Accident and Health Insurance Topics

TYPES OF HEALTH POLICIES

While life insurance covers the risk of loss caused by physical death, health insurance covers the risk of loss caused by a "living death." When a person sustains an accidental injury or sickness, medical expenses must be paid in addition to the normal living expenses. While a person is recovering, they may not be able to work, and as a result, their income is reduced. Health insurance is intended to insure the risk of income loss caused by accidental injury or illness and associated medical costs.

In this section we will review the different types of health insurance available to a prospective insured.

A. Disability income

The purpose of disability income insurance is to provide disabled individuals with periodic income while they cannot work. Disability income insurance prevents individuals from depleting their personal savings to afford the normal costs of living in addition to the medical expenses associated with disability. In other words, disability income policies serve as a substitute paycheck. It is important to note however, that while disability income policies are designed to cover costs of living while disabled, they are not designed to provide enough benefits to cover the costs of medical bills. For medical bill coverage, individuals should purchase a medical expense policy.

The following chart will give you a brief overview of the different types of disability insurance.

<table>
<thead>
<tr>
<th>Disability Income Policies</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Individual Disability Income</strong></td>
</tr>
<tr>
<td><strong>Business Overhead Expense (BOE)</strong></td>
</tr>
<tr>
<td><strong>Business Disability Buyout</strong></td>
</tr>
<tr>
<td><strong>Group Disability Income</strong></td>
</tr>
<tr>
<td><strong>Key Employee</strong></td>
</tr>
</tbody>
</table>
Let's take a deeper look at these types of disability income insurance policies.

1. **Individual disability income policy**

Disability Income Insurance provides benefits for loss of income resulting from accidental injury or sickness preventing the covered person from being able to work. Benefit payments are paid periodically, at least monthly, and are a fixed amount or percentage (usually 60–70%) of the individual’s lost income. The insured’s occupation and earned income are the most important underwriting factors for disability insurance, but the cost of the policy is also determined by the definition of disability and the length of benefit and elimination periods.

**Defining Total Disability**

Individuals qualify for disability income benefits if they meet the insurer’s definition of total disability. Insurers require the person to be unable to perform the work duties of his “own occupation” or “any occupation.”

- **Own Occupation** disability income policies pay benefits when the insured cannot perform the work duties of his occupation. Own occupation benefits are limited to two years, and are reserved for individuals with specialized training.
- **Any Occupation** disability income policies are more restrictive, requiring the insured to be unable to perform the duties of any occupation in which the individual is qualified based on education, experience, or training.
- **Presumptive Disability** is a condition such as loss of sight, hearing, speech, or use of arms or legs, which qualifies as total disability, regardless of ability to work.

**Accident vs. Sickness**

Some disability income policies define total disability in terms of whether it resulted from an accident or a sickness. Accidents policies use two definitions for accidents.

- **Accidental Means** definition is more restrictive and requires the injury to be unintentional and unexpected. In other words, the insured must be unaware that the risk would create a loss, and be unaware that the events leading up to the risks have the potential for loss.
- **Accidental Bodily Injury** definition covers all injuries except self-inflicted.

Sickness is any illness, disease, or condition appearing after the policy’s effective date.

2. **Business overhead expense policy**

Business Overhead Expense (BOE) policies help small businesses pay overhead expenses when the owner becomes disabled. The business owner owns the policy and pays the premiums, but the benefits are used to pay the business' expenses such as rent, utility bills, and employee salaries. The BOE policy does not pay the owner's salary. BOE policies have elimination periods of 30 days or less and benefit periods of one to two years.

3. **Business disability buy–sell policy**
Accident and Health Insurance Topics

A disability buy-sell policy is used to establish how ownership in a business is transferred upon an owner's disability. Important facts include the following:

- The business owns the policy, pays premiums and receives the benefits.
- The benefit is used by the business to purchase the disabled owner's share in the business.
- The elimination period in buy-sell policies is one to two years.
- The benefits may be paid in monthly periodic payments or in a lump sum.

4. Group disability income policy

In group disability income policies, the employer, association or organization sponsors and owns the group contract. Group plans are generally designed to prevent “over insurance.” Group policies do not usually require individual underwriting. Depending on the type of renewal provision, the insurance company may have the right to increase premiums on an entire class of insureds.

5. Key employee/partner policies

Key Person disability income policies pay benefits to businesses when a key employee is disabled. The purpose of the coverage is to allow the business to hire additional help while the employee is disabled. Key persons include:

- business owners,
- stockholders, and
- executive managers who are active in the company.

The amount of the disability income benefit is based on the key person's economic value to the business – the loss of income that would occur from reduced sales and hiring a replacement employee while the key person is disabled. Benefits may be paid as monthly periodic benefits, or in a lump sum. The business owns the policy, pays the premiums, and receives the benefits. The key person is the insured individual, who must sign the application, consenting to the coverage.

B. Accidental death and dismemberment

Accidental death and dismemberment (AD&D) policies pay a lump sum payment if the insured dies in an accident, or loses major body parts in an accident. An AD&D policy covers loss that occurs within a certain time period of the accident, such as 90 days.

The AD&D policy pays a principal sum if the insured dies or loses both hands, both arms, both legs, or vision in both eyes due to an accident. If the insured only loses one extremity or vision in one eye, the policy will pay 50% of the principal sum.

C. Medical expense insurance

Medical expense plans cover the cost of medical care. They are indemnity contracts intended to indemnify or make whole the policyowner for medical costs resulting from a covered accident or sickness.
Accident and Health Insurance Topics

- Policies have deductibles and coinsurance, requiring the insured to share the cost.
- Medical expense plans pay benefits through reimbursement to the policyholder, on a service basis directly to the providers, or on an indemnity basis with fixed amounts based on the condition or service.

Here is an overview of the different types of Medical Expense Insurance:

### Medical Expense Insurance

<table>
<thead>
<tr>
<th>Type of Medical Expense Insurance</th>
<th>Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic Hospital, Medical, and Surgical</td>
<td>No deductibles or coinsurance; Low limits for catastrophic coverage</td>
</tr>
<tr>
<td>Major Medical Policies</td>
<td>Broad coverage; Higher limits for catastrophic coverage; Have deductibles, coinsurance, eligible expenses, and benefit limits</td>
</tr>
<tr>
<td>Health Maintenance Organizations (HMOs)</td>
<td>Prepaid plans focused on preventive care; Requires in-network referral to a specialist from primary care physician; Physicians paid by capitation</td>
</tr>
<tr>
<td>Preferred Provider Organizations (PPOs)</td>
<td>Group of medical facilities and physicians that provide services at a reduced cost; Insureds choose provider but benefits for non-preferred providers are reduced; Physicians paid on fee-for-service basis</td>
</tr>
<tr>
<td>Point of Service Plan (POS)</td>
<td>Mix of HMO and PPO; Members can choose in-network providers or out-of-network providers at an additional cost; Physicians paid by capitation</td>
</tr>
<tr>
<td>Flexible Spending Accounts (FSAs)</td>
<td>Tax-advantaged savings accounts; Funds used for qualified medical expenses</td>
</tr>
<tr>
<td>Health Reimbursement Accounts (HRAs)</td>
<td>Savings accounts with a high deductible health plan owned by employers for their employees; Contributions are made by employer</td>
</tr>
<tr>
<td>Health Savings Accounts (HSAs)</td>
<td>Savings account with a high deductible health plan owned by employee; Contributions are from employee’s paycheck before tax</td>
</tr>
</tbody>
</table>

1. Basic hospital, medical, and surgical policies
Accident and Health Insurance Topics

Basic plans have no deductibles or coinsurance, and low limits for catastrophic coverage. Basic plans do not exist today as standalone contracts, but are still part of many modern insurance plans.

The three basic plans are medical, hospital, and surgical:

- Medical covers nonsurgical physician’s fees for accident or sickness.
- Hospital covers costs of hospitalization except for physician’s fees and surgeries.
- Surgical covers surgeon fees, anesthesia, and post-surgery recovery.

