

# CHAPTER 13: HEALTH AND DISABILITY INSURANCE



**Let's Begin...**

## Health Insurance Basics

### **Managed care plans**

Managed care plans provide comprehensive health services to their members and offer financial incentives for patients to use providers under contract with the plan. That's how managed care plans keep their costs low. Instead of paying for each service that a patient receives separately, the plans pay providers in advance. That's why insurance professionals call these plans prepaid care.

HMOs have been in existence for many years. However, their popularity increased dramatically after the passage of the Health Maintenance Organization Act by the federal government in the late 1970s.



Managed care imposes controls on the use of health care services, the providers of health care services, usually through **health maintenance organizations** (HMOs) or **preferred provider organizations** (PPOs).

Managed care plans can be organized as for-profit (commercial) corporations or non-profit corporations. In most scenarios, however, a managed care plan is a for-profit corporation with responsibilities to stockholders that take precedence over responsibilities to the insured. The HMO directly and indirectly controls the amount of health care that the doctors in its network are allowed to provide to the insured.

What's worse is that, if the insured switches insurance to a managed care plan and the insured's personal physician isn't in the network, the insured probably can't continue to go to the same doctor. And, even if he or she is a member, the insured's office visits still may be restricted—particularly if the insured's doctor is a specialist.

## **Health Maintenance Organizations (HMOs)**

An HMO is an entity that contracts with medical facilities, physicians, employers and sometimes individual patients to provide medical care to a group of individuals. This care is usually paid for by a company or other group at a fixed price per patient. Patients generally do not have any significant "out-of-pocket" expenses.



The principal objectives of HMOs aim to reduce medical expenses by:

- stressing preventive medicine—physical exams and diagnostic procedures;
- reducing the number of unnecessary hospital admissions;
- reducing the average number of days per hospital visit;
- reducing duplication of benefits; and
- saving on administrative costs.

If you join an HMO, you'll pay a monthly or quarterly premium. That premium will remain the same—whatever your medical history and whether or not you use the plan's services. The plan will also charge a co-payment for certain services. For example: \$35 for an office visit or \$15 for a prescription. This is one of the ways in which the plans adjust for people who use the services more heavily than others.

By joining an HMO, you may have only a few out-of-pocket expenses for medical care—as long as you use doctors or hospitals that participate or are part of, the HMO. HMOs generally don't require you to pay deductibles or co-insurance.

HMOs deliver care directly to patients. Whether patients go to a medical facility to see a doctor or to a specific doctor's office, their business relationship is with the HMO. To many people, the health care providers appear to be interchangeable subcontractors.



This appearance isn't exactly accurate. If you belong to an HMO, you usually have to receive your medical care through the plan by selecting a primary care physician who coordinates your care. A primary care physician may be a family practice doctor, an internist, pediatrician, etc. He or she is responsible for referring you to specialists.

While most of these specialists will be participating providers in the HMO, there are circumstances in which patients enrolled in an HMO may be referred to providers outside the HMO network and still receive coverage.



"Your HMO allots only one hour to perform hip-replacement surgery. After that, our candy strippers Chip and Brenda will take over."

## **The Mechanics of HMOs**

Nearly 38 million members enrolled in a total of 550 HMOs in 1991—up from 6 million in 1976, according to the Group Health Association of America. Why would so many people join? To save money on their premiums.

HMOs were formed to control skyrocketing medical costs and provide preventative health care before members got sick. (It's a lot less expensive to pay for hypertension medication than a heart transplant, after all.)

They keep their costs down by getting hospitals, doctors and other medical personnel to join the HMO. These providers offer health care to the HMO's members in return for a pre-paid monthly charge. So, you can go to the provider as often as you need to for the same monthly premium—plus an additional small fee (or co-payment) per office visit or per prescription. Most other medical services are fully covered by an HMO, such as hospital stays.

However, in exchange for lower premiums, you give up your freedom of choice (unless of course, your doctor is part of the HMO and listed as your primary physician). Rather than being penalized by getting less of a reimbursement, as in a PPO plan, with an HMO you'd have to pay the whole bill yourself. (Clearly, this is a strong incentive to see only providers within the HMO.) Today, many HMOs have added options to their plans which allow you to see a doctor of your choice who is out of network—of course, this, too, will cost considerably more than a co-payment. HMOs usually sell their plans to businesses, which offer them to employees. But these days, with the increase in the number of independent contractors, it is becoming easier to join an HMO on your own.

