence
- Most long-term care insurance policies will pay benefits when you cannot perform **at least two Activities of Daily Living (ADL).**
- **The Activities of Daily Living** are a series of basic activities performed by individuals on a daily basis necessary for independent living at home or in the community. There are many variations on the definition of the activities of daily living, but most organizations agree there are 5 basic categories.

  1. **Personal hygiene** - bathing, grooming and oral care
  2. **Dressing** - the ability to make appropriate clothing decisions and physically dress oneself
  3. **Eating** - the ability to feed oneself though not necessarily to prepare food
  4. **Maintaining continence** - both the mental and physical ability to use a restroom
  5. **Transferring** - moving oneself from seated to standing and get in and out of bed

Categories of long-term care

- **Skilled nursing care** is continuous, around-the-clock care provided by licensed medical professionals under the direct supervision of a physician. Skilled nursing care is usually administered in nursing homes.
- Intermediate nursing care is provided by registered nurses, licensed practical nurses, and nurse's aides under the supervision of a physician. It's provided in nursing homes for stable medical conditions that require daily, but not 24-hour, supervision.
- Custodial care provides assistance in meeting daily living requirements, such as bathing, dressing, getting out of bed, toileting, and so on.

Home and Community-Based Services

Home health care is care provided in the insured's home, usually on a part-time basis. It can include skilled care (e.g., nursing, rehabilitative, or physical therapy care ordered by a doctor) or unskilled care (e.g., help with cooking or cleaning).

Adult Day Care

Adult day care is designed for those who require assistance with various activities of daily living, while their primary caregivers (usually family or friends) are absent

Respite Care

Respite care is designed to provide a short rest period for a family caregiver.

Continuing Care

Designed to provide a benefit for elderly individuals who live in a continuing care retirement community

Taxation of LTC Benefits

- Qualified LTC insurance contracts are treated in the same manner as accident and health insurance contracts
- Amounts received under an LTC contract are **excluded from income** because they are considered amounts received for personal injuries and sickness
- There is a limit on these amounts and these limits are adjusted for inflation annually

Long Term Care Partnership Plan

The Long-Term Care Partnership Program is a Federally-supported, state-operated initiative that allows individuals who purchase a qualified long-term care insurance policy or coverage to protect a portion of their assets that they would typically need to spend down prior to qualifying for Medicaid coverage. The difference between a Long-Term Care Partnership Plan and a Non-Partnership Plan is asset protection

Social Security

- **PURPOSE**

The Social Security system provides a basic floor of protection to all working Americans against the financial problems brought on by death, disability, and aging. Social Security augments but does not replace a sound personal insurance plan. Unfortunately, too many Americans have come to expect Social Security will fulfill all their financial needs. The consequence of this misunderstanding has been disillusionment by many who found, often too late, they were inadequately covered when they needed life insurance, disability income, or retirement income.

Social Security, also known as Old Age, Survivors, and Disability Insurance (OASDI), was signed into law in 1935 by President Roosevelt as part of the Social Security Act. Social Security was established during the Great Depression to assist the masses of people who could not afford to sustain their way of life because of unemployment, disability, illness, old age, or death.

➢ WHO IS COVERED

Social Security extends coverage to virtually every American who is employed or self-employed, with few exceptions. Those not covered include:

- Most federal employees hired before 1984 who are covered by Civil Service Retirement or another similar plan
- Approximately 25% of state and local government employees who are covered by a state pension program and elect not to participate in the Social Security Program
- Railroad workers covered under a separate federal program called the Railroad Retirement System

➢ HOW BENEFITS ARE DETERMINED

A person must be insured under the Social Security program for survivors, disability, or retirement benefits to pay. Social Security benefits are based on how long a covered worker has worked throughout his life.

Insured Status

Social Security establishes benefit eligibility based on an "insured" status. There are two types of insured statuses that qualify individuals for Social Security benefits:

- To obtain **Fully Insured Status**, a covered worker must accrue a total of 40 quarters of credit, which is about 10 years of work.
- To be considered **Currently Insured**, and thus eligible for limited survivor benefits, a worker must have earned 6 credits during the last 13-quarter period.

Social Security Payroll Taxes

- Funding for Social Security is collected from FICA payroll taxes.
- Social Security payroll taxes are collected from employers, employees, and self-employed individuals.
- FICA tax is applied to an employee's income up to a certain income amount. This amount is called the taxable wage base.
- There is a maximum amount of earnings that can be subject to Social Security tax each year. This amount is indexed each year to the national average wage index. This maximum applies to employers, employees, and self-employed individuals. Medicare Part A taxes are not subject to a maximum taxable wage cap.

Taxation of Social Security Benefits

- Social Security benefits are subject to federal income tax if the beneficiary files an individual tax return and his annual income is greater than $25,000.
- Joint filers will pay federal income tax on their Social Security benefits if their income is greater than $32,000.

Calculating Benefits

- Based on the individual's average monthly wage during his working years.
- The primary insurance amount (PIA) is used to establish the benefit. It is equal to the worker's full retirement benefit at age 65.
- If a worker retires early, for example at age 62, his retirement benefits will be 80% of his PIA and will remain lower for the covered worker's life.
- The PIA is based on the average earnings over your lifetime.

➢ TYPES OF OASDI BENEFITS

Survivors Benefits

Social Security Survivors benefits or death benefits: pay a lump-sum death benefit or monthly income to survivors of deceased covered workers.

Survivor's benefits: include a $255 lump-sum death benefit, surviving spouse benefits, child's benefit, and parent's benefit.

- A surviving spouse without dependent children is eligible for Social Security survivor benefits as early as age 60.
- Survivor benefits are also available to:
  - A spouse of any age who is caring for children under age 16
  - Children under age 18
  - Children under age 19 who are full time students
  - Children at any age if disabled before age 22 and remain disabled
- A Social Security benefit of 75% of the Primary Insurance Amount (PIA) is given to an underage child of a deceased worker.

Disability Benefits

- Only available to covered workers **who are fully insured,as defined by Social Security,** at the time of disability.
- Disability income benefits are paid to the covered worker in the amount of the PIA after a **5-month** waiting period.
- Only available prior to the age of 65
- Does not pay partial disability or short-term disability benefits
- Disability must be total and expected to last 12 months or end in death
- Benefits include monthly payments to the disabled worker, spousal benefits, and child's benefits.
- **Definition of Disability:** In order to be considered totally disabled, an individual has to qualify according the following requirements:
  - The inability to engage in any gainful work that exists in the national economy
  - The disability must result from a medically determinable physical or mental impairment that is expected to result in early death, or has lasted, or is expected to last for a continuous period of 12 months

Retirement Benefits

- Benefits are only available to covered workers who are fully insured upon retirement.
- Benefits are paid monthly.
- If a covered worker retires at the normal retirement age, he will receive 100% of the PIA.
- If a covered worker retires early at the age of 62, the maximum Social Security benefit is 80% of the PIA. This reduction remains all through retirement.
- Retirement benefits pay covered retired workers at least 62 years of age, their spouses and other eligible dependents monthly retirement income.
- Retirement benefits include monthly retirement payments to the covered worker, spousal benefits, and child's benefits.

Black-Out Period

- Benefits paid to the surviving spouse of a deceased person who was receiving Social Security.

- The “black-out period” begins when Social Security survivorship benefits cease.
- This is when the youngest child turns 16 years old, or immediately if there are no children.
- The “black-out period” ends when the surviving spouse turns at least 60 years old.

Health Insurance Policy Provisions, Riders, and Exclusions

➢ NAIC MODEL HEALTH INSURANCE POLICY PROVISIONS

- Years ago, the National Association of insurance Commissioners (NAIC) developed a model Uniform Individual Accident and Sickness Policy Provisions Law
- Almost all states have adopted this model law or similar legislation or regulations
- The purpose of the NAIC law was to establish uniform or model terms, provisions, and wording standards for inclusion in all individual health insurance contracts

Twelve Mandatory Policy Provisions

1. Entire Contract

- The entire contract includes the actual policy and the application
- It states that nothing outside of the contract (the contract includes the signed application and any attached policy riders) can be considered part of the contract
- It also assures the policyowner that **no changes will be made to the contract or waive any of the provisions after it has been issued**, even if the insurer makes policy changes that affect all policy sales in the future. This, however, does not prevent a mutually agreeable change or modifying the contract after it has been issued.
- Any change to a policy must be made with the approval of an executive officer of the insurance company whose approval must be endorsed on the policy or attached in a rider
- This mandatory health policy provision states that the policy, including endorsements and attached papers, constitutes the entire insurance contract between the parties
- *We can't send you additional paperwork later. THE ENTIRE POLICY AND APPLICATION is sent to you and that makes up your ENTIRE CONTRACT.*

2. Time Limit on Certain Defenses

- **The Time Limit on Certain Defenses** provision limits the time during which the insurance company may challenge the validity of an insurance claim based on a misstatement made on the insured's application.
- Under the time limit on certain defenses provision, the policy is incontestable after it has been in force a certain period of time, usually two years.
- This is similar to the incontestable clause in a life insurance policy. Unlike life policies, a fraudulent statement on a health insurance application is grounds for contest at any time, unless the policy is guaranteed renewable.
- An insurance company can usually contest the information contained in an accident and health application starting on the date the insurance company dates the policy
- *There is a TIME LIMIT for which you must DEFEND yourself. This applies to the contestable period (application), preexisting conditions, and new claims (conditions that must be met while a claim is pending.*
- *If you file a claim that you broke your leg yesterday, and the insurance company sees you moving a grand piano up 5 flights of stairs, you will probably have to DEFEND your claim. However, at some point, it is expected your leg will heal.*

3. Grace Period

- The purpose of the **Grace Period** is to give the policyowner additional time to pay overdue premiums.

- The policyowner is given a number of days after the premium due date during which time the premium payment may be delayed without penalty and the policy continues in force
- Depending on the state, the minimum grace periods typically specified are **7 days** for policies with weekly premium payments (i.e., industrial policies), **10 days** for policies with premiums payable on a monthly basis, and **31 days** for policies payable on an annual basis.
- If an insurer pays an individual accident and health insurance claim during a policy's grace period, the amount of unpaid premium may be subtracted from the reimbursement
- *Grace period is the same definition for your insurance bill as it is for all of your other bills. Don't pick it as an answer if the question isn't talking about paying your bill late and keeping your insurance.*
- *Remember Aunt Grace's Birthday 7 (makes payments more than once a month, weekly) – 10 (makes premium payments once a month) – 31 (makes Premium payments less than monthly (quarterly, semiannually, etc.). 7-10-31*

4. Reinstatement

- The Reinstatement provision specifies that if an insured fails to pay a renewal premium within the time granted but the insurer subsequently accepts the premium, coverage may be restored.
- Under certain conditions, a policy that has lapsed may be reinstated.
- Reinstatement is automatic if the delinquent premium is accepted by the company or its authorized agent and the company does not require an application for reinstatement.
- If it takes no action on the application for 45 days, the policy is reinstated automatically.
- To protect the company against adverse selection, losses resulting from sickness are covered only if the sickness occurs at least 10 days after the reinstatement date.
- Accidents are covered immediately upon reinstatement
- To reinstate any policy, you need: A reinstatement application, statement of good health, all back premiums.