2. Major medical policies

Major medical policies provide broader coverage with higher limits for catastrophic coverage, and have deductibles, coinsurance, eligible expenses, and benefit limits.

There are several types of deductibles in major medical policies.

- Flat Dollar Deductible: The flat dollar deductible requires the insured to pay the deductible each time he receives a medical service. The insured pays the deductible for each claim.
- Per Cause Deductible: The per cause deductible is paid for each cause in which medical care is sought.
- Maximum Annual Deductible: A third type of deductible is the maximum annual deductible also referred to as an all cause, calendar year, or cumulative deductible per person or per family (family maximum deductible). Once the insured has cumulatively paid enough medical expenses out-of-pocket to fulfill the annual deductible, the policy will begin to pay benefits.

After the deductible is paid, coinsurance applies. The policy specifies what percentage of the medical expense the insurer and insured are responsible for paying. Usually, the insurer is responsible for the larger portion. One example of coinsurance is 80/20 in which case the insurer pays 80% and the insured pays 20%.

After coinsurance is paid, some major medical policies incorporate a stop-loss feature, also referred to as an out-of-pocket limit, which prevents the insured from incurring catastrophic loss. Once the insured’s total out-of-pocket expenses reach the stop-loss limit, the insurer pays the remaining eligible expenses. The insured’s total out-of-pocket expenses are comprised of the total amount of deductibles and coinsurance paid. After the stop-loss limit is reached, the insurer will pay the remaining eligible expenses.

Inside Limits and Maximum Benefit

Inside limits are within a policy and place dollar limits for certain medical service. Most policies also have a maximum lifetime benefit per individual (usually $1 million).

Restoration of benefits

Some major medical policies include a feature called the restoration of benefits. This allows the maximum lifetime benefit to be restored to its original amount after a large portion of the benefits have been used.
3. Health Maintenance Organizations (HMOs)

Health Maintenance Organizations (HMOs) are prepaid plans focused on preventive care, requiring the insured to be referred to a specialist by the primary care physician. Facilities and physicians must be in-network providers contracted with the HMO. Physicians are paid by capitation. HMOs have the following characteristics:

- Before an HMO can offer coverage and benefits to the public, the HMO must obtain a certificate of authority from the state’s Department of Insurance.
- The HMO owns or contracts with a clinic and staffs it. It subcontracts with a hospital.
- Members may use only the group facilities and primary care providers (PCPs).
- Only the PCP can refer a patient to a specialist or hospital.
- The HMO provides free preventative medical care (annual physical exams and routine well-child visits, immunizations, age related preventative treatment, etc.) in an effort to identify and treat problems early, thus promoting health and saving money.
- The HMO has control both of the producers and the purchasers of health care (the medical facilities and staff and the members who will use them). Thus, it stands a good chance of containing costs more efficiently than other managed care models.
- Each member of the HMO pays a specified monthly flat fee for membership.
- Each member must be provided with a description of the specific procedure for lodging and resolving any complaints about the plan.

4. Preferred Provider Organizations (PPOs)

Preferred Provider Organizations (PPOs) are a group of medical facilities and physicians that provide services at a reduced cost. Facilities and physicians are paid on a fee-for-service basis. Insureds are free to choose their service providers, but benefits for non-preferred providers are reduced. Examples include:

- large employers
- trade unions
- BlueCross BlueShield groups
- traditional insurance companies
- local groups of hospitals

5. Point of Service (POS) plans

Point-of-Service (POS) plans are a mix of HMO and PPO arrangements. Members can choose in-network or out-of-network providers, but pay more for out-of-network except in emergencies. Physicians are paid by capitation.

- In-network Coverage
Accident and Health Insurance Topics

In-network coverage means the insured receives care through the network of doctors and hospitals participating in the plan, and all care is coordinated by the insured’s primary care physician, who acts as gatekeeper.

The PCP is the “gatekeeper” and makes all referrals to specialists and all arrangements regarding hospitalization.

In-network coverage is the highest level of coverage in the plan: the plan will pay more for medical services, and the insured won’t have to submit claim forms.

- Out-of-network Coverage

Out-of-network coverage applies when the insured receives care from a medical provider who does not participate in the plan’s network of providers, and the care is not coordinated by the PCP.

In out-of-network coverage, the insured usually pays more of the actual cost of care than if they had used in-network coverage, and they must also submit claim forms to receive benefits. Services rendered by non-preferred providers must be covered at a rate of at least 80% of the coverage offered for the services of preferred providers.

Note: Emergencies are exempted from the lower level of coverage in out-of-network service.

6. Flexible Spending Accounts (FSAs)

FSAs are tax-advantaged savings accounts in which funds are used for qualified medical expenses and dependent care. There are two types of FSAs: qualified medical expense accounts; and dependent care expense accounts.

An individual may reimburse qualified expenses for a spouse or dependents in either account. Funds in an FSA are subject to the use-it or lose-it rule, where all the funds must be used in the plan year. FSA funds can be used for a wide range of medical expenses such as over-the-counter drugs and child care.

- Eligibility

FSA plans are established and offered through an employer for the benefit of its employees. Employee contributions are made through a voluntary withholding of wages/salary, which is often referred to as a salary reduction agreement. Some plans even involve employers contributing to the account, as well.

- Contribution Limits

Prior to the Patient Protection and Affordable Care Act that was signed into law in 2010, there was no limit on the amount of money you or your employer could contribute to the accounts. There is now an annual limit for qualified medical expense accounts that is indexed annually. The limit is the maximum contribution that each employee may make for the year, regardless of whether the employee has a spouse or dependents whose expenses are also reimbursed through his or her qualified medical expense account.
Accident and Health Insurance Topics

• **Tax Benefits**
  
  FSA funds are not subject to federal income or Social Security taxes. Employees contribute a portion of their income earnings to the savings account pre-tax, which lowers their taxable income. In addition, withdrawals may be tax free if you are paying for qualified medical expenses.

7. **Health Reimbursement Accounts (HRAs)**

Health Reimbursement Accounts (HRAs) are savings accounts with a high deductible health plan established by employers for their employees. The employer sets aside funds for employee’s medical expenses. Employees are reimbursed by their employer for their medical expenses. Contributions are made by the employer, not through employee-elected salary reductions.

• **Eligibility**
  
  HRAs are established and offered through an employer for the benefits of the employee. The employer makes contributions to the HRA, not the employee.

• **Contribution Limits**
  
  There are no contribution limits for HRAs.

• **Tax Benefits**
  
  Employer contributions are tax-deductible as a business expense. Benefits are not taxable to employees. The employer establishes employee eligibility rules and funds rollover.

8. **High Deductible Health Plans (HDHPs) and related Health Savings Accounts (HSAs)**

HSAs replaced Medical Savings Accounts in 2003. HSAs are a combination of a savings account and high deductible health plan. Funds in an HSA may be used by the individual, their spouse, and their dependents.

Deductibles may be embedded or non-embedded. An **embedded deductible** is when an HSA has two deductibles: an individual, and a family deductible. The individual deductible is embedded in the family deductible, permitting each family member the opportunity for the policy to cover their medical bills before the total family deductible is met. An HSA with a **non-embedded deductible** only has the family deductible. The entire deductible must be met before the plan pays any benefits. The deductible can be satisfied by one family member, or by several.

• **Eligibility**
  
  To be eligible for an HSA, an employee must meet the following requirements:

  o Cannot have other health insurance coverage (except disability income, long-term care or limited coverage);

  o Cannot be eligible for Medicare; and
Accident and Health Insurance Topics

- Cannot be a dependent on another person’s tax return.

• Contribution Limits
  HSAs have minimum deductibles and contribution limits that are indexed annually, as well as a maximum out-of-pocket spending, which is the maximum amount an individual must spend out-of-pocket before catastrophic coverage begins to pay 100% of qualifying medical expenses.

• Tax Benefits
  The employer and employees make contributions to health savings accounts. Contributions are vested immediately. Contributions are tax deductible for individuals and are made on a salary-reduction basis. Employer-made contributions are not taxable income to the employee.
  Funds in an HSA can be used tax-free (no tax on principal or interest) for qualified health expenses. If funds are used for non-health purchases, a 20% penalty, plus tax is assessed. Funds in an HSA rollover from year to year. Withdrawals made after the age of 65 for non-health purchases are taxed, but not penalized.