Federal employee benefit law passed during the 1970s requires employers who offer health care benefits to offer enrollment in an HMO as an alternative to an indemnity plan. Employers falling under this Act are those that:

- have 25 or more employees and are within the service area of a federally qualified HMO;
- are paying at least minimum wage; and
- offer a health plan to their employees.

HMOs are sometimes owned and controlled by commercial insurance companies, however, many are independently owned. Blue Cross and Blue Shield plans—or their affiliates—own and operate several dozen of the largest HMOs in the U.S. Other organizers of HMOs include governments, hospitals, employers, unions, consumer groups and local communities.

HMOs must operate within a specified geographical area known as the service area. The service area must be approved by the State Department of Insurance and all members of the HMO must reside in the prescribed service area. The service area is usually a city or a part of a city and occasionally an entire state. In the later 1990s, service areas began to play a diminished role.

HMOs must be state qualified (able to provide services within a single state or states) or federally qualified (able to provide services in specified areas throughout the nation for national contracts like the United Auto Workers, Teamsters or government employees). If an HMO is federally qualified, it must also be state qualified in the states where it serves members obtained through a national contract.

## Three HMO Models

HMOs provide service through one or more of three “models” of operation.

The **Group Practice Model (GPM)**, also known as the Medical Group Model, is composed of a group of physicians of varying specializations practicing in one facility. It is similar to a clinic-type operation. Under the group practice model, the HMO contracts with a medical group to provide the insured with health care services.



If the medical group provides services to HMO members only, it is called a closed panel medical group. Under a closed panel HMO, physicians are usually salaried employees of the HMO and work at a clinic owned by the HMO. If the medical group provides services to HMO members in addition to other, nonmember patients, it is called an open panel medical group. Under an open panel, doctors are not salaried and treat HMO subscribers in their own offices. Generally, the insured would not need to go farther than the medical group for the health care, unless of course hospitalization is needed.

The medical group refers the insured internally, within the medical group, to physicians of differing specializations as needed (i.e. pediatrician, surgeon etc.). Special arrangements can be made if a specialist of a particular type of medicine is needed and not a part of the medical group. The insured’s HMO also contracts with hospitals in the area to provide the insured with services that are not available through the medical group or if the insured requires surgery, etc.



The **Staff Model** health care delivery system is actually owned, operated, staffed etc., by the HMO. The HMO controls the physician group and the physicians and other health care professionals are employees of the HMO. The HMO could also build a medical group facility and hire physicians to staff it and provide health care services to members.

The key element of a Staff Model is that the HMO’s own employees and facilities are being used to provide health care services to the HMO’s members.

An **Independent Practice Association Model (IPA)** is a network of individually practicing physicians who contract with the HMO to provide the insured with health care services. Unlike the Group Practice Model, an IPA’s physicians are located throughout a geographic area and are operated independently of each other.

If the insured selects an IPA, the insured would receive a list of physicians of varying specializations to choose from. Initially, the insured would choose the insured’s own primary care physician (usually a general practitioner or if for a child oftentimes a pediatrician) and visit this physician for treatment.

However, if the insured’s primary care physician cannot render treatment, then he or she will refer the insured to the appropriate specialist within the IPA network. Like the Group Practice Model, the physicians of an IPA may utilize hospitals affiliated (that is, contracted) with the HMO to render services not available at their independent practices.

Physicians who are part of an IPA treat patients on an open panel (HMO members and nonmembers) or closed panel (HMO members only) basis, depending on their contract with the HMO.

## HMO Co-Payments



Many HMOs and other managed care plans require members to make a co-payment when they get treatment. A co-payment is a specific dollar amount or percentage of the cost of a service that the insured must pay in order to receive a basic health care service.

Co-payments are rarely more than \$20—but they are due every time the insured visits a health care provider.

Example: the insured may be required to pay a \$15 co-payment for an office visit to a physician or the insured might be required to pay a 30 percent co-payment (30 percent of the cost of the services) for alcohol and drug rehabilitation.