5. Notice of Claim

- **The notice of claim provision describes the policyowner's obligation to notify the insurance company of a claim in a reasonable period of time**
- Typically, the period is **20 days** after the occurrence or a commencement of the loss, or as soon thereafter as is reasonably possible
- *You need to let the insurance company know that you are going to be filing a claim, so they are expecting your claim forms.*

6. Claim Forms

- It is the company's responsibility to supply a claim form to an insured within **15 days** after receiving notice of claim
- If the insurance company fails to send out the claim forms within the time period required by the provision, the insured should submit the claim in any form, which must be accepted by the company as adequate proof of loss
- *You can submit your claim using a napkin and crayon as long as you provide all the necessary information.*

7. Proof of Loss

- The statement that an insured must give an insurance company to show that a loss actually occurred is a Proof of Loss
- After a loss occurs, or after the company becomes liable for periodic payments (e.g., disability income benefits), the claimant has **90 days** in which to submit proof of loss.

- *Insurance company can't pay you if you don't prove there is a loss.*

8. Time of Payment of Claims

- The **time of payment of claims** provision provides for immediate payment of the claim after the insurer receives notification and proof of loss.
- If the claim involves disability income payments, they must be paid at least **monthly** if not at more frequent intervals specified in the policy
- The purpose of the **Time of Payment of** Claims provision is to prevent the insurance company from delaying claim payments
- *You did your part (Paid your bill and got injured/sick/ etc.) now the insurance company has to immediately do our part (Pay you) and it can't be less often than monthly, or you wouldn't be able to pay your bills.*

9. Payment of Claims

- The payment of claims provision in a health insurance contract specifies how and to whom claim payments are to be made.
- Payments for loss of life are to be made to the designated beneficiary
- If no beneficiary has been named, death proceeds are to be paid to the deceased insured's estate. Claims other than death benefits are to be paid to the insured.
- *Should the insurance company pay you, or the doctor, or someone else?*

10. Physical Exam and Autopsy

- The physical exam and autopsy provision entitles a company, at its own expense, to make physical examinations of the insured at reasonable intervals during the period of a claim, unless it's forbidden by state law.
- *Forget everything you learned on "Law and Order," only the state can forbid an autopsy. You gave up your (and your families) rights to refuse when you applied for insurance.*

11. Legal Actions

- The insured cannot take legal action against the company in a claim dispute until after **60 days** from the time the insured submits proof of loss.
- The legal action provision in a health contract is limited to no more than 5 years.
- The Legal Action provision provides the insurer adequate time to research a claim
- *At least give the insurance company 2 months to take care of you before you take them to court.*

12. Change of Beneficiary

The insured, as policyowner, may change the beneficiary designation at any time unless a beneficiary has been named irrevocably.

Eleven Optional Provisions

1. Change of Occupation

This provision also allows the insurer to reduce the maximum benefit payable under the policy if the insured switches to a more hazardous occupation or to reduce the premium rate charged if the insured changes to a less hazardous occupation

2. Misstatement of Age

- The misstatement of age provision allows the insurer to adjust the benefit payable if the age of the insured was misstated when application for the policy was made
- The insurer can adjust the benefit to what the premiums paid would have purchased at the insured's actual age
- If the insured was older at the time of application than is shown in the policy, benefits would be reduced accordingly
- The reverse would be true if the insured were younger than listed in the application

3. Other Insurance with This Insurer

Under this provision, the total amount of coverage to be underwritten by a company for one person is restricted to a specified maximum amount, regardless of the number of policies issued. This provision is designed to protect the insurer by controlling over insurance through its own policies.

4. Insurance with Other Insurer

In attempting to deal with the potential problem of over insurance, the insurance with other insurer provision states that benefits payable for expenses incurred will be prorated in cases where the company accepted the risk without being notified of other existing coverage for the same risk.

5. Insurance with Other Insurers

Similar to the previous, the insurance with other insurers provision allows an insurer to pay benefits to the insured on a pro-rata basis when the insurer was not notified prior to the claim that the insured has other health coverage.

6. Relation of Earnings to Insurance

If disability income benefits from all disability income policies for the same loss exceed the insured's monthly earnings at the time of disability, the relation of earnings provision states that the insurer is liable only for that proportionate amount of benefits as the insured's earnings bear to the total benefits under all such coverage.

7. Unpaid Premiums

If there is an unpaid premium at the time a claim becomes payable, the amount of the premium is to be deducted from the sum payable to the insured or beneficiary.

8. Cancellation

- Though prohibited in a number of states, the provision for cancellation gives the company the right to cancel the policy at any time with 45 days' written notice to the insured
- This notice must also be given when the insurer refuses to renew a policy or change the premium rates
- If the cancellation is for nonpayment of premium, the insurer must give 10 days' written notice to the insured, unless the premiums are due monthly or more frequently
- The cancellation provision also allows the insured to cancel the policy any time after the policy's original term has expired by notifying the insurer in writing

9. Conformity with State Statutes

Any policy provision that is in conflict with state statutes in the state where the insured lives at the time the policy is issued is automatically amended to conform with the minimum statutory requirements.

10. Illegal Occupation

The illegal occupation provision specifies that the insurer is not liable for losses attributed to the insured's being connected with a felony or participation in any illegal occupation.

11. Intoxicants and Narcotics

- The insurer is not liable for any loss attributed to the insured while intoxicated or under the influence of narcotics.
- Losses due to injuries sustained while committing a felony, or attempting to do so, also may be excluded

➢ OTHER HEALTH INSURANCE POLICY PROVISIONS and RIDERS

The Policy Face

The Policy face contains a summary of the type of policy and the coverage provided by the policy. It Identifies the insured, the term of the policy (the effective date and termination date), and how the policy can be renewed.

Insuring Clause

- The insuring clause is the part of the health insurance policy that states the kind of benefits provided and the circumstances under which they will be paid.
- The purpose of the insuring clause in a Health and Accident policy is to specify the scope and limits of the coverage provided.
- The insuring clause is the part of the health insurance policy that identifies the specific type of benefits or health care services that are covered by that policy and the circumstances under which they will be paid.
- *Any promises the INSURER makes will be in the INSURING clause.*

Consideration Clause

- In health insurance, the insurance company exchanges the promises in the policy for a two-part consideration from the insured. (Consideration is an exchange of something of value on which a contract is based). A health insurance contract is valid only if the insured provides consideration in the form of:
- The initial full minimum premium required
- The statements made in the application

- *The applicant begs, "Please CONSIDER me for insurance. Here is my completed application, my initial premium, and how much money/how often I agree to pay. Please CONSIDER me!"*

Probationary Period

- Specified number of days after an insurance policy's issue date during which coverage is not afforded for sickness.
- A Probationary Period provision in a health insurance contract becomes effective at the inception of the policy

Conversion Privilege for Dependents

- Beginning October 1, 2010, the Affordable Health Care Act mandated that all policies and plans **must provide dependent coverage up to age 26**
- Adopted children, stepchildren, and foster children usually are eligible for coverage
- As long as a policy is in force, coverage for a child generally continues until the child marries or reaches the limiting age

Mandatory Second Surgical Opinion Provision

A mandatory second surgical opinion provision typically requires the insured to seek a second opinion for surgeries that are on a list of elective surgeries

Waiver of Premium

The Waiver of Premium provision waives the payment of premiums after the insured has been totally disabled for the specified period of time. The following disabling acts are usually excluded from this provision: self-inflicted injuries, wartime or military service injuries, and injuries received during the commission of a crime.

Owner's Rights Provision

Defines the person who may name and change beneficiaries, select options available under the policy, and receive any financial benefits from the policy.

Free-Look Provision

Gives the policyowner the right to return the policy for a full premium refund within a limited period of time after the delivery of the policy.

Assignment Provision

The transfer of ownership in a life insurance policy. The new owner is known as the assignee.

- **Absolute assignment:** Under an absolute assignment, the transfer is complete and irrevocable, and the assignee receives full control over the policy and full rights to its benefits.
- **Collateral assignment:** A collateral assignment is one in which the policy is assigned to a creditor as security, or collateral, for a debt. If the insured dies (or sometimes becomes totally\permanently disabled), the creditor is entitled to be reimbursed out of the benefit proceeds for the amount owed. The insured's beneficiary is then entitled to any excess of policy proceeds over the amount due to the creditor.

Beneficiary designation

Where the policyowner indicates who is to receive the proceeds. The second provision is

Settlement options

Where the ways in which the proceeds can be paid out or settled are explained.

Discretionary Provision

Limits the way a court can review a claim denial and makes it difficult for the court to conduct a fair review of the claim. Some states have enacted laws that prohibit Discretionary provision because they are designed to protect the insurance company.

Maternity Benefits

- A maternity provision may provide a fixed amount for childbirth or a benefit based upon a specified multiple of the daily hospital room benefit
- Frequently, the maternity benefit is available only as an added benefit for an additional premium

States that have "**no loss no gain**" provision laws require a replacing policy to pay for ongoing claims under the policy it replaces

Guaranteed Insurability Option Rider

Allows a policyowner to purchase additional life insurance coverage at specified dates without providing evidence of insurability.

Payor Provision (Rider)

Provides waiver of premiums if the adult premium-payor should die or, with some policies, become totally disabled.

Accidental Death Benefit Rider (Double Indemnity)

Provides an additional amount of insurance usually equal to the face amount of the base policy if the cause of death was an accident.

Return of Premium Ride

Provides that in the event of the death of the insured within a specified period of time, the policy will pay, in addition to the face amount, and amount equal to the sum of all premiums paid to date.

Cost of Living Rider

Gives applicants the ability to guard against the eroding effects of inflation.

Long-Term Care Rider

Help safeguard against the financial burden of long-term care. In addition to that, it provides an acceleration of the death benefit to help pay for costs involved with long-term care.