9. Stop loss
  After coinsurance is paid, most major medical policies incorporate a stop-loss feature, also referred to as an out-of-pocket limit, which prevents the insured from incurring catastrophic loss.
  Once the insured’s total out-of-pocket expenses reach the stop-loss limit, the insurer pays the remaining eligible expenses.
  Some policies specify they will cover 100% of eligible expense after a certain dollar amount of out-of-pocket expenses. Other policies may state that coinsurance will apply only to the next $5,000 of eligible expenses after the deductible is paid, after which the insurer will cover the remaining eligible expenses.

D. Medicare supplement policies
  Medicare supplements help cover costs not paid by Medicare, such as deductibles, coinsurance, and actual charges. These policies have become practically a requirement for seniors due to the exclusions, limitations and copay requirements of Medicare. While it is possible to obtain a Medicare Supplement Policy prior to reaching age 65, most Medicare supplement policyholders are older, living on a fixed income, and apprehensive about dealing with insurance. For this reason, states have enacted strict guidelines for the formation of Medicare supplement contracts.

Medicare supplement policies must contain the following standard provisions:

- Duplicating the benefits of Medicare is prohibited.
- Policyholders must be provided a free look period of 30 days.
- An outline of coverage, detailing policy features, benefits and provisions, must be provided to applicants.
- Medicare Supplement policies must be guaranteed renewable or non-cancellable.
Accident and Health Insurance Topics

- The loss ratio (total amount of benefits paid out compared to the total amount of premium dollars collected) for Medicare Supplement policies must be at least 75% for group contracts and 65% for individual contracts.
- Accident and sickness losses are treated the same, and the accidental means test cannot be used.
- Medicare Supplement policies must automatically accommodate annual changes in Medicare coinsurance and deductibles.
- Once a Medicare policy has been in effect for a period of six months, benefits cannot be limited or denied because the individual has pre-existing conditions. Pre-existing conditions are defined as conditions for which medical treatment or advice was received by a physician in the six months prior to the policy effective date.
- Medicare Supplement policy limitations and exclusions cannot be more stringent than those of Medicare.
- Conversion to an individual policy must be offered if group Medicare Supplement coverage is terminated and not replaced.
- Individuals who become eligible to receive Medicaid benefits are permitted to suspend their Medicare Supplement policy if the request is made within 90 days of receiving Medicaid benefits for a maximum of two years. Upon ineligibility for Medicaid, the individual's coverage will automatically resume within 90 days of Medicaid benefits ending.

E. Group insurance

Group health insurance shares several of the same concepts of group life insurance. These include:

- Organizations may not be formed for the sole purpose of obtaining insurance;
- Most group insurance are employer groups;
- The employer holds the master contract, while the covered employee receives a certificate of insurance;
- Group insurance reduces adverse selection. This means that the benefit schedules are set;
- Administrative costs are lower; and
- Premiums are paid by the employer and are deductible as a business expense.

1. Group conversion

Group health plans must provide the right of all eligible persons covered under the group policy to convert to an individual policy without evidence of insurability.

Conversion privileges are effective if the person was terminated for any reason except involuntary termination for cause, lost coverage due to the entire class of coverage being discontinued, or the insured's dependent child reaches an age where coverage terminates.

Policies may require the individual to have been covered continuously for a set period of time, often no more than three months.

Coverage provided by a conversion policy usually provides benefits most similar to that provided under the group policy; however, the person may elect a lesser form of coverage.
2. Differences between individual and group contracts

Group insurance provides insurance for many people under one master contract. The group is underwritten as a whole, not each individual. Each member insured under the group plan is issued a certificate of insurance as evidence of coverage. Members insured under the group plan are not party to the contract, only the insurance company and the group entity.

Group insurance, as compared to individual insurance policies, has the following distinctions:

- More people are covered by a group plan through their employer than by an individual insurance plan.
- It is typically easier to qualify for a group plan than an individual plan.
- The unit cost for group insurance is generally less than for a comparable individual plan.

Group health insurance policies are contracts between an insurer and an employer, union, or other association. Group health contracts are established for the benefit of the group members. People enrolling in Group health plans usually do not have to undergo a medical exam as a prerequisite to enrollment.

3. General concepts

Groups must exist naturally. The group contract is issued to the employer, union, or association, and each member or employee receives a certificate of coverage. The group health insurance policy is the master contract. The policyholder is the employer, union, or other association, not the insured members.

Group health insurance policies have the following standard provisions:

- Grace Period: 31 days is allotted for nonpayment of premium
- Incontestability: The policy is incontestable for at least 2 years
- Evidence of Insurability: Individuals do not have to prove evidence of insurability unless enrolling after the group enrollment period

Employer-sponsored Plans: Employer-sponsored plans make up the largest portion of group insurance. Employers may individually contract group coverage with an insurer or join with other employers in Multiple Employer Trusts (METs) or Multiple Employer Welfare Arrangements (MEWAs).

Rating: Group health insurance policy rates are usually based on experience rating in which premiums are based on the claims experience of the entire group. With community rating, premiums are based on the actual or projected costs of insureds in a particular geographic location with reference to insureds’ age, gender, occupation and health. With community rating, each member pays the same premium.

Underwriting: Insurers of group plans evaluate the risk of the entire group, not each individual.
Accident and Health Insurance Topics

- Coverage is accepted or denied and premiums are set based on evaluating the age, sex, and occupation of the group.
- Insurers may not request medical information of groups of 50 or more.
- Each member of the group has the same coverage, including eligibility requirements and probationary period.
- Plans may not unfairly discriminate against certain individuals and all eligible individuals must be permitted to enroll.

Participation Levels:

- Contributory Plans are funded by the employer and employee premiums, and require 75% participation of eligible employees.
- Noncontributory plans are fully funded by the employer, and require 100% participation of eligible employees.

Eligibility for Coverage: Open Enrollment is a 30-day period each year, in which all eligible employees must be permitted to enroll, change coverage, or add dependents.

- Proof of insurability is not required during open enrollment.
- Insurers and employers generally require employees to be full-time to be eligible, and often require a probationary period of 30–90 days before they are eligible for coverage.
- Eligible dependents include spouses, children (including stepchildren and adopted children), and dependent parents. Children age 19–23 are required to be unmarried and full-time students. Disabled children have no age limit.

Coordination of Benefits: In the event of more than one insurance policy, the primary policy will pay benefits according to its limits, and the secondary policy will pay the remainder to its limits.

Change of Insurance Companies: If the employer changes insurance companies, all eligible employees under the old plan are covered by the new plan without a probationary period, and coinsurance and deductibles are carried over.

Termination of Coverage: Employee coverage may only be terminated if the employee is terminated, fails to make premium payments, or exceeds maximum benefit limits.

4. COBRA

COBRA allows employees and their dependents to continue group health coverage after termination or loss of eligibility for up to 18 months (36 months for dependents). COBRA only applies to companies of 20 or more employees.

Coverage under COBRA must be requested within 60 days and may require payment of 102% of the premium rate under the group plan. COBRA ceases if the insured becomes eligible for Medicare, becomes insured under another group plan, fails to pay premiums, or the benefit period ends.

5. HIPAA

HIPAA was enacted to protect coverage of individuals and their families who change or
lose jobs. Individuals with at least 18 months of creditable coverage are guaranteed issue under the new employer's plan. Creditable coverage provides proof of insurance. Creditable coverage may be applied to reduce waiting periods and exclusions for preexisting conditions.

HIPAA requires guaranteed renewability for group insurance except for nonpayment of premiums, violations of terms, or fraud. HIPAA also established standards for Protected Health Information (PHI), which includes individuals’ current and prior medical history.