➢ COMMON EXCLUSIONS OR RESTRICTIONS

- Exclusions and restrictions are situations or conditions which are not covered or covered with substantial limits.
- The common ones are injuries due to war or an act of war, self-inflicted injuries, and those incurred while the insured is serving as a pilot or crew member of an aircraft
- Other exclusions are losses resulting from suicide, hernia (as an accidental injury), riots, or the use of drugs or narcotics
- Losses due to injuries sustained while committing a felony, or attempting to do so, also may be excluded
- Foreign travel may not be excluded in every instance, but extended stays overseas or foreign residence may cause a loss of benefits
- Occupational injuries and illnesses are covered by Workers' Compensation and typically excluded
- The exclusions section is NOT included in the policy face (first page of an insurance policy)

Preexisting Conditions

- Medical expense and disability income policies usually exclude paying benefits for losses due to preexisting conditions pertaining to illness, disease, or other physical impairments
- Such exclusions are subject to the "time limit on certain defenses" provision. Any preexisting condition that the insured has disclosed clearly in the application usually is not excluded or, if it is, the condition is named specifically in an excluding waiver or rider.

Waivers for Impairments

- When an insurance company does not cover a loss due to a specific condition the insured has. This is usually called an impairment rider.
- If the insured's condition improves, the company may be willing to remove the waiver.

➢ RENEWABILITY PROVISIONS

Health insurance is not permanent in nature, unlike life insurance and annuities. Hence, health insurance policies contain a wide range of renewability provisions, which allows the insurer to cancel health insurance at different points during the life of the policy. Generally speaking, the more favorable the renewability provision is to the insured policyholder, the higher the premium. The insured, can typically cancel the policy at any time, and the policy can always we canceled by the insurer if premium is not paid within the grace period. There are five principal renewability classifications:

Cancelable Policies

- May be terminated by either the insured or the insurer
- The renewability provision in a cancelable policy allows the insurer to cancel or terminate the policy at anytime
- Cancelable policies also allow the insurer to increase premiums
    - *This is the ONLY type of renewability where the insurer can cancel at any time. This type of renewability is illegal in most states.*

Optionally Renewable Policies

The renewability provision in an optionally renewable policy gives the insurer the **option** to terminate the policy on a date specified in the contract.

Conditionally Renewable Policies

- A conditionally renewable policy allows an insurer to terminate the coverage but only in the event of one or more conditions **stated in the contract**
- They typically are related to the insured reaching a certain age or losing gainful employment
- A conditionally renewable policy can increase premiums at time of renewal

Guaranteed Renewable Policies

- The renewal provision in a guaranteed renewable policy specifies that the policy must be renewed (as long as premiums are paid) until the insured reaches a specified age, such as 60 or 65.
- Guaranteed renewable policies normally have increasing premiums
- If rates are increased on a guaranteed renewable policy, the must be increased for an entire rate class
- *"We're definitely going to renew you, but we may raise the premiums so high you won't want to keep the insurance."*
- *This is the common renewability for Medicare Supplement and Long-term care policies.*

Nonrenewable Policies

- Nonrenewable policies are normally associated with short-term health insurance. These are policies that are for established policy lengths of a year or less and are considered temporary.

Noncancelable Policies

- A noncancelable policy cannot be cancelled nor can its premium rates be increased under any circumstances (other than reaching a specific age or non-payment of premiums)
- Noncancelable provisions are most commonly found in disability income policies. They are rarely used in medical expense policies
- Noncancelable policies may not be changed in anyway by the insurer (sometimes up to a specified age), so long as the premiums are paid.
- *"We're stuck with you. We can't cancel you, we can't raise the premiums or do anything else to entice you to cancel."*
- *This is common for disability policies.*

Underwriting and Policy Issue

➢ UNDERWRITING PROCESS

- **Underwriting** is the process of risk selection
- The process used by an insurance company to determine whether or not an applicant is insurable and if so, how much to charge for premiums
- Material facts can affect an applicant being accepted or rejected
- One of the main responsibilities of an **underwriter** is to protect the insurer against adverse selection.
- The underwriting process involves reviewing and evaluating information about the applicant and establishing individual against the insurer's standards and guidelines for insurability and premium rates. The most common sources of underwriting information include:

1. Application

The application is the starting point and basic source of information used by the insurance company in the risk selection. Although applications differ from company to company they all have the following same components. Insurable interest must exist between the policyowner and insured at the time when the application is made. It does not necessarily have to exist when the policy proceeds are actually paid.

Part I of the Application

- General Information – Age, DOB, Sex, Address, Marital Status, Occupation,
- Details about the requested insurance coverage:
  - Type of policy
  - Amount of insurance
  - Name and relationship of the beneficiary
  - Other insurance the proposed insured owns
- Other information personal information
  - Tobacco use
  - Hazardous hobby
  - Foreign travel
  - Aviation activity
  - Military service.

Part II of the Application

- Medical Information – Health History
  - Part II focuses on the proposed insured's health and asks a number of questions about the health history.
  - This medical section must be completed in its entirety for every application.
  - Depending on the proposed policy, this section may or may not be all that is required in the way of medical information.
- The individual to be insured may be required to take a medical exam and/or provide a blood test or urine specimen.

Part III of the Application

- Agent's Report (Statement) - Agent's personal observations of the applicant.
- Includes the applicant's financial condition, character, background, purpose of sale, and how long agent has known the applicant.
- Part III of the application is often called the agent's report. This is where the agent reports personal observations about the proposed insured.

- Because the agent represents the interests of the insurance company, the agent is expected to complete this part of the application fully and truthfully.

2. Credit Report

- An applicant's credit history is sometimes used for underwriting and to determine the likelihood of making premium payments.
- The Fair Credit Reporting Act requires the applicant be notified in writing if a credit report will be used. The applicant must also be notified if the premium is increased because of a credit rating.

3. Applicant Statements

- **Warranties** are statements that are guaranteed to be literally true**.** A warranty that is not literally true in every detail, even if made in error, is sufficient to render a policy void.
- **Representation** are Statements made by applicants that are substantially true to the best of their knowledge, but not warrantied as exact in every detail.

4. Medical Report

- A medical report is sometimes used for underwriting policies.
- If the information in the medical section warrants further investigation into the applicant's medical conditions, the underwriter may need an **attending physician statement (APS)**.

5. Inspection Reports

- Companies are allowed to obtain inspection reports under The Fair Credit Reporting Act.
- The **Fair Credit Reporting Act of 1970 (FCRA)** regulates the way credit information is collected and used to protect the rights of consumers for whom an inspection or credit report has been requested.
- It established procedures for the collection and disclosure of information obtained on consumers through investigation and credit reports.
- If an insurance company requests a credit report, the consumer must be notified in writing.
- This report provides information about the applicant's character, lifestyle, and financial stability.
- When an investigative consumer report is used in connection with an insurance application, the applicant has the right to receive a copy of the report.

6. Medical Information Bureau (MIB):

- The MIB is a nonprofit trade organization which maintains medical information about individuals.
- Information from the MIB is used by life and health insurers.
- This helps insurance companies from adverse selection by applicants, as it detects misrepresentations, helps identify fraudulent information, controls the cost of insurance, and helps underwriters evaluate risk.
- Information received from the Medical Information Bureau (MIB) about a proposed insured may be released to the proposed insured's physician.
- An insurance company would NOT notify the MIB if an application is declined.

7. Special Questionnaires

- Special questionnaires are used for applicants involved in special circumstances, such as aviation, military service, or hazardous occupations or hobbies.
- The questionnaire provides details on how much of the applicant's time is spent in these activities.

➢ FIELD UNDERWRITING PROCEDURES

Field underwriting is completed by the agent. Unlike the insurer, the agent has face-to-face contact with the applicant which can aid the insurer in risk selection. As field underwriters, agents help reduce the chance of adverse selection by:

- Assuring the application is filled out completely and correctly
- Collect the initial premium
- Forwarding the application to the insurer in a timely manner
- Seeking additional information about the applicant's medical history if requested
- Notifying the insurer of any suspected misstatements in the application
- Delivering the policy

Application Errors

- If an agent realizes that an applicant has made an error on an application, the agent must correct the information and have the applicant initial the changes
- An incomplete application will be returned to the agent
- The agent can NEVER change the application without the customer present to initial the changes

Signatures

- The agent and the applicant are required to sign the application
- If the applicant is someone other than the proposed insured, except for a minor child, the proposed insured must also sign the application
- Having an applicant that is different from the insured (parent and minor child) is considered third party ownership

USA Patriot Act:

- The USA Patriot Act was enacted in 2001.
- It requires insurance companies to establish formal anti-money laundering programs. The purpose of the act is to detect and deter terrorism.

Buyer's Guide

- Provides general information about the types of insurance policies available, in language that can be understood by the average person
- *This is what a PPO is, this is what an HMO is, these are the basics of the 10 Medigap options, etc.*

Policy Summary

- Provides specific information about the policy purchased, such as the premium and benefits.
- *Mom calls you excited because she bought new health insurance. This allows you to quickly see what "health insurance" specifically did she buy: Medicare Supplement, Major Medical, Critical Illness, Long-term Care?*

Suitability Form

- Ensures that the customer is best suited for the policy they are purchasing.
- *Prevents the sale of unnecessary insurance for example a customer on Medicaid would not be suited for a Medicare Supplement policy because Medicare Supplement policies are typically expensive, and the customer is already receiving Medicaid due to financial need.*

➢ RISK FACTORS and CLASSIFICATIONS

Applicant Ratings and Classifications

Once all the information about a given applicant has been reviewed, the **underwriter** will utilize several different types of information in determining the insurability of the individual and the risk that the applicant poses to the insurer. This is evaluation is known as **risk classification**. The producer must provide a **privacy notice** to an applicant if personal information about that applicant is disclosed and is passed along to the insurer or its affiliates. The following rating classification system is used to categorize the favorability of a given risk:

Preferred
Low/Better than Average Risk – Lower Premiums - *nonsmoker, weight within an ideal range, nondrinker*
Standard
Average Risk – No Extra Ratings or Restrictions - standard terms and rates
Substandard
High Risk – Rated Up – higher premiums or restricted coverage – *chronic conditions, insulin diabetes, heart disease*
Declined/Uninsurable
Not Insurable – potential of loss to insurance company is too high – *terminal illness, too many chronic conditions*

- Lower risks tend to have lower premiums.
- If an applicant is too risky, the insurer will decline coverage.
- Besides outright rejection, there are three techniques commonly used by insurers in issuing health insurance policies to substandard risks:
    - Attaching an **exclusion (or impairment) rider or waiver** to a policy
    - Charging an extra premium
    - Limiting the type of policy or coverage issued
- The insurance company will NEVER alter the PROVISIONS of an insurance policy due to risk

Risk Factors

Physical Condition

An applicant's present physical condition is of primary importance when evaluating health risks

Moral Hazards

- The habits or lifestyles of applicants
- Personalities and attitudes may draw attention in the underwriting process
- Moral hazards include
    - Excessive drinking and the use of drugs represent serious moral hazards
    - Applicants who are seen as accident prone or potential malingerers (feigning a continuing disability in order to collect benefits)
    - Poor credit rating
    - Dishonest business practices

Occupation

- Some types of work are more hazardous than others, the premium rates for a person's health insurance policy may be affected by their occupation.

- There is little physical risk associated with professional persons, office managers, or office workers.
- However, occupations involving heavy machinery, strong chemicals, or high electrical voltage, for example, represent a high degree of risk for the insurer.

Change of occupation provision:

- if the insured changes to a less hazardous job, the insurer will return any excess unearned premium
- if the change is to a more hazardous occupation, the benefits are reduced proportionately, and the premium remains the same

Age

- Generally, the older the applicant, the higher the risk.
- Health insurance claims costs tend to increase as the age of the insured increases

Sex

- Men show a lower rate of disability than women, except at the upper ages
- Women are sometimes required to undergo more expensive testing like a Pap test, which is used for detecting cervical cancer
- Women have a longer life expectancy than men

History

- Medical history may point to the possibility of a recurrence of a certain health condition.
- An applicant's family history may reflect a tendency toward certain medical conditions or health impairments.

Avocations

Certain hobbies an applicant may have (such as skydiving or mountain climbing) may increase his/her risk to the insurer

Insurable Interest

- An insurable interest exists if the applicant is in a position to suffer a loss should the insured incur medical expenses or be unable to work due to a disability
- As with life insurance, insurable interest is a prerequisite for issuing a health insurance policy
- You have insurable interest in yourself
- A producer may be the beneficiary of an applicant's policy of the producer has insurable interest on an insured

➢ Premiums, Receipts, and Effective Date

Premium Factors

Besides risk factors, there are many other standard items that impact the cost of premium for a health insurance policy.

Morbidity

Whereas mortality rates show the average number of persons within a larger group of people who can be expected to die within a given year at a given age, morbidity rates show the expected incidence of sickness or disability within a given group during a given period of time.

Interest

Just as with life insurance, interest is a major element in establishing health insurance premiums. A large portion of every premium received is invested to earn interest. The interest earnings reduce the premium amount that otherwise would be required from policyowners.

Expenses

- Every business has expenses that must be paid, and the insurance business is no different.
- Each health insurance policy an insurer issues must carry its proportionate share of the costs for employees' salaries, agents' commissions, utilities, rent or mortgage payments, maintenance costs, supplies, and other administrative expenses.

Benefits

- The number and kinds of benefits provided by a policy affect the premium rate
- The greater the benefits, the higher the premium. To state it another way, the greater the risk to the company, the higher the premium.

Claims Experience

- Before realistic premium rates can be established for health insurance, the insurer must know what can be expected as to the dollar amount of the future claims
- The most practical way to estimate the cost of future claims is to rely on claims tables based on past claims experience
- Experience tables have been constructed for hospital expenses based on the amounts paid out in the past for the same types of expenses
- Experience tables have also been developed for surgical benefits, covering various kinds of surgery based on past experience

Community Rating

This concept requires health insurance providers to offer health insurance policies within a given geographical area at the same price to all individual or group plans without medical underwriting, regardless of their health status.

Initial Premium

- It is best for both the proposed insured and the agent to have the initial premium paid with the application and forwarded to the insurer
- For the agent, this will help solidify the sale and may accelerate the payment of commissions on the sale

- If the premium is not paid with the application, the agent should submit the application to the insurance company without the premium
- The policy will not become effective until the initial premiums is collected even if it is approved and issued

Premium Mode (Mode of Premium Provision)

- The policy feature that permits the policyowner to select the timing of premium payments
- If the policyowner chooses to pay premium more than once per year, there may be additional charges because the company will have additional charges in billing and collecting the premium payments
- For health insurance, premium payment options include

o Annual
o semi-annual
o quarterly
o Monthly

- Unlike life insurance, there is no "single-pay" option for health insurance policies

Receipts

- Agents should make every effort to collect the initial premium with the application.
- The agent issues the applicant a premium receipt upon collecting the initial premium.
- The only time a customer will receive a receipt is if they pay their initial premium at the time of application. No receipt will be given at any other time.
- There are two types of premium receipts that determine when coverage will begin

Conditional Receipt:

- The producer issues a conditional receipt to the applicant when the application and premium are collected
- The conditional receipt denotes that coverage will be effective once the applicant proves to be insurable either on the date the application was signed or the date of the medical exam
- This may also be described as when the conditions of the receipt are met
- If the insurer accepts the coverage as applied for, the coverage will take effect from the date of the application or medical exam, whichever is later

Binding Receipt:

- Under a binding receipt, coverage is guaranteed until the insurer formally rejects the application
- This may also be described as Insurer is bound to coverage until the application is formally rejected
- Even if the proposed insured is ultimately found to be uninsurable, coverage is still guaranteed until rejection of the application

➢ POLICY ISSUE AND DELIVERY

Policy Issue

- Happens when the insurer "approves" the application, they are "issuing the policy"
- Technically a policy could be **ISSUED** and not delivered for days or weeks later

Effective Date of Coverage

- The effective date identifies when the coverage is effective and establishes the date by which future annual premiums must be paid
- If the initial premium is collected at the time of application, the effective date is dependent on the type of receipt given to the applicant

- In some cases, the insurer requires the agent to collect a statement of good health from the insured at the time of delivery.
- If the initial premium is not submitted with the application, the policy effective date is the date the policy is delivered to the applicant, premium collected, and statement of continued good health signed. Coverage will not be in effect until all of those things happen.

Statement of Good Health

- Verifies that the insured has not become ill, injured or disabled during the policy approval process (time between submitting application and delivery of the policy)
- Is used when the applicant did not submit the initial premium with the application
- In such cases, common company practice requires that, before leaving the policy, the agent must collect the premium and obtain from the insured a signed statement attesting to the insured's continued good health
- Also used when reinstating a policy

Policy Delivery

All of the following acts can be considered means of delivery: mailing policy to the agent; mailing the policy to applicant; and the agent personally delivering policy.

Personal Delivery

- Allows the producer to explain the coverage to the insured (such as the riders, provisions, and options)
- Builds trust and reinforces the need for the coverage.

Constructive Delivery

- Occurs if the insurance company intentionally relinquishes all control over the policy and turns it over to someone acting for the policyowner, including the company's own agent.
- Mailing the policy to the agent for unconditional delivery to the policyowner also constitutes constructive delivery, even if the agent never personally delivers the policy.
- If the company instructs the agent not to deliver the policy unless the applicant is in good health, there is no constructive delivery.

➢ TAX TREATMENT OF HEALTH INSURANCE PREMIUMS AND BENEFITS

As a rule of thumb, insurance premiums and benefits are taxed in one of two ways:

Premiums are tax deductible

- Paid before your paycheck is taxed or removed from your taxable income when you file taxes
- In this case the benefits will be taxed (because you are already saving taxes on the premiums)

Premiums are NOT tax deductible

- Paid after your paycheck is taxed and are not removed from your taxable income
- In this case, the benefits of the policy would be tax free

Taxation of Disability Income Insurance

- Premiums paid for personal disability income insurance are **not deductible** by the individual insured, but the disability benefits are **tax-free** to the recipient

- When a group disability income insurance plan is paid for entirely by the employer and benefits are paid directly to individual employees who qualify, **the premiums are deductible by the employer. The benefits, in turn, are taxable to the recipient**
- If an employee contributes to any portion of the premium, her benefit will be received **tax-free in proportion to the premium contributed**

Taxation of Medical Expense Insurance

- Incurred medical expenses that are reimbursed by insurance may not be deducted from an individual's federal income tax
- Incurred medical expenses that are not reimbursed by insurance may only be deducted to the extent they exceed 7.5% of the insured's adjusted gross
- Benefits received by an insured under a medical expense policy are not included in his gross income because they are paid to offset losses he incurred
- For self-employed individuals, 100% of their health insurance premium is tax deductible (as of 2003)

Group Insurance Premium Taxation

- Premiums paid by an employer for the benefit of employees are tax deductible to the employer.
- Premiums paid by the employer are NOT tax deductible nor are they taxable to the employee.

➢ MANAGED CARE

Policy Design

The design or structure of a policy and its provisions can have an impact on an insurer's cost containment efforts.

- A higher deductible will help limit claims
- Coinsurance is another important means of sharing the cost of medical care between the insured and the insurer
- Shortened benefit periods can also prove beneficial from a cost containment standpoint

Medical Cost Management

Defined as the process of controlling how policy owners utilize their policies. There are four general approaches insurers use for cost management: mandatory second opinions, precertification review, ambulatory surgery, and case management.

Mandatory Second Opinions

- In an effort to reduce unnecessary surgical operations, many health policies today contain a provision requiring the insured to obtain a second opinion before receiving elective surgery
- Under the mandatory second surgical opinion provision, an insured typically will pay more out-of-pocket expenses for surgeries for which only one opinion was obtained
- The mandatory second surgical option provision can help contain the cost of a group medical plan

Precertification Review

- To control hospital claims and prevent unnecessary medical costs, many policies today require policy owners to obtain approval from the insurer before entering a hospital for elective surgeries
- A pre-hospitalization authorization program (pre-certification) determines whether the requested treatment is medically necessary
- Pre-admission, pre-hospitalization, and pre-certification are all common names used for this particular type of managed care

- Pre-certification occurs before the treatment is provided
- Pre-admission testing usually involves evaluating an individual's overall health prior to being hospitalized for surgery
- Preadmission testing helps control health care costs primarily by reducing the length of hospitalization
- Failure to obtain a preadmission certification in non-emergency situations reduces or eliminates the health care provider's obligation to pay for services rendered

Concurrent (Utilization) Review

- A health insurance company's opportunity to review a request for medical treatment to confirm that the plan provides coverage for your medical services
- Health care is reviewed as it is being provided
- Involves monitoring the appropriateness of the care, the setting, and the length of time spent in the hospital
- This ongoing review is directed at keeping costs as low as possible and maintaining effectiveness of care by determining if the recommended treatment is appropriate

Ambulatory Surgery

The advances in medicine now permit many surgical procedures to be performed on an outpatient basis where once an overnight hospital stay was required these outpatient procedures are commonly referred to as ambulatory surgery.

Case Management

- Case management involves a specialist within the insurance company, such as a registered nurse, who reviews a potentially large claim as it develops to discuss treatment alternatives with the insured
- The purpose of case management is to let the insurer take an active role in the management of what could potentially become a very expensive claim

Point-of-service Plans

- A point-of-service plan allows the insured to choose either an in-network or an out-of-network provider at the time care is needed.
- With in-network coverage, the insured receives care through a particular network of doctors and hospitals participating in the plan
- All care is coordinated by the insured's **primary care physician**, which includes referrals to specialists
- An insured receiving out-of-network care usually pays more of the cost than if it had been in-network (except for emergencies)

Florida General Laws

➢ Office of Insurance Regulation

The mission of the Office of Insurance Regulation is to promote the public welfare by maintaining the solvency of insurance companies.