F. Long Term Care (LTC)

While most individuals believe that Medicare will cover their expenses in the event that they need to be placed into a nursing home, Medicare will only do so if the insured is placed into a nursing home as a result of accident or sickness. Most individuals who need to be placed into a nursing home, are placed there because of an inability to take care of themselves or perform activities of daily living. That is what Long Term Care insurance is for. In this section, we will take a closer look at the definitions and provisions relating to Long Term Care insurance.

1. Individual LTC contracts

Long-term care (LTC) policies are intended to help individuals with daily activities they are no longer capable of performing themselves. LTC policies must provide coverage for at least 12 months (some states – 24 months). To be eligible for LTC benefits, the insured must be incapable of performing some of the activities of daily living (ADLs), such as bathing, dressing, eating, mobility, transferring, toileting, and continence. Most policies require inability to perform at least two ADLs or be cognitively impaired. Many policies have minimum age of 50 and maximum age of 89 for eligibility. LTC policies cannot require hospitalization prior to LTC nursing home coverage.

Levels of Care

Levels of care are the types of care covered by a LTC policy.

- Skilled Care: Nursing care and rehabilitation needed on a daily basis.
- Intermediate Care: Nursing care and rehabilitation needed occasionally.
- Custodial/Residential Care: Care provided to assist an individual with ADLs.
- Home Health Care: Care provided in an individual's home.
- Adult Day Care: Care provided to an individual who does not need 24-hour care. Adult day care may be provided in the home or at an adult day care facility.
- Respite Care: Care that allows an individual's primary caregiver to have a break from caregiving duties.

The benefit period of a LTC policy is the maximum period that benefits will be paid to an insured.

Optional Benefits

- Guarantee of Insurability: Benefit levels increase without the insured needing to prove insurability. The benefit increase is typically limited to 5% per year.
- Return of Premium: A portion of the premiums paid will be returned if an LTC
Accident and Health Insurance Topics

- policy is lapsed, or an insured dies before benefits are paid out.
- Hospice Care: Some LTC policies may provide care for hospice, which focuses on providing pain management and comfort, rather than curing an individual’s ailments.

Nonforfeiture Options

Only qualified LTC plans are required to provide nonforfeiture protection by federal law. Nonforfeiture provisions prevent policyholders from forfeiting policy cash values or benefits if the policy lapses.

Inflation Protection: Qualified LTC policies must provide inflation protection by federal law. Nonqualified LTC plans must offer inflation protection, but it does not have to be included in policies. Inflation protection allows the policy benefits to increase annually without requiring the insured to provide evidence of insurability.

Disclosures

LTC policies must provide a 30–day free look period. Policies cannot restrict coverage only to skilled care. Applicants must be given the shopper’s guide (outline of coverage) prior to completing the application.

Elimination Period: Many LTC policies have an elimination period similar to that found in a disability income policy, after which LTC benefits begin. In the case of LTC, the elimination period is usually 30 days or longer, during which period the insured must be confined to a nursing facility.

Waiver of Premium: The insurer may include a provision which waives payment of premiums while the insured is receiving LTC benefits for a specified time period (usually 90 or 180 days). Premiums resume after LTC ceases.

Qualified LTC Plans

Qualified LTC plans are tax–qualified, allowing premiums to be deducted as a business expense for employers, and deducted based on age for individuals. Benefits are not taxable.

2. Group/voluntary LTC contracts

Individuals who are insured under group LTC coverage must be provided with the right to convert to individual LTC coverage upon termination of group coverage (unless termination is due to nonpayment of premium) without needing to provide evidence of insurability.

Individuals must apply for the individual coverage and pay the premium within 31 days of the group coverage termination date.

G. Limited Benefit Plans

Limited insurance provides specialized coverage such as AD&D, which only provides coverage for accidental death and dismemberment. Limited health insurance policies are also referred to as conditional contracts because they do not pay benefits unless
specific conditions are met. Other limited policies include travel accident, hospital, income, credit health or disability, prescription, vision, dental, blanket coverage, and dread disease (cancer, heart disease, stroke, blindness, muscular dystrophy, multiple sclerosis, etc.)

1. Cancer (or specified diseases) plans and Critical Illness plans

Dread disease, also known as critical illness and specified disease policies, cover specific diseases.

An example of a dread disease policy is a cancer or heart disease policy.

Dread diseases occur infrequently, but when an individual does contract a dread disease, the medical costs associated with it can be extremely high.

Dread disease policies can offer relatively inexpensive coverage compared to full coverage medical expense plans, which may exclude coverage for dread disease, regardless.

2. Worksite (employer-sponsored) plans

Worksite plans are employer-sponsored plans, such as wellness plans which foster healthier lifestyles for employees. Such wellness plans focus on healthy diets and physical exercise.

3. Hospital indemnity plans

Hospital Income / Hospital Indemnity policies pay a flat dollar benefit for each day the insured is confined to a hospital. The dollar benefit varies by policy and may range from $50 to $200 per day. The income benefit may be paid daily, weekly, or monthly. The amount is not based on the insured’s income earnings.

Premiums for hospital income are low because it is limited coverage. The insured is not restricted to using the hospital income benefit for medical purposes, and may use it for whatever purpose desired.

Once the insured is discharged from the hospital, the benefits cease. Hospital indemnity policies are often sold as riders to disability income policies, but may also be sold as standalone policies.

4. Dental

Dental benefits are typically not included in traditional medical expense plans. Dental benefits are more frequently sold as specialized medical expense plans on a group basis and rarely as individual policies. Dental plans can also be set up as employer group dental expense plans.

5. Vision

Vision expense plans cover the cost of annual eye exams, and either eyeglasses or contact lenses every two years. Vision care policies may be purchased separately, or in some cases are included in group health plans.
Vision plans may exclude sunglasses, replacement lenses or frames and medical or surgical costs that are covered by other health insurance policies.

HEALTH POLICY PROVISIONS, CLAUSES, AND RIDERS

The NAIC developed the Uniform Individual Accident and Sickness Policy Provisions Law also known as the model health insurance policy provisions. All states have adopted the NAIC model laws. The NAIC model provisions provide standardization for all individual health insurance policy provisions and identify the rights of the insurer and policyowner.

Each state or insurer’s wording of the model provisions may have slight variations, but the general concepts are identical. If insurers word the provisions differently, the wording must be at least as favorable as the law provides.

A. Mandatory provisions

1. **Entire Contract:** The entire contract consists of the application, if attached, the policy, and any endorsements. Any change must be approved by the policyholder.

2. **Incontestability:** Policies are incontestable after two years, except for fraud. Policies may not deny, limit, or exclude coverage on the grounds of misstatement (except fraud) once the policy is incontestable.

3. **Grace Period:** A grace period must be offered to allow payment of delinquent premiums and the policy to remain in effect.

4. **Reinstatement:** Policies must allow for a period of reinstatement upon payment of current and past due premiums.

5. **Notice of Claim:** Notice of claims must be given to the insurer within 20 days of loss.

6. **Claim Forms:** If the insurer does not provide claim forms within 15 days of receiving notice, the insured may submit proof of loss on any form.

7. **Proof of Loss:** Written proof of loss must be provided to the insurer within 90 days after the date of loss. In no event, except for absence of legal capacity, may proof of loss be submitted after one year from the date of loss.

8. **Time of Payment of Claims:** Claims must be paid upon receipt of proof of loss. Periodic payment of claims must be made on at least a monthly basis.

9. **Payment of Claims:** Claims are paid to the insured or the medical service provider, except death benefits, which are paid to the designated beneficiary or the insured’s estate.

10. **Physical Examination and Autopsy:** The insurer, at its own expense, has the right to examine the insured or autopsy, if reasonably required and not prohibited by law.

11. **Legal Action:** No legal action may be taken prior to 60 days after written proof of loss is provided to the insurer.
12. **Change of Beneficiary:** The policyowner has the right to change the beneficiary, unless an irrevocable designation is made.

13. **Misstatement of Age:** If the insured’s age is misstated, benefits are based on the premiums paid had the policy been issued at the correct age.