Note: The Office of Insurance Regulation has primary responsibility for regulation, compliance and enforcement of statutes related to the business of insurance and the monitoring of industry markets.

- The insurance policy forms used in Florida are approved by the **Office of Insurance Regulation (OIR)**

Insurance laws in Florida are administered by the Chief Financial Officer, the Financial Services Commission and the Commissioner of the Office of Insurance Regulation. The Chief Financial Officer (CFO) is independently elected and serves as the head of the Department of Financial Services. Although commissioners are sometimes elected, they are mainly appointed by the governor.

Bureau of Unclaimed Property
The **Chief Financial Officer** oversees the Bureau of Unclaimed Property, which holds unclaimed property accounts valued at more than $1 Billion, mostly from dormant accounts in financial institutions, insurance and utility companies, securities and trust holdings.

Hearings
The Financial Services Commission may hold hearings for any purpose within the scope of the insurance code deemed necessary, such as:

- Person engaging in unfair competition, or any unfair or deceptive act
- Person engaging in business of insurance without a license
- The best interest of the public would be served

➢ Licensing

A licensee may **not** transact insurance business in Florida until the licensee is **appointed** by an insurer.

Individuals looking to acquire an insurance license must meet the following eligibility requirements:

- **Must be at least 18 years old**
- **Must be a US citizen or legal alien**
- **Must be a Florida resident**
- **May not be an employee of the United States Department of Veterans Affairs**
- **May not be a funeral director or direct disposer**
- **Complete a 40-Hour pre-licensing education course**
- **Pass the insurance state licensing examination**
- **Must be trustworthy and competent**

Continuing education
An agent needs to abide by the following guidelines every **two years** to maintain their license:

- **24 hours** of continuing education every two years for agents licensed **less than 6 years**
- **20 hours** of continuing education for every two years for agents licensed **more than 6 years**
- **Any continuing education must include a minimum 5 hours in ethics**
- Pay license fees, appointment and renewal fee
- Continue to be **appointed** with an insurance company

Suspension, termination, revoking of a license

The Chief Financial Officer has the power to suspend or revoke the license of an insurance agent who violates the Insurance Code. In lieu of suspension or revocation, the CFO has the authority to issue fines or order probation.

There are a number of situations where the Chief Financial Officer (CFO) can impose penalties or suspend, terminate, or revoke a license:

- Failure to answer a subpoena or an order of the CFO can result in a $1,000 fine
- Violation of a cease and desist order can result in a fine up to $50,000
- Willful violation of the Insurance Code is a misdemeanor
- Willfully submitting fraudulent signatures on an application or policy- related document is a third degree felony and is subject to a $5,000 to $75,000 fine for each violation
- In the event someone breaks an insurance law for which there is no definable penalty, one can be charged $5,000 for the first offense and $10,000 for every subsequent offense
- Provided incorrect, misleading, incomplete or untrue information in the license application
- Violating any insurance laws, regulations, subpoena, or orders from the Commissioner
- Attempting to obtain a license through fraud or misrepresentation
- Obtaining to obtain a license through fraud or misrepresentation
- Intentionally misrepresent the terms of an insurance contract
- Been convicted of a felony
- Committed any insurance unfair trade practice
- Using fraudulent, coercive, or dishonest practices or demonstrating incompetence, untrustworthiness, or financial irresponsibility in this or any other state.
- Having an insurance license denied, suspended, or revoked by another state
- Forging a name to an insurance document or application
- Cheating on an insurance license examination
- Knowingly accepting insurance business from an unlicensed individual
- Failing to comply with a court order imposing child support
- Failing to pay state income tax
- Obtaining license for the purpose of writing controlled business
- An agent's license will terminate if the agent allows **48 months** to elapse without being appointed for the class or classes of insurance listed on the license

➢ Agents and Agencies

Agent
An agent is an individual who has been authorized by an insurer to be its representative and to perform all of the following acts:

- Solicit applications for insurance
- Collect premiums from policyowners
- Render services to prospects and clients
- Field underwriting if necessary

Appointment
The authority given to an agent to transact business on behalf of the insurer is called **appointment.**

Change of address
If an agent changes his/her residence address, the Department of Financial Services must be notified within **30 days.**

Reporting of actions
If an agent is found guilty of a felony, he/she is required to notify the Department of Insurance within **30 days.**

Agencies

- An insurance agency is any business location where insurance transactions take place that can only be performed by licensed insurance agents
- There must be an **agent in charge** at each licensed agency location where insurance transactions take place
- A licensed insurance agent may be the agent in charge of additional branch office locations of the agency as long as insurance activities **do not** occur at any location when the agent is **not physically present**

Home agencies
The Department of Financial Services considers all of these factors when determining whether an agent's home is an insurance agency:

- Listing the location address on business cards/marketing materials and solicits business to be done at that location
- There is a sign on the house indicating an agent is there
- The agent meets clients there
- Insurance transactions take place at the location

Professional Employer Organization
A Professional Employer Organization typically handles only **administration functions**.

➢ Certificate of Authority

Before an insurance company can sell insurance in a specific state, they must apply for a license or Certificate of Authority from that state's Department of Insurance. Once approved and given a Certificate of Authority, they are eligible to transact insurance.

➢ Insurance Transaction

"Insurance Transaction" includes any of the following:

- **Solicitation or inducement to purchase insurance**
- **Negotiations toward the sale of insurance**
- **Executing a contract of insurance**
- **Issuing an insurance contract**
- **Advising on coverages and claims**

A licensee may **not** transact insurance business in Florida until the licensee is **appointed** by an insurer.

The agent's primary responsibility in the application process is to the **insurer**.

➢ Unfair Trade Practices

Twisting
Twisting occurs when an insurance agent convinces a policyowner to cancel their current policy so that they can purchase new life insurance policy with another company. This would involve the agent using misrepresentations or incomplete comparisons of the advantages and disadvantages of the two policies. Twisting is a form of misrepresentation and is illegal.

Churning **Churning occurs when an agent has a policyholder replace one policy for another with the same company for the sole purpose of making more commission. This can involve using the cash value and/or dividends of an existing policy to purchase another policy with the same insurer.** This normally is done using misrepresentation or deception and is not in the policyholder's bestinterest.

Note: Agents who use **twisting or churning** can be charged with a first degree misdemeanor and a fine from $5,000 to $75,000 for each violation

Sliding **Sliding occurs when an agent tells an applicant that in order to get the product they want, they are required by law to get an additional product as well**. It can also mean **falsely representing to an applicant that specific coverage is included in the policy applied for with no additionalcharge.**

Coercion
Coercion is when an agent uses physical or mental force, with the intent of convincing an applicant to buy insurance.

Misrepresentation
Misrepresentation is when an agent **uses publications, sales materials, or makes statements that are false, misleading, or deceptive to unfairly influence the purchase of a policy.**

- **An example of misrepresentation would be when an agent tells a client that dividends are guaranteed**

Defamation
Defamation occurs when an oral or written statement is maliciously made that is **intended to injure a person in the insurance business or be critical and misleading about the financial condition of a person or company.**

Fraud
Fraud occurs when someone intentionally deceives another with the intent to gain financially.

Unfair discrimination
It is an illegal practice to unfairly discriminate against a person in any way on an insurance-related matter. An example would be providing different terms of coverage for different policyowners in the same risk classification. Fair discrimination is necessary for the issuance of life insurance policies, which is based on mortality.

Controlled Business
Controlled business is coverage written by an agent on his/her own life, health, property, immediate family, or business associates. Most states will not issue a license to a person if it is determined that their primary purpose is to write controlled business.

Note: Normally no more than **50%** of an agent's insurance sales are allowed to come from controlled business

Rebating
Rebating happens when an agent refunds part of their commission, or exchanges anything of value to induce someone to purchase an insurance policy. Rebating is allowed in Florida **if the agent rebates insureds in the same actuarial class.**

False advertising It is an illegal practice to falsely advertise insurance products **or publish misleading information about its insurance coverage.** This includes making false statements about the financial condition of an insurer.

- An insurer exaggerating its dividends in a publication is also considered a form of false advertising

➢ Unfair Claims Settlement

The following acts, omissions, or practices are defined as unfair and deceptive claim settlement practices when knowingly committed or performed with such frequency as to indicate a general business practice, and are prohibited:

- **Misrepresenting to insured's pertinent facts or policy provisions relating to coverage at issue**
- **Failing to acknowledge and act reasonably promptly upon communications with respect to an insurance claim**
- **Failing to adopt and implement reasonable standards for prompt investigation and processing of insured's claims**
- **Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements are completed and submitted by insured's**
- **Not attempting in good faith to effect prompt, fair and equitable settlements of claims on which liability has become reasonably clear; Refusing or delaying a settlement solely because there is other insurance available to partially or entirely satisfy the claim loss; the claimant who has a right to recover from more than one insurer has the right to choose the coverage from which to recover and the order in which payment is to be made**
- **Compelling insured's to initiate suits to recover amounts due under an insurance policy by offering substantially less than the amount ultimately recovered in those suits**

Domestic, Foreign, and Alien Companies

Insurance companies are classified according to the location of its corporation. Regardless of where the insurance company is incorporated, it still has to get a Certificate of Authority before transacting insurance within a state.

The following definitions apply:

Domestic insurance company: A company that **resides and is incorporated under the laws of the state in which its home office is located.**

Company chartered in Florida would be a domestic company in Florida.

Foreign insurance company: A company whose **home office is located in another state.** It is considered to be a foreign company in all states except for its home state.

Company chartered in Texas would be a foreign company in Florida.

Alien insurance company: is one that is **chartered and organized in any country other than the United States**. It is considered an alien insurance company in all states.

Company chartered in Canada would be an alien company in Florida.

Authorized, Unauthorized, and Eligible Companies

Authorized insurer: An insurance company that has qualified and received a Certificate of Authority from the Department of Insurance (or sometimes called Department of Financial Services) to sell insurance in that state.

- Also called an admitted insurance company

Unauthorized Insurer: An insurance company that has been denied or not yet applied for a Certificate of Authority and may not sell insurance in that state.

- Also called a non-admitted insurance company
- Possible consequences for placing with an unauthorized insurer include: conviction of a third degree felony, liability for all unpaid claims, and revocation of all insurance licenses

Stock and Mutual Companies

Stock Insurance Company: An insurance company that is owned and controlled by stockholders (shareholders). The stockholders provide the capital and share in profits or losses.