B. **Optional provisions**

**Change of Occupation:** If the insured is injured or contracts sickness after having changed occupations to one classified as more hazardous than that stated in the policy, the insurer must pay only the portion of the indemnities provided in the policy as the premium paid would have purchased at the rates and within the limits fixed by the insurer for such hazardous occupation.

C. **Other provisions and clauses**

1. **Insuring clause:** The insuring clause is the insurer’s promise to pay benefits, typically located on the policy face.

2. **Free look:** Each policy must provide notice to the insured of the right to examine (free look) for a period of 10 days from the date of delivery to return for a full refund of premiums and fees.

3. **Consideration clause:** The consideration clause states the promises exchanged between the insured and the insurer.

4. **Probationary period:** A probationary period is the time between the effective date of the policy and date coverage begins.

5. **Elimination period:** The elimination period is the time between sickness, accident, or disability occurs and benefits become payable. Elimination periods are used in disability income and long-term care policies.

6. **Waiver of premium:** A waiver of premium provides continuation of coverage in the event of permanent and total disability without payment of premiums.

7. **Exclusions:** The following are common exclusions for health insurance policies:
   - The consumption of alcohol or narcotics;
   - Terroristic acts or other acts of war;
   - Participation in a felony;
   - Pre-existing conditions;
   - Self-inflicted injuries;
   - Injuries otherwise covered through Workers’ Compensation coverage;

8. **Preexisting conditions:** Preexisting conditions are medical conditions for which the insured has previously sought treatment or advice. Preexisting conditions may be excluded or limited for a specified period.

9. **Recurrent disability:** Policies must state whether recurrent disability is an existing or new claim, or has elimination period.
10. **Coinsurance**: Coinsurance provides for payment of service by the insurer and insured, usually 80% and 20%.

11. **Deductibles**: Deductibles are the amount the insured must pay for services before benefits are payable.

12. **Eligible expenses**: Eligible expenses are benefits or services provided under the policy coverage.

13. **Copayments**: Copayments are fixed price schedule for services and are paid by the insured.

14. **Pre-authorizations and prior approval requirements**: It is approval by the insurer that may be required for some services or policies.

15. **Usual, reasonable, and customary (URC) charges**: The policy must be defined in the policy.

16. **Lifetime, annual, or per cause maximum benefit limits**: It caps payments by the insurer and can be annual, lifetime, or per incident.

**D. Riders**

Another name for policy riders is policy add-ons. Health insurance policies can be customized by adding policy riders or endorsements to meet the specific needs of a client. While a policy rider adds additional benefits to a health insurance policy, it also usually raises the premium amount.

1. **Impairment/exclusions**: Excludes coverage for a specific condition that would otherwise be covered under the policy.

2. **Guaranteed insurability (Future Increase Option)**: Allows the insured to purchase additional disability income coverage at future dates regardless of insurability.

3. **Multiple indemnity (double, triple)**: Provide for payment of double or triple the accidental death or dismemberment benefits based on the cause of death or specific type of dismemberment.

**E. Rights of renewability**

An insurance policy must contain a provision for renewability that is either noncancellable, guaranteed renewable, conditionally renewable, or optionally renewable. Single-term nonrenewable policies must provide a nonrenewable provision stating that the policy may not be renewed.

**Rights of Renewability**

| Noncancelable | Insured has the right to continuation by making timely payment of premiums |
### Accident and Health Insurance Topics

<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cancelable</strong></td>
<td>Allows the insurer to cancel the policy at any time with notice; the insurer must returned unearned premiums</td>
</tr>
<tr>
<td><strong>Guaranteed Renewable</strong></td>
<td>Provides continuation to a specified age subject to payment of premiums; Premiums can be increased by classes of insureds</td>
</tr>
<tr>
<td><strong>Conditionally Renewable</strong></td>
<td>Allows the insurer the right to not renew for any reason specified in the policy; Premiums can be increased</td>
</tr>
<tr>
<td><strong>Optionally Renewable</strong></td>
<td>Allows the insurer the right to not renew for any reason; Premiums can be increased</td>
</tr>
</tbody>
</table>

1. **Noncancelable**: Provide the insured the right to continuation of coverage by making timely payment of premiums. No changes in coverage or premiums are permitted without the insured’s consent. The noncancelable renewability provision is the same as the guaranteed renewable provision except that premiums cannot be increased.

2. **Cancelable**: Allow the insurer to cancel the policy at any time with notice, provided the insurer returns all unearned premiums.

3. **Guaranteed renewable**: Provide continuation of coverage to a specified age subject to payment of premiums, but allows premium increases by classes of insureds.

4. **Conditionally renewable**: Policies that allow the insurer the right to not renew for any reason specified in the policy and premiums can be increased.

5. **Optionally renewable**: Policies that allow the insurer the right to not renew for any reason, and premiums can be increased.

6. **Period of time for renewal**: The policy must state in the renewal provision the period of time provided to the insured to renew coverage. Depending on the policy and the state, the insurer may require the insured to renew coverage by submitting an application to the insurer or merely payment of the premium after the expiration date of the initial policy.

### SOCIAL INSURANCE

It may be helpful to think of Medicare as Medical expense insurance coverage that we pay for and is triggered by a covered accident or illness, that insureds pay for during their working years and use during their retirement years. Medicare has deductibles and coinsurance.

Medicaid, however, is not insurance. Medicaid is aid. Insureds do not pay for it and it has no deductibles or copayments. Insureds become eligible if they experience a covered accident or sickness.

**A. Medicare**
Accident and Health Insurance Topics

Medicare is federally-funded social insurance for people age 65 and older. Individuals who qualify for Social Security disability, ESRD (End Stage Renal Disease), or Lou Gehrig’s disease also qualify.

Medicare is funded by FICA payroll tax. Employers and employees each pay 1.45% taxes, and self-employed individuals must pay the entire 2.9%.

Medicare is administered by the Center for Medicaid Services (CMS). The CMS contracts with private organizations (called intermediaries) to enroll providers, process claims, and investigate fraud.

When Medicare was first introduced, it was composed of hospital and medical coverage (only Parts A and B), known as “Original Medicare.” Since then, it has expanded to offer managed care and prescription drug coverage. The four types of Medicare coverage include:

- Part A: Hospital Insurance
- Part B: Medical Insurance
- Part C: Managed Care (Medicare Advantage)
- Part D: Prescription Drug Coverage

<table>
<thead>
<tr>
<th>Medicare</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Part A</td>
<td>Hospital</td>
</tr>
<tr>
<td>Part B</td>
<td>Doctors</td>
</tr>
<tr>
<td>Part C</td>
<td>Medicare Advantage</td>
</tr>
<tr>
<td>Part D</td>
<td>Prescription Drugs</td>
</tr>
</tbody>
</table>

Individuals age 65 or older or those qualifying through disability, ESRD, or Lou Gehrig’s disease are eligible for Medicare benefits if they are a legal resident for at least five consecutive years and have paid Medicare taxes for at least 10 years.

1. Primary, secondary payor

Medicare is the primary payor if the individual is retired. Medicare is secondary if the individual is currently employed and insured under an employer health plan, or is in the first 30 months of ESRD. Medicare is also secondary to no-fault insurance, liability, black lung benefits, and Workman’s Compensation.

2. Medicare Parts A, B, C, D

Part A: Hospital Insurance

Medicare Part A provides hospital insurance, which covers inpatient care and some costs associated with skilled nursing, hospice, and home health care. Funding for Part A comes from FICA payroll taxes. Individuals may apply for Part A at age 65, or after a waiting period of 24 months for disability.

Initial enrollment is the seven-month period spanning the three months prior to and
Accident and Health Insurance Topics

after reaching age 65. General enrollment is January 1st through March 31st. Special enrollment is for individuals delayed because of coverage by an employer group health plan.

Part A provides benefits for hospitalization except physician's fees.

- Days 1–60 require a deductible before payment of all approved charges.
- Days 61–90 require daily coinsurance before payment of all approved charges.
- After day 90, the individual begins to use lifetime reserve days (total 60 days).

Daily coinsurance is required prior to payment of all approved charges. After all lifetime reserve days have been used, the individual pays all costs out-of-pocket.

Part A provides benefits for skilled nursing facilities (SNF) after a three-day hospitalization. Days 1–20, Medicare pays all approved charges. Days 21–100 require daily coinsurance before payment of all approved charges. After day 100, the individual is responsible for paying all costs.

Other Coverage

- **Blood**: An individual that needs blood while an inpatient must pay for the first three pints of blood received in a calendar year (blood deductible).
- **Home Health Care**: Home Health is provided for up to 100 days after an inpatient hospital stay.
- **Hospice Care**: Hospice is for individuals who have a terminal illness that is expected to result in death within six months. The terminal illness must be validated by a physician. Hospice care focuses on pain relief, not curing the individual. Medicare Part A covers all approved charges (except for room and board at home or in a nursing home) for hospice care including temporary inpatient hospital stays and inpatient respite care.
- **Respite Care**: Respite Care is temporary care that allows an individual’s family member or caregiver to have time off from caring for the individual.

**Part B: Medical Insurance**

Medicare Part B provides medical insurance, which covers physician’s fees, outpatient care, and preventive care. Part B is funded through monthly premium payments and federal revenue. Individuals covered by Part A are eligible for Part B. Part B requires monthly premiums based on income. Eligible individuals must enroll in Part B during the enrollment periods. Individuals pay an annual deductible and 20% of all covered charges. Medicare pays the remaining 80%. Part B also covers 100% of charges for home health visits and 80% of medical equipment.

Part B excludes coverage for private duty nurses, custodial care, home health care after 100 days, cosmetic surgery, the first three pints of blood, dental, vision, hearing, acupuncture, chiropractic care, and prescription drugs.

**Claims Terminology, Appeals and Other Key Terms**

- **Actual Charge**: A physician’s or medical provider’s actual bill for services rendered.
Accident and Health Insurance Topics

- **Advance Beneficiary Notice**: Individuals with Original Medicare may receive an advance beneficiary notice (ABN) from their medical providers. The ABN states which medical services Medicare will not or probably will not cover.
- **Appeal**: An appeal is an action that an individual can take if he disagrees with the payment of Medicare plans for medical services and prescription drugs.
- **Medicare Approved Charge**: The Medicare approved charge/amount is the dollar amount that Medicare considers to be the reasonable charge for a particular medical service.
- **Assignment**: Assignment occurs when physicians and medical providers accept the predetermined Medicare approved charge as full payment for covered services. Physicians and medical providers that do not accept assignment are permitted to charge higher rates than the Medicare approved charge; however, they cannot charge more than the limiting charge which is 15% higher than the Medicare approved charge.
- **Carriers**: Private organizations which administer Medicare Part B benefits. Each state or region has its own carrier.
- **Durable Medical Equipment**: Necessary medical equipment prescribed by a physician for use in an individual’s home, such as walkers, wheel chairs, and oxygen.
- **Excess Charge**: The difference between the actual charge and the Medicare approved charge.
- **Intermediaries**: Intermediaries, or fiscal intermediaries (FI), are private organizations contracted to administer Medicare Part A benefits, enroll medical providers and investigate fraud. Each state or region has its own intermediary.
- **Non-Participating**: Physicians, medical providers and suppliers who have the option of accepting Medicare assignment.
- **Participating Doctor or Suppliers**: Physicians, medical providers and suppliers who sign agreements to accept assignment for Medicare claims, charging the Medicare approved charge.
- **Peer Review Organizations**: Physicians and other medical professionals selected by the government to audit the quality of care received by Medicare patients.

**Part C: Managed Care**

Medicare Part C (Medicare Advantage) provides coverage of Parts A and B, as well as some prescription benefits, through private insurers approved by Medicare. The premium is combined for Parts A and B. An individual is eligible for Part C if enrolled in Parts A and B, lives in the service area, and doesn’t have ESRD. Individuals may enroll during the initial or general enrollment period.

Part C is designed to cover Parts A and B, so an individual cannot have Part C coverage and a Medicare supplement policy. Because Part C has some prescription benefits, individuals who enroll in Parts C and D will automatically be disenrolled from Part C. Individuals with ESRD cannot join Part C.

**Part D: Prescription Drug Coverage**

Medicare Part D provides prescription drug coverage and is offered through private prescription drug plans approved by Medicare. Individuals must be enrolled in Parts A and B to receive Part D benefits. Individuals must enroll during the initial or general enrollment period. Part D requires and annual deductible and coinsurance of 25% of
Accident and Health Insurance Topics

covered costs. Once the plan reaches $2,970, the individual must pay 79% of charges until meeting the out-of-pocket limit of $4,750 and Medicare pays the remainder. This is called the “doughnut hole.”

B. Medicaid

Medicaid is a dually-funded state and federal welfare program providing health care coverage for individuals with limited incomes. Medicare and Medicaid are dual-eligible programs, meaning individuals may qualify and receive benefits from both.

To qualify for Medicaid nursing home and home health care benefits, the individual must demonstrate lack of means as well as be disabled, blind, or over age 65. Medicaid public assistance is for individuals with dependent children or who are blind, disabled, or pregnant.

Medicaid provides coverage for physician and nursing services, inpatient and outpatient hospital care, labs and x-rays, home health care, screenings and treatment, family planning, prescriptions, dental, private nursing, glasses, and supplies. Medicaid requires individuals to deplete or “spend down” resources before receiving benefits.

C. Social Security benefits

Supplemental Security Income (SSI) benefits are monthly income paid by Social Security to individuals with limited incomes, are disabled or blind, or are age 65 and older. SSI is different from Social Security benefits, and pays for an individuals’ food, shelter and clothing needs.

OTHER HEALTH INSURANCE CONCEPTS

A. Total, partial, and residual disability

Individuals qualify for disability income benefits if they meet the insurer’s definition of total disability. Insurers require the person to be unable to perform the work duties of his “own occupation” or “any occupation.”

- Own Occupation disability income policies pay benefits when the insured cannot perform the work duties of his occupation. Own occupation benefits are limited to two years, and are reserved for individuals with specialized training.
- Any Occupation disability income policies are more restrictive, requiring the insured to be unable to perform the duties of any occupation in which the individual is qualified based on education, experience, or training.
- Presumptive Disability is a condition such as loss of sight, hearing, speech, or use of arms or legs, which qualifies as total disability, regardless of ability to work.

Partial Disability is the inability to perform one or more duties or the inability to work full-time. Partial disability benefits pay the portion of lost income (usually 50% of total disability benefits) for up to six months.

Residual Disability is when the insured returns to work after total disability, but is unable to perform some of his prior duties. Residual disability pays the difference in the
insured’s income before and after disability or 50% of total disability benefits.

B. Owner’s rights

The policyowner (synonymous with policyholder) is the person who has all ownership rights under the policy (such as assignment and naming beneficiaries), pays premiums and accepts the policy when delivered. Group insurance contracts are between the insurer and the policyowner. The policyowner is the employer, association, labor union, trusteeship, or any other type of eligible group. The policyowner purchases and is the sponsor of the group contract for the benefit of its employees or members. The policyowner is issued a master contract and has control and ownership of the policy. Members insured under the group policy are not issued their own policy; instead, each member receives a certificate of insurance that serves as proof of insurance coverage.

C. Dependent children benefits

Dependents are the family members to whom coverage is extended. Children must be covered from the moment of birth or adoption; however, the insurer may require notification of the birth or adoption within 31 days in order to continue coverage. Coverage of dependent children must continue until age nineteen (19), or if the dependent child is unable to be employed due to mental or physical impairments and is dependent on the policy owner for support, there is no age limit and coverage will continue.

D. Primary and contingent beneficiaries

The beneficiary is the named person or persons who receive policy benefits. Beneficiaries can be primary or contingent. Primary beneficiaries are first to receive any benefit payouts, while contingent beneficiaries are beneficiaries that receive benefits in the event the primary beneficiary is unable to do so (i.e. had predeceased the insured).

E. Modes of premium payments (annual, semiannual, etc.)

The payment of premiums provision stipulates:

- When premium payments are due,
- How they must be paid, and
- To whom they must be paid.