- Stock Insurance Companies are considered **Non-participating or Non-par** because the policyowners do not share in the profits of the company
- Their objective is to produce a profit for its owners, the stockholders
- Stock Insurance Companies that issues both participating and non-participating policies are referred to as a company doing business on a **mixed plan**

Mutual life insurance companies: are owned and controlled by its policyowners. These policyholders elect a board of trustees or directors to manage the firm. The profits of a mutual insurance company are returned to the policy owners in the form of dividends or retained as surplus to meet future obligations.

- Mutual Insurance Companies are considered **Participating or Par** because the policyowners do share in the profits of the company
- Objective is to provide insurance to its owners, the policyowners, at the lowest possible net cost

➢ **Advertising**

Advertisement may include any method of communication

- In a newspaper, magazine, or other publication
- In the form of a notice, circular, pamphlet, letter, or poster
- Over any radio or television

Advertisement does not include

- Material used solely for the training and education of an insurer's employees, agents, or brokers
- Internal communication within an insurer's own organization
- Correspondence between a prospective group or blanket policyholder and an insurer during negotiations

Testimonials

Testimonials and endorsements used in advertisements must be genuine and represent the current opinion of the author.

Disparaging comparisons and statements

An advertisement must not directly or indirectly make unfair or incomplete comparisons of policies, contracts, or benefits.

Identity of insurer

The name of the actual insurer must be stated in all of the insurer's advertisements. The form number or numbers of the policy advertised must be stated in any invitation to contract. An advertisement must not use a trade name, name of the parent company of the insurer, or any other device that would be misleading to the true identity of the actual insurer.

Statement about an insurer

An advertisement must not contain statements that are untrue or misleading with respect to the assets, corporate structure, financial standing, age, or relative position of the insurer.

Advertising file

Each insurer must maintain at its home office a complete file of its advertising materials, available for inspection, for a period of 4 years.

Gifts

An agent is allowed to give advertising gifts to a prospective customer, provided they do not exceed $25.

➢ Florida Life and Health Insurance Guaranty Association

The Florida Life and Health Insurance Guaranty Association was established to provide funds **to protect an insured in the event of an insurer's insolvency.**

- **The Life and Health Guaranty Association is funded by insurance companies through assessments**
- Agents are prohibited from using the existence of the Life and Health Guaranty Association for selling, soliciting, or inducing purchase of an insurance policy

➢ Code of Ethics

Agent Ethics

Trade practices: The life insurance industry has been declared to be a public trust in which service of all agents of all companies have a common obligation to work together in serving the best interest of the insuring public.

Note: The Code of Ethics specifically forbids agents or companies to engage in any act of twisting, rebating, defamation, or misrepresentation.

Fiduciary responsibility: An agent must handle funds of a client or insurance company honestly and fairly and NOT use them for the agent's own purposes.

Licensed Agents: Agents may not submit applications to an insurer unless the name of the insurer is legibly typed or printed on the first page of the application at the time coverage is bound or the premium is quoted. The application must also disclose the name and license identification number of the agent as shown on the agent's license. This information must be legibly typed, printed, stamped, or written. A copy of the completed application must be provided to the prospective insured.

Every insurance policy issued in the state of Florida must specify the following:

- **The names of the parties to the contract**
- **The subject of the insurance**
- **The risks insured against**
- **The effective date and period of coverage**
- **The premium**
- **The conditions pertaining to the insurance**
- **The form numbers and edition dates of all endorsements attached to the policy**

National Association of Insurance and Financial Advisors (NAIFA)
The National Association of Insurance and Financial Advisors is a **professional organization whose code of ethics is incorporated into Florida law and whose responsibility it is to establish the activities of agents.**

Florida Life Laws

Rules of disclosure

The **"rules of disclosure"** review what needs to be provided to each prospective purchaser of a life insurance policy. This includes **a buyer's guide, policy summary, and 14 day free-look period.**

Minimum age

The minimum age at which an individual can sign a life insurance application is **15 years.**

Contestable period

A provision that the policy terms shall be incontestable after it has been in force for a period of **2 years** from its date of issue (unless the purpose for taking out the coverage was **fraud**).

Free-look period

Free Look provision allows an insured a period of **14 days** from the delivery date of the policy to look over the new policy and return it for a full premium refund if dissatisfied for any reason.

Note: the 14 day period begins when the applicant receives the policy in **the mail or is delivered by an agent.**

Buyer's guide

Buyer's Guide provides basic information about an insurance policy. This document explains how a buyer should go about choosing the amount and type of insurance to buy, and how a buyer can save money by comparing the cost of similar policies.

Note: The insurer must provide **a buyer's guide** along with **a policy summary** to any prospective purchaser before accepting the applicant's initial premium or upon the applicant's request.

Grace Period

Life insurance policies must provide a grace period of 30 days after the due date. If the insured dies during the grace period, the insurance company may deduct any premium due from the death benefit.

Interest Rates

The maximum fixed policy loan interest rate that an insurer can charge in Florida is 10%. Adjustable rates for policy loans are based on **Moody's corporate bond index.**

Named Beneficiary

In Florida, if a policy is made payable to a named beneficiary, a creditor can make no claim on the proceeds.

Senior Citizen Grace Periods
In Florida, anyone **over the age of 64** will **receive an additional 21 days beyond the normal policy grace**

period. Suicide

Clause

In Florida, if an insured commits suicide **within 2 years** of policy issue, the beneficiary will only receive a refund of premiums paid. After two years, the face amount will be paid in the event of suicide.

Industrial Policies When an

insured has industrial life insurance policies with a single insurance company that total $3,000 or more in face value, the insured has the option to convert all of these policies into one ordinary life insurance policy at standard premium without evidence of insurability.

Reinstatement

An insurance company that requires an application for reinstatement has **45 days** to reject the application before reinstatement is automatic. In other words, if the insurer takes no action within 45 days, the policy is considered reinstated automatically.

Excess Business

Under Florida law, **"excess business"** is permitted when **an agent's own company is not able to write the amount of insurance requested by the applicant.** Excess business is that portion of a risk above the limits of that which the agent's own insurer will accept. A licensed life agent may place excess or rejected risks with any other authorized insurer without being required to secure an appointment as to such other insurer.

Excess Charges

Excess charges occur when an agent knowingly collects money for a premium or an additional charge for insurance that is not provided for in the policy.

ERISA

ERISA supersedes Florida state law relating to employee retirement plans. The savings clause in ERISA protects the following areas of state regulation:

- **Insurance**
- **Banking**
- **Securities**

Agent Responsibilities

While life insurance agents should be generally familiar with all Florida insurance regulations, the following 3 are of particular importance:

- **The Solicitation Law:** spells out the information and procedures required of agents and insurers when proposing life insurance to a prospective buyer;
- **Replacement Rule:** sets forth the requirements and procedures to be followed by insurance companies and agents when a proposal is being made in which a prospective life insurance buyer will be replacing existing insurance contracts with the proposed new insurance
- **Code of Ethics:** establishes a broad outline defining appropriate and inappropriate business behavior for life insurance agents.

➢ Replacement

Replacement

Replacement is strictly regulated and requires full disclosure by both the agent and the replacing insurance company. Replacement regulations exists to assure that purchasers receive specified information and it also reduces the opportunity for misrepresentation. Policy replacement is defined as a transaction in which a new policy or contract is to be purchased, and the agent is aware that an existing policy or contract has been, or will be:

- Lapsed, forfeited, surrendered or partially surrendered, assigned to the replacing insurer or otherwise terminated
- Converted to reduced paid-up insurance, continued as extended term insurance, or otherwise reduced in value by the use of nonforfeiture benefits or other policy values
- Modified to cause a reduction in benefits or length of policy term
- Subjected to loans exceeding **25% of the cash value**
- Reissued with a reduction in cash value
- Used in a financed purchase

Duties of the replacing agent

- Present to the applicant a **Notice Regarding Replacement** that is signed by both the applicant and the agent. A copy must be left with the applicant.
- Obtain a list of all existing life insurance and/or annuity policies to be replaced including policy numbers and the names of all companies being replaced.
- Leave the applicant with the original or a copy of written or printed communications used for presentation to the applicant.
- Submit to the **replacing insurance company** a copy of the Replacement Notice with the application.
- An agent must disclose the possible tax consequences of replacing or exchanging an existing annuity or life insurance policy.

Duties of the replacing insurance company

- Require from the agent a list of the applicant's life insurance or annuity contracts to be replaced and a copy of the replacement notice provided to the applicant.
- Send each existing insurance company a written communication advising of the proposed replacement within a specified period of time of the date that the application is received in the replacing insurance company's home or regional office. A policy summary or ledger statement containing policy data on the proposed life insurance or annuity must be included.

The replacement of existing life insurance policies with new contracts of life insurance requires a written Comparison and Summary Statement at the **policyowner's request**.

Conservation

An agent's attempt to stop the replacement of an existing life insurance policy or annuity is known as conservation.

➢ Group Life Insurance

Certificate

Instead of a policy, the participants under a group plan are issued **certificates of insurance** as evidence that they have coverage.

- Each person insured under a Group Life insurance policy is a certificate holder

The certificate must contain the following information:

- **Group policy number**
- **Description of insurance protection to which the certificate-holder is entitled**
- **The name of the insured, beneficiaries and dependents (if any)**
- **The rights and conditions**

Conversion

In Florida, group life policies must contain a conversion privilege that allows for conversion to an individual policy for a specified period of time.

- **Converted individual policies do not require evidence of insurability**

Eligibility

Participants are given a period of time, known as the **eligibility period**, to join the group plan. Other plans use an open enrollment period, in which case all new employees must wait until the next enrollment period before joining the group plan. **In Florida, there is no minimum number of insureds required for a group life insurance policy.**

Note: Those who do not enroll at the first opportunity can be required to provide evidence of insurability

Group life statutes

- The employees eligible for group insurance under the policy shall be all of the employees of the employer.
- In the event of a termination of a group life plan or termination of a covered employee, a person covered by a group policy has the right to convert such coverage to an individual policy within **the conversion period (31 days)** without proving insurability. If this right is exercised, the employee is responsible for the payment of premium.
- There are **no restrictions** regarding the assignment of coverage under a group life insurance policy

Cancellation

An insurer must notify each certificate holder (employee) when the master policy has expired or is being cancelled.

- 13 The insurer may take such action through the policyholder (employer)

Fraternal life insurance organizations

Fraternal life insurance organizations are nonprofit providers of life insurance that is covered by a special section of the Florida insurance code.