The premium mode is stipulated. Premium modes include:

- monthly,
- quarterly,
- semiannually or
- annually.

F. Nonduplication and coordination of benefits (e.g., primary vs. excess)
Accident and Health Insurance Topics

In the event the insured is covered by more than one policy for the same condition or benefit, the coordination of benefits provision defines the method for determining which insurance company is the primary insurer and which insurance company is the secondary insurer.

In order to protect against a disabled person receiving greater income by being disabled than they can earn by working, most group disability plans offset policy benefits with wage continuation plans, Social Security, and Workers’ Compensation.

By using the coordination of benefits provisions, all these policies coordinate together in order to prevent duplication of benefits.

G. Occupational vs. non–occupational

Disability income policies can provide either occupational or nonoccupational coverage. Occupational policies pay disability income benefits regardless of whether the disability resulted from a work–related incident or not. Nonoccupational policies only pay benefits if the disability resulted outside of work or is not work–related and the insured is eligible for Workers' Compensation benefits.

H. Tax treatment of premiums and proceeds of insurance contracts (e.g., disability income and medical expenses, etc.)

Every insurance policy has direct or indirect tax consequences. The tax effect of health insurance benefits is based on whether premiums were taxed. If the premiums are tax–deductible, the benefits are taxed as income. If the premiums are not tax–deductible, the benefits are tax–free, as long as they do not exceed the actual cost of medical expenses. The following chart provides an overview of the taxation of health insurance policies.

<table>
<thead>
<tr>
<th>Health Policy Taxation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Individual</strong></td>
</tr>
<tr>
<td><strong>Disability Income</strong></td>
</tr>
<tr>
<td><strong>Medical Expense</strong></td>
</tr>
<tr>
<td><strong>Long Term Care</strong></td>
</tr>
</tbody>
</table>
Accident and Health Insurance Topics

| Medicare Supplement | Premiums are tax-deductible only if an individual’s unreimbursed medical expenses exceed 7.5% of his adjusted gross income; Benefits are tax-free. | Premiums paid by employer are tax-deductible; Premiums paid by the employee are tax-deductible only if an employee’s unreimbursed medical expenses exceed 7.5% of his adjusted gross income; Benefits are received tax-free as long as they do not exceed the actual cost of medical expenses |

**Personally-owned Health Insurance**

The tax effect of health insurance benefits is based on whether premiums were taxed.

- Disability Income Insurance: Not tax-deductible; however, disability income benefits are tax-free.
- Medical Expense Insurance: Premiums are tax-deductible only if an individual’s unreimbursed medical expenses exceed 7.5% of his adjusted gross income; Deductions must be itemized on tax return; Benefits are received tax-free.
- Long-term Care Insurance: Premiums are tax-deductible only if an individual’s unreimbursed medical expenses exceed 7.5% of his adjusted gross income; Deductions must be itemized on tax return; Benefits are received tax-free as long as they do not exceed the actual cost of medical expenses.
- Medicare Supplement: Premiums are tax-deductible only if an individual’s unreimbursed medical expenses exceed 7.5% of his adjusted gross income; Deductions must be itemized on the individual’s tax return; Benefits are received tax-free.

**Employer Group Health Insurance**

- Disability Income: Premiums are tax-deductible as a business expense and not taxed as income of the employee.
- Medical and Dental Expense: Premiums paid by the employer are tax-deductible. Premiums paid by the employee are tax-deductible only if the employee’s unreimbursed medical expenses exceed 7.5% of his adjusted gross income; Deductions must be itemized on tax return; Benefits are received tax-free as long as they do not exceed the actual cost of medical expenses.
- Long-term Care Insurance: Premiums are tax-deductible only if an employee’s unreimbursed medical expenses exceed 7.5% of his adjusted gross income; Deductions must be itemized on tax return; Benefits are received tax-free as long as they do not exceed the actual cost of medical expenses.
- Medicare Supplement: Premiums are tax-deductible if paid by employer; If paid by employee, policies are tax-deductible only if an employee’s unreimbursed medical expenses exceed 7.5% of his adjusted gross income; Deductions must be itemized on tax return; Benefits are tax-free as long as they do not exceed the actual cost of medical expenses.
- Accidental Death and Dismemberment: Premiums paid by the employer are tax-deductible; Not taxable income to employee; Benefits are received tax-free.
Accident and Health Insurance Topics

• Medical Expense Coverage for Sole Proprietors and Partners: Tax-deductible as a business expense, not to exceed income earned that year; Premiums cannot be deducted if the individual is eligible for coverage under his or his spouse’s employer-subsidized health plan; Benefits received tax-free as long as they do not exceed the actual cost of medical expenses.

Business Insurance

• Key Person Disability Income: Premiums are not tax-deductible as a business expense; however, the disability income benefits received by the business are tax-free.
• Buy-Sell Policy: Premiums are not tax-deductible as a business expense; however, the benefits are received tax-free.
• Overhead: Premiums are tax-deductible as a business expense. Benefits are taxable.
• Disability Reducing Term Insurance: Premiums are not tax-deductible for the business. Benefits are received tax-free.

Special Savings Plans

• Health Savings Accounts: By contributing to an HSA, plan participants reduce their adjustable gross income, lowering their tax responsibilities. Contributions to an HSA are made on a pre-tax basis; interest grows tax-deferred.
• Health Reimbursement Accounts: Employer contributions are tax-deductible as a business expense and are not part of the employee’s taxable income. Benefits are received tax-free.
• Flexible Spending Accounts: Employees deduct pre-tax dollars from their income earnings and deposit them in an employer-sponsored FSA. Employees submit receipts for eligible medical expenses for reimbursement up to the annual maximum.
• Consumer-Driven Plans: Consumer-driven healthcare plans combine the use of HSAs and HRAs to pay for routine medical expenses and high-deductible coverage. Eligible HSA withdrawals and HRA reimbursements are non-taxable.

Social Security Disability

• Payroll Tax: SSDI is a social program funded by payroll taxes withheld from every individual’s paycheck. The tax is split between employers and employees.
• Benefits: Social Security Disability benefits are taxable based on the adjusted gross income of the individual.

I. Managed care

Managed care plans include Blue Cross and Blue Shield, in which subscribers can purchase HMO, PPO, and POS plans.

• Health Maintenance Organizations (HMOs) are prepaid plans focused on preventive care, requiring the insured to be referred to a specialist by the primary care physician. Facilities and physicians must be in-network providers contracted with the HMO. Physicians are paid by capitation.
• Preferred Provider Organizations (PPOs) are a group of medical facilities and
physicians that provide services at a reduced cost. Facilities and physicians are paid on a fee-for-service basis. Insureds are free to choose their service providers, but benefits for non-preferred providers are reduced.

- **Point-of-Service (POS) plans** are a mix of HMO and PPO arrangements. Members can choose in-network or out-of-network providers, but pay more for out-of-network except in emergencies. Physicians are paid by capitation.

**J. Workers Compensation**

Most employers are required to have Workers' Compensation insurance to cover accidental injury and sickness employees incur as a result of employment.

In order for an employee to be eligible for Workers' Compensation benefits, they must work for an employer that has Workers' Compensation insurance, and the employee must incur an accidental injury or sickness that occurs as a result of employment.

Workers' Compensation benefits include medical, disability income, death, and rehabilitation benefits.

Medical benefits are provided to an employee until the condition is completely treated or cured.

Disability income benefits are relatively small, but are paid after the employee undergoes a waiting period called an elimination period. If the disability extends beyond the elimination period, then disability income benefits will be paid in an amount of 66\(\frac{2}{3}\)% of weekly wages for a permanent total or temporary total disability. For partially disabled employees, the weekly benefit is equivalent to the percentage of wages lost due to inability to work.

Death benefits include a one-time burial payment and weekly income in an amount of 66\(\frac{2}{3}\)% of the deceased employee’s weekly wage for a dependent spouse and children. Each state has a maximum time and amount limit for weekly income benefits.

Rehabilitation benefits include physical and occupational therapy, medical equipment and cost of living expenses while the employee is being rehabilitated.