Entities

The following entities for selling life insurance are legal in the State of Florida

- Personal producing general agencies
- Independent agency systems
- Career agency systems

Eligibility requirements for associations

The following are the eligibility requirements for an association to purchase life insurance for its members on a group basis:

- The group must be a natural group (organized for some reason other than to obtain group insurance)
- A minimum of 100 participants is required for a contributory plan
- The group must have been in existence for two years
- The group must hold regular meetings at least on an annual basis

Noncontributory group

In a noncontributory group, the policy must cover **100% of eligible persons**.

➢ Viatical Settlements

Allows someone with a terminal illness to sell their existing life insurance policy to a third party for a percentage of the face value. To receive a percentage of the policy face value, an owner of a life policy may sell the policy to a **viatical settlement provider.** The new owner continues to make the premium payments and will eventually collect the entire death benefit. Viatical settlement brokers must be licensed before conducting any viatical transactions. **Proceeds of the viatical settlement contract could be subject to the claims of creditors.**

Note: the original policy owner is called the Viator and the new third party owner is called the Viatical or sometimes called the Viatee. **A viatical settlement broker can advertise the availability of viatical settlements, introduce viators to viatical settlement providers, and charge a fee for their services.**

➢ Variable Products

- An agent who wants to sell Variable annuities must be licensed by the state, which includes examinations in Life and Variable contracts.
- Agents marketing variable life insurance must be licensed and appointed as a life and variable

contract agent, and a **broker dealer**

- Variable annuities are regulated by both the **Department of Financial Services and the Securities Exchange Commission**
- A variable annuity policyholder must be informed of the accumulated value of the contract during the premium payment period **at least once each year**

➢ Suitability in Annuity Transactions

Standards and procedures are in existence to ensure that anyone looking to purchase, exchange, or replace an annuity is properly informed and the recommendations given to them are in their best interests. The intended goal of this regulation is a consumer who has had their insurance needs and financial objectives properly addressed.

The following list is information that should be taken into consideration when making suitable recommendations concerning the purchase, exchange, or replacement of an annuity:

- Age
- Annual income
- Financial situation and needs
- Financial experience
- Financial objectives
- Intended use of the annuity
- Financial time horizon
- Existing assets
- Liquidity needs
- Net worth
- Risk tolerance
- Tax status
- Present income

Florida Health Laws

➢ Required provisions

Entire contract

A provision that the **policy, application, and all attachments** shall constitute the entire contract between the parties.

- **States that the agent does NOT have the authority to change the policy or waive any of its provisions**

Time limit on certain defenses (Incontestable Period)

A health or disability policy is incontestable after it has been in force for a period of **2 years.** Only fraudulent misstatements in the application may be used to void the policy or deny any claim at this point.

Grace Period

The grace period for health and accident insurance is required to be no less than 7 days for weekly premium policies, 10 days for monthly premium policies and, 31 days for all other policies. If premium is paid within the grace period, coverage shall remain in effect.

Reinstatement

If a health policy is reinstated after it had lapsed for nonpayment, there is a waiting period of **10 days** before a claim covering sickness will be covered. Injuries sustained from an accident, however, will be covered immediately.

- If the insurer takes no action within **45 days** after receiving the reinstatement application, the policy is considered automatically reinstated

Notice of claim

Written notice of a claim must be given within **20 days** after a covered loss starts or as soon as reasonably possible.

Claim forms

An insurance company will send forms for filing proof of loss to a claimant within **15 days** after company receives notice of a claim.

Proof of loss

Written proof for any loss must be given to the insurance company within **90 days**.

Time payment of claims

The time payment of claims provision allows insurers **45 days** after receiving notice and proof of loss in which to pay or deny the claim.

- The minimum schedule of time in which claims MUST be made to an insured under an Individual Disability policy is **monthly**

Right to examine (free-look)

Health insurance policies must provide a minimum free-look period of **10 days** upon policy delivery. This allows the policyowner time to decide whether or not to keep it. If the policyowner decides not to keep the policy within the 10 days allowed, a full refund will be given.

- A person who is eligible for Medicare has a free-look period of 30 days

Legal Actions

No legal action can be initiated within **60 days** after proof of loss has been submitted to the insurance company. In addition, no legal action can be initiated after **5 years** from the initial time written proof of loss has been provided.

Advertisements

- All advertisements for health insurance shall make clear the identity of the insurer
- Insurance companies are responsible for the accuracy of testimonials

Physical Exams and Autopsies

The insurer has the right to examine the insured during the claim process and to an autopsy when death is involved and where it is not forbidden by law.

Illegal occupation

The insurer shall not be liable for any loss to which a contributing cause was the insured being engaged in a felony or illegal occupation.

Change of beneficiary

The change of beneficiary provision allows the policyowner to change the policy beneficiary if so desired as long as the beneficiary designation is revocable. This provision also gives the policyowner the right to surrender or assign the policy without obtaining the beneficiary's permission.

➢ Pre-existing conditions

Individual health insurance

Florida law prohibits individual health insurance policies (other than disability income insurance) from excluding coverage for preexisting conditions for longer than 24 months following the effective date of coverage, based upon a condition that had manifested itself during the previous 24-month period in such a manner as would cause an ordinarily prudent person to seek medical advice or treatment.

Group health insurance

For group health insurance: Pre-existing conditions (conditions for which medical advice, diagnosis, care or treatment was recommended or received in the **6 months prior** to the effective date of enrollment) may be excluded for a maximum of **12 months** from the date of enrollment **(18 months for late enrollees)**. Creditable coverage will be used to reduce the exclusion period, unless the individual has a coverage gap of 63 days prior to enrollment in the group plan.

- The underwriting and issuance of a master group health policy in Florida requires that all employees or members must be eligible to participate regardless of individual health history

Replacement health insurance

When a person covered by a health insurance plan moves to another plan, any credit toward fulfilling the preexisting requirement on the prior plan will be transferred to the new plan.

Pre-existing conditions, replacement policies

When replacing an individual health policy in Florida, the required replacement notice to the applicant must include **notice that pre-existing conditions may not be covered.**

An individual's waiting period for pre-existing conditions is reduced when he or she has "creditable coverage." Creditable coverage is previous coverage under another group or individual health plan when there has not been a break in coverage of **63 days**. The 63-day period begins when the individual's previous coverage ended. It ends when coverage under your plan begins, or, if earlier, when your group's waiting period for eligibility begins.

Under HIPAA requirements **18 months** of "creditable coverage" are required in order for a person who does not have access to other health insurance to be given the opportunity to purchase an individual health insurance policy

➢ Florida Eligibility Requirements and Offers

Newborn child coverage

All health plans that provide coverage to family members of the insured, must provide coverage for the insured's newborn child from **the moment of birth** for a period of **18 months.**

Handicapped children

In Florida, coverage for a child who is dependent on the parents for support due to a physical handicap may be continued beyond the contractual limiting age when **the child is incapable of self sustaining employment.**

Adopted and prospective adopted children

All health plans must provide coverage to the insured's adopted children on the same basis as other dependents.

Substance abuse

All health plans must provide benefits when an insured is confined for treatment of alcoholism or drug abuse in a licensed medical care facility.

Mental Health

All health plans must provide benefits when an insured is confined for in-patient treatment of mental illness in a licensed medical care facility.

Converted policies

At the option of the insurer, a separate converted policy may be issued to cover a dependent.

Genetic testing

The use of genetic information or test results by health insurers or HMO's is prohibited.

Definition of small employer

A small employer is one that employs not more than 50 employees

When offering a health benefit plan to small employers, the carrier MUST offer **at least the standard plan**

- A small employer carrier that offers health coverage in the small employer group market shall renew or continue in force that plan at the option of the small employer

Exclusive Provider Organization

A provider that has entered into a written agreement with a health insurance company to provide health care services for certain insureds. It can offer these services through its own facilities or a network of health care professionals, or it may use another facility, such as an HMO.

Dread disease policies

Dread Disease policies cover a single disease or illness only.

Discount Medical Plan

An arrangement or contract in which a person, in exchange for fees or other consideration, provides access for plan members to the services of providers of medical services at a discount.

Contributory group plan

Under Florida law, there is **no specific minimum percentage participation** for employees covered by employee group health insurance.

Coordination of benefits (COB)

The purpose of the coordination of benefits (COB) provision, found only in group health plans, is to avoid duplication of benefit payments.

Association plans

Association Plans **must be fully insured by an authorized insurer**, so the insurer is subject to state regulation.

Prepaid Limited Health Service Organization (PLHSO)

A PLHSO is any person, corporation, partnership, or any other entity that, in return for a prepayment, undertakes to provide or arrange for, or provide access to, the provision of a limited health service to enrollees through an exclusive panel of providers for the following services:

- Ambulance services
- Dental care services
- Vision care services
- Mental health services
- Substance abuse services
- Chiropractic services
- Podiatric care services
- Pharmaceutical services

➢ COBRA

The Consolidated Omnibus Budget Reconciliation Act (COBRA) is a federal law that requires employers with 20 or more employees to include a continuation of benefits provision for former employees and their dependents. COBRA guarantees that the participant can continue the group coverage (at their own expense) at group rates if their participation in the group plan is terminated because of a qualifying event.

Qualifying events: include the death of the employee, termination of employment (except for termination because of gross misconduct) or a reduction in work hours, which results in the participant no longer qualifying for group coverage.

Note: It is important to remember that COBRA benefits apply only to group health insurance, not group life insurance.

Continuation of group coverage

Employees who have been covered under a group health plan for at least **3 months** before their termination to be eligible to continue their coverage under COBRA. They must request continuation within **31 days** following termination.

Mini COBRA

Florida's Health Insurance Coverage Continuation Act (Mini COBRA) applies to employers who employ less than 20 employees.

➢ Florida Employee Health Care Access Act

The purpose of the Florida Employee Health Care Access Act is to **make group health insurance available to employers with 50 or fewer employees.**

- The provisions of the Florida Employee Health Care Access Act require that **all small group health benefit plans be issued on a "guaranteed-issue" basis**

➢ Florida Healthy Kids Corporation

Florida Healthy Kids offers health insurance for children ages 5-18. Health Kids is designed to provide quality, affordable health insurance for families not eligible for Medicaid.

- Families with children covered by the Florida Healthy Kids Corporation program pay only a **portion of the premium**

➢ Long-Term Care

Definition

Long-term care insurance is designed to provide coverage for diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services in a setting other than an acute care unit of a hospital.

- A health insurance agent license is required in order to solicit Long-term care insurance in the State of Florida
- Long-term care insurance is any policy designed to provide coverage for at least 12 consecutive

months for each covered person on an expense-incurred, indemnity, prepaid, or other basis

Notice to buyer

A **"notice to buyer"** must be on the first page of each long-term care policy delivered in. It explains that some long-term care costs may not be covered.

Outline of Coverage

An outline of coverage is required and provides a very brief description of the important features of the policy. It is considered a summary of coverage. It requires:

- A summary of the policy's principal exclusions and limitations
- A statement of the policy's renewal and cancellation provisions
- A description of the policy's principal benefits and coverage

Renewability Provision

Individual long-term care insurance policies shall contain an appropriately captioned renewability provision on the **first page of the policy form**.

- The renewability provision shall clearly state that the coverage is guaranteed renewable or noncancellable

Pre-existing Conditions

Pre-existing conditions are those for which medical advice or treatment was recommended by or received from a health provider within **six months** preceding the effective date of an individual long-term care policy.

Free look

A **30 day** free look period is required for long-term care policies.

Inflation Protection

All insurers issuing long-term care insurance policies must offer, as an optional benefit, **an inflation protection feature** which provides for automatic future increases in the level of benefits without evidence of insurability. Adjustments must be at a level which provides reasonable protection from future increases in the costs of care for which benefits are provided**.**

Lapse notice

An insurer must mail a long-term care lapse notice at least 30 days prior to the effective date of cancellation to both the policyholder and a specified secondary addressee.

Home Health Care

Long-term care policies must pay for "at-home" care at **the same daily amount as paid for a nursing home** if the insured meets the qualifications for nursing home care.

Limitations and Exclusions

Exclusion or limitation of benefits on the basis of Alzheimer's Disease is NOT permitted. However, limits

and exclusions may be placed on:

- Preexisting conditions or diseases
- Alcoholism and drug addiction
- War or acts of war
- Participation in a felony, riot or insurrection
- Suicide or self-inflicted injury
- Aviation (except for fare-paying passengers)

➢ Medicare Supplements

- Insurers must file with the Commissioner a copy of any Medicare supplement advertisement before it is to be used in Florida
- The marketing of Medicare Supplements is regulated to prevent sales of **excessive insurance**, **inaccurate policy comparisons**, and the **failure to display notice of limitations to the buyer**
- The **agent who solicits the application** is primarily responsible for determining the appropriateness of a Medicare supplement policy for a proposed insured
- Every agent soliciting Medicare Supplements must provide a **suitability form**
- To verify if replacement is involved in a Medicare Supplement sale, insurance law requires that a question about replacement appear on **the application form**
- If a Medicare Supplement policy is sold, the agent must deliver an Outline of Coverage to the applicant **no later than when the application is taken**
- When a Medicare supplement policy is purchased during the open enrollment period, the policy must be issued **regardless of health status**
- Free-look period for Medicare Supplements is **30 days**
- The open enrollment period for Medicare (and Medicare Supplements) begin **3 months before your 65th birthday** and lasts for 7 months
- An insurer may exclude coverage for a preexisting condition on a Medicare Supplement Policy for up to **6 months**.

➢ Prohibited Long-term care and Medicare Supplement Sales Practices

- **Twisting:** Using misrepresentations or inaccurate comparisons to induce a person to terminate or borrow against their current insurance policy to take out an insurance policy with another

insurer

- **High pressure tactics:** Used to induce the purchase of insurance through force, fright, threat, or undue pressure
- **Cold lead advertising:** Failing to disclose that the purpose of the marketing effort is insurance solicitation
- **Misrepresentation:** Misrepresenting a material fact in selling a long-term care insurance policy

➢ HMO Definitions

Member: A person who makes a contract or on whose behalf a contract is made with a health maintenance organization for health care services.

Provider: Any person, including a physician or hospital, who is licensed or otherwise authorized in this state to provide health care services.

Subscriber: A person who makes a contract with a health maintenance organization, either directly or through an insurer or marketing organization, under which the person or other designated persons are entitled to the health care services.

Individual contract: A contractual agreement for the provision of health care services on a prepaid basis entered into between an HMO and a subscriber covering the subscriber and the subscriber's dependents.

- An insurer may NOT issue an HMO contract

Every subscriber must receive a benefits package that includes a copy of the HMO contract and certificate and a member's handbook. The contract must contain all of the provisions required by law, such as:

- Must clearly state all services covered by contract
- Must state all limitations
- Enrollment
- Rates charged shall not be excessive
- Procedures for emergency treatment outside the HMO's geographic area
- Grace period of no less than 10 days
- Preexisting conditions in children may not be excluded
- Contract must be accompanied by an identification card
- Statement of time limit of certain defense clause (2 years) must be included
- Rate of payment must be clearly stated

➢ Dental

Restorative

Restorative dentistry is the procedure for restoring the function and integrity of a missing tooth structure. Examples include fillings, crowns, and dental bridges.

Oral surgery

Oral and maxillofacial surgery is surgery to treat many diseases, injuries and defects in the head, neck, face, jaws and the hard and soft tissues of the oral and maxillofacial region.

Endodontics

Endodontics is the branch of dentistry dealing with diseases of the dental pulp. Root canals would be an example. Endodontics is commonly excluded or limited from a dental policy.

Periodontics

Periodontics is a dental specialty that involves the prevention, diagnosis and treatment of disease of the supporting and surrounding tissues of the teeth or their substitutes. It also involves the maintenance of the health, function, and esthetics of these structures or tissues.

Prosthodontics

Prosthodontics is a branch of dentistry dealing with the replacement of missing parts using biocompatible substitutes such as **bridgework or dentures**

Orthodontics

Orthodontics is the treatment of irregularities in the teeth (esp. of alignment and occlusion) and jaws, including the use of braces.

Dental 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, however, dental coverage and claims are handled separately with a separate deductible. There also may be a probationary period in group dental insurance to help hold down coverage for preexisting conditions. Some dental policies are scheduled, meaning benefits are **limited to specified maximums per procedure**, with first dollar coverage. Most, however, are comprehensive policies that work in 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.

Here are some other bullet points to consider when addressing dental plans:

- **A pre-treatment estimate** of the cost of dental services may be required whenever the patient

requires dental treatment

- Comprehensive dental plans usually provide routine dental care services without deductibles or coinsurance to encourage preventative care (such as teeth cleanings, fluoride treatments etc)
- Dental plans are typically indemnity plans, which pay benefits based on a predetermined, fixed rate set for the services provided…regardless of the actual expenses incurred.
- To prevent adverse selection in a group dental expense plan, the plan may require any of the following: **probationary periods, waiting periods, evidence of insurability, or limits on annual benefits**
- With prepaid dental plans, **coverage is limited to a closed panel of dentists**
- The absence of deductibles on routine examinations encourages preventive care in dental insurance
- Dental treatment expenses required to repair an injury would normally be covered under a hospital or medical expense policy.
- Some hospital and medical expense plans will provide coverage for some dental related services related to the jaw or facial bones. Some of these include: reduction of any facial bone fractures; removal of tumors; treatment of dislocations, facial and oral wounds/lacerations in order to repair an injury; and the removal of cysts or tumors of the jaws or facial bones.

PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA OR ACA)

Exchanges

- Created by the **Affordable Care Act (ACA)** health reform bill to help individuals and small businesses purchase health insurance coverage.
- The purposes of the exchange include:
  - Reduce the number of uninsured in the state
  - Facilitate the purchase and sale of qualified health plans in the individual market
  - Assist qualified employers in the state in enrolling their employees in qualified health plans
  - Assists individuals in accessing public programs, premium tax credits, and cost-sharing reductions
- Under the Affordable Care Act (ACA), the health insurance exchange will perform all of the following roles:
  - Certify health plans as qualified, based on pre-determined criteria
  - Utilize individual, unique formats for presenting health benefit plan options
  - Verify and resolve inconsistent information provided to the exchange by applicants

Essential health benefits

Beginning January 1, 2014, the exchange shall allow any qualified plans that meet the minimum standards established by the exchange to be offered in the exchange. All plans must include the following:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative services and devices
- Laboratory services
- Preventative and wellness services and chronic disease management
- Pediatric services, including oral and vision care

Metal levels

There are four tiers of "qualifying health plans" you or your employer can purchase on the exchange. They range from lower quality, but more affordable "Bronze plans", to "Silver plans" to a more expensive plan with better coverage called a "Gold plan". There is also a "Platinum plan" which is the highest quality and cost plan. Lower premium plans will have higher deductibles, less benefits and larger out of pocket costs. The actuarial level is calculated as the percentage of total average cost for covered benefits that a plan will cover.

- Bronze Plans: 60% actuarial level of coverage provided
- Silver Plans: 70% actuarial level of coverage provided
- Gold Plans: 80% actuarial level of coverage provided
- Platinum Plans: 90% actuarial level of coverage provided

Preexisting conditions

Health plans cannot limit or deny benefits or deny coverage for a child younger than age 19 because of preexisting conditions. This applies to both group and individual policies

Lifetime and annual limits

The ACA prohibits health plans from putting lifetime dollar limits on most benefits that are received by an insured.

- For plans starting on or after September 23, 2012, but not before January 1, 2014, the annual dollar limit is $2 million. After January 1, 2014, there are no annual dollar limits
- Plans are allowed to put an annual dollar limit on health care services that are not considered essential

Grandfathered Plans

- Grandfathered plans are plans that were purchased before March 23, 2010. These plans do not have to follow the ACA's rules and regulations or offer the same benefits, rights and protections as new plans.
- An exception to this is a grandfathered plan cannot impose lifetime limits on how much health care coverage people may receive
- Grandfathered health plans may lose their grandfathered status if the insurer significantly raises coinsurance charges, deductibles, or co-payment charges.

Other ACA requirements

- As defined by the Affordable Care Act, the MAXIMUM amount an individual can contribute to a Flexible Savings Account is $2,500
- Under the Affordable Care Act (ACA), parents can insure their dependent adult children up to their 26th birthday, even if they are married or not living with their parents
- Low-income individuals and families whose incomes are between 100% and 400% of the federal poverty level will receive federal subsidies on a sliding scale if they purchase insurance via an exchange
- Beginning January 1, 2014, the Patient Protection and Affordable Care Act (ACA) will require adjusted community rating in the **small group market**. Small group health plans will be allowed to vary rates only **based on whether the policy covers an individual or family, geographic area, age, and tobacco use**
- If an insurer fails to adhere to the Affordable Care Act requirements related to internal appeals, **the internal appeal may be deemed exhausted for purposes of submitting an external review**
- According to the Affordable Care Act, if a large employer does NOT provide health insurance and owes an employer mandate penalty, the annual penalty is calculated by **multiplying $2,000 by the number of full time employees minus 30**
- On or after January 1, 2014, employers with no more than 25 full time equivalent (FTE's) with average annual wages of less than $50,000 may be eligible for a tax credit of up to 50% of the premiums paid by the employer
- You may qualify for employer health care tax credits through SHOP if you have fewer than 25 full-time employees making an average of about $50,000 a year or less