**K. Subrogation**

*Subrogation* is the right of the insurer to assume the rights of the insured and sue the responsible third party for damages inflicted upon the insured.

**FIELD UNDERWRITING PROCEDURES**

In this section we will cover the process involved with applying, issuing, and delivering insurance policies. The first step is completing the application. Next, the underwriting process helps determine the classification of risks and rates of the policy. And finally, we will look at the delivery of the policy.
A. Completing application

The application is one of the primary sources of information used in underwriting an insurance policy. The person who applies for coverage must complete and submit the application. In most cases, the application is attached to, and becomes part of the contract. The application is attached to the policy so that it becomes a legal part of the insurance contract. Therefore, if the insurer discovers intentional misstatements in the application, the application can be used as a legal document.

**Required 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 (in some states once a minor reaches the age of 15, the minor is eligible to contract for a life or health insurance policy). It is important for the agent to be present to witness any and all signatures. Disclosure forms and additional questionnaires that the applicant must complete must be signed by both the agent and the applicant. If automatic checking account drafts will be used for premium payment, the applicant must sign agreeing to such.

B. Explaining sources of insurability information (e.g., MIB Report, Fair Credit Reporting Act, etc.)

The Medical Information Bureau is a nonprofit trade organization which maintains
medical information about individuals. Information from the MIB is used by life and health insurers. Member insurers supply the MIB with confidential aversive information about an applicant for insurability purposes. Information collected includes underwriting information such as an individual’s hazardous activities and impairments to insurability; however, the MIB does not collect claims information or how much coverage an individual has. Insurers may access MIB information on an applicant only if needed for additional investigation. Insurers cannot refuse to issue policies solely on information supplied by the MIB.

Consumer Reports are any written, oral, or other communication of information by a consumer reporting agency about a consumer’s credit worthiness, character, general reputation, personal characteristics or mode of living which are used to determine a consumer’s eligibility for credit, insurance, employment, or other authorized purposes. The person seeking a consumer report on an individual must have a valid business need for the information.

Investigative Consumer Reports contain information on a consumer’s character, general reputation, personal characteristics, or mode of living, but are obtained through personal interviews with neighbors, friends, or associates of the consumer. Investigative consumer reports cannot be performed unless the consumer has been notified in writing of the report within three days of when the report was initially requested.

The Fair Credit Reporting Act (FCRA) was passed in 1970 with the purpose of regulating the way credit information is collected and used. The Act requires consumer reporting agencies to implement policies and procedures to preserve the confidentiality, accuracy, relevance, and appropriate utilization of consumer’s private credit information. There are two types of reports insurance underwriters will utilize to obtain credit information about an applicant:

- Consumer Reports and
- Investigative Consumer Reports.

Consumers must be informed that they have the right to request additional information about the report; such information must be provided to consumers within five days, if requested. Consumers must be informed at the time of application that a consumer report may be requested, regardless of whether a report is actually ordered or not. Consumers should also be informed that they have the right to request additional information about the report, such as the name of the company that provided them with a report.

C. Initial premium payment and receipt and consequences of the receipt (e.g., medical examination, etc.)

Producers should make every effort to collect the initial premium with the application. The producer issues the applicant a premium receipt upon collecting the initial premium.

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 certain conditions 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. There are two types of conditional receipts: insurability and approval. The difference between the two receipts is when coverage begins. With the insurability receipt, coverage begins on the application date or date of medical exam. The insurability receipt provides interim coverage as long as the applicant is insurable as applied for. If not, coverage is not effective. Unlike the insurability receipt, the approval receipt does not provide interim coverage; however, coverage begins when the application is approved by the insurer.

Binding Receipt: The binding receipt or the temporary insurance agreement provides coverage from the date of the application regardless of whether the applicant is insurable. Coverage usually lasts for 30 to 60 days, or until the insurer accepts or declines the coverage. Binding receipts are rarely used in life insurance, and are primarily used in auto and homeowners insurance.

D. Submitting application (and initial premium if collected) to company for underwriting

The agent’s report, which is used for underwriting, but does not become part of the contract, includes the following information:

- their observations of the applicant,
- information about the applicant’s financial condition,
- the applicant’s background,
- the applicant’s character, and
- a disclosure of the agent’s relationship to the applicant.

An agent should complete the agent’s report before sending the completed application to the insurer’s home office.

Once the underwriter establishes that an applicant is insurable, the underwriting process begins. The underwriter will:

- evaluate information about the applicant and
- select a risk classification and premium rate that matches the degree of risk undertaken.

After the application clears underwriting, the insurer will issue the policy for delivery, and the insurance producer will deliver the policy to the policyowner.

E. Ensuring delivery of policy and related documents to client

A policy is delivered after the insurer approves the application and issues the policy for delivery. The policy does not take effect until the initial premium has been collected, the
application approved, and the policy is issued and delivered. Some insurers require a Statement of Good Health to be signed and collected from the insured, verifying that the insured has not become ill, injured, or disabled during the policy approval process.

F. Explaining policy and its provisions, riders, exclusions, and ratings to clients

The applicant must receive a document explaining the coverage purchased, policy provisions, riders, exclusions, and the names of the insurer and agent. In health insurance, this is called the outline of coverage.

G. Replacement

Part 1 of the application includes information about existing policies if the proposed coverage is intended to replace existing coverage. If the agent discovers that the proposed coverage is replacing existing coverage, the policy is considered a replacement, meaning that the agent must comply with certain regulations regarding replacement.

H. Contract law

In this section, we will discuss general contract law including the essential elements of a contract, terms and concepts, and how they apply to the insurance contract.

Insurance policies are legal contracts. A contract is a legally binding agreement between two or more parties where a promise of benefits is exchanged for valuable consideration.

1. Elements of a contract

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

- Offer and acceptance,
- Consideration,
- Competent parties, and
- Legal purpose.

2. Insurable interest

Insurable interest states that an individual must have a valid concern for the continuation of the life or well being of the person insured. Insurable interest must be shown when an individual applies for a life or health insurance policy. When the insured becomes sick, injured or dies, insurable interest does not need to be shown.

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. Insurable interest must exist at the time of application.

3. Warranties and representations

Warranties are statements that are guaranteed to be true and are part of the legal
Accident and Health Insurance Topics

Contract. Breach of warranty is grounds for voiding an insurance contract. Representations are statements made by the insured, to the best of his knowledge.

4. Unique aspects of the health contract

The most important factors in underwriting a health insurance policy are:

- physical condition,
- moral hazards, and
- occupation.

Physical Condition: An applicant’s physical condition is the most important factor in evaluating health risks.
Moral Hazards: An applicant’s lifestyle and habits also have an effect on risk selection and classification.
Occupation: An applicant’s occupation is important for predicting the likelihood and severity of a disability.

- **Conditional**: Insurance contracts are conditional because certain conditions must be met by all parties to the contract when a loss occurs in order for the contract to be legally enforceable.

- **Unilateral**: Insurance contracts are said to be unilateral because they are one-sided. Only the insurance company makes legally enforceable promises to pay benefits in the event of a covered loss. The applicant does not make any legally enforceable promises to the insurance company, not even the payment of premiums. However, if the applicant fails to pay premiums, the insurance company has the right to cancel the contract.

- **Adhesion**: Insurance contracts are contracts of adhesion. In a contract of adhesion there is only one author – the insurance company. The applicant does not write any part of the insurance contract. Therefore, insurance companies must adhere to the insurance policy. Insurance contracts are often referred to as “take it or leave it” contracts because the insurance company writes the insurance contract, to which the insured must adhere.

**Unique Aspects of Contracts**

<table>
<thead>
<tr>
<th>Conditional</th>
<th>Certain conditions must be met by all parties to the contract when a loss occurs in order for the contract to be legally enforceable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unilateral</td>
<td>One-sided agreements; only the insurer is legally bound</td>
</tr>
<tr>
<td>Adhesion</td>
<td>Take it or leave it contract; the insured has no say in the contract terms or conditions</td>
</tr>
</tbody>
</table>