Some HMOs don't require any co-payment for a considerable number of their services. Co-payments for alcohol and drug rehabilitation and services for mental and emotional disorders are usually expressed as a percentage of the cost of the service and are therefore more costly to the member. Co-payments for supplemental services are often considerably more than for basic services.

## Guidelines Plans Must Follow

HMOs, like traditional indemnity insurance companies, cannot engage in certain types of business practices, policies, etc. Specifically, the HMO is prohibited from excluding the insured's preexisting conditions from coverage, from unfairly discriminating against the insured based on age, sex, health status, race, color, creed, national origin or marital status.

The HMO is also prohibited from terminating the insured's coverage for reasons other than:

- nonpayment any of premiums or co-payments;
- fraud or deception;
- a violation of contract terms;
- failure to meet or continue to meet eligibility requirements; or
- a termination of the group contract under which the insured is covered.



Because an HMO provides service benefits rather than reimbursement benefits, they are required to follow guidelines prescribed by the Insurance Department to assure quality service to members.

These guidelines specify the requirements for reasonable hours of operation and after-hours emergency health care and standards to insure that sufficient personnel will be available to attend to the insured's needs. The guidelines also require adequate arrangements to provide inpatient hospital services for basic health care and a requirement that the services of specialists be provided as a basic health care service.

## Preferred Provider Organizations (PPOs) and Point of Service (POS) Plans



Preferred provider organizations and point-of-service plans are the other major types of managed care. These plans combine the features of fee-for-service plans and HMOs. These plans provide choice regarding physician, hospital, etc.; an HMO restricts choice to a network provider. PPOs and POSs generally offer more flexibility than HMOs; but their premiums tend to be somewhat higher.



With a PPO or a POS, unlike most HMOs, you will get some reimbursement if you receive a covered service from a provider who is not in the plan. Of course, choosing a provider outside the plan's network will cost you more than choosing a provider in the network. These plans will act like fee-for-service plans and charge you co-insurance when you go outside the network. What is the difference between a PPO and a POS plan? A POS plan has primary care physicians who coordinate patient care; and in most cases, PPO plans do not.

In many cases, a PPO is under contract to—or a subsidiary of—a commercial insurer. Under such a program, the overall plan benefits may include preventive health care, diagnostic services, physicians' services, inpatient and outpatient benefits, etc. These types of services and benefits are provided under the basic medical plan and/or the PPO option.



**Unlike HMOs, PPOs do not utilize primary care gatekeepers.** A single physician does not manage an individual's health care services. PPOs—a cross between regular fee-for-service plans and HMOs—are designed to provide the insured with increased benefits if the insured uses doctors and hospitals within its network.

Commercial insurers implemented PPOs as an answer to some of the negative aspects of HMOs, such as the limited choice members had of physicians. A PPO is a nice compromise if the insured doesn't want to pay for traditionally expensive fee-for-service coverage, but want more choice than an HMO offers.



Here's how a PPO works. Like an HMO, the insurance company contracts with certain physicians and provides a "preferred provider" network of doctors and specialists that the insured can choose to go to. However, unlike HMOs, the insured doesn't have to go to the doctors in the preferred provider network and the insured doesn't have to get referrals from the insured's primary care physician to see a specialist.

However, if the insured is in a PPO, the insured will be encouraged to use the preferred provider to keep costs down for both the insured and the insurance company. If the insured does, the insured will pay for services with co-payments, just like an HMO or the insured receives a higher coinsurance amount than the insured would if the insured used a doctor that is not in the preferred provider organization.

A PPO allows the insured to choose between cost savings and freedom of choice in selecting a health care professional.

Example: If Joan used a doctor in the PPO network, she might get 90 percent coinsurance, so she would only have to pay 10 percent of the cost of the medical service and she would have a low deductible (the part that she must pay first before the insurance company starts paying anything).

Generally, a deductible for PPO coverage ranges between \$200 and \$500 per year. If the insured doesn't use the PPO network often, the insured might only have 70 percent co-insurance and a higher deductible. That would mean that the insured would pay a higher deductible (somewhere between \$500 and \$1,000 per year per individual) and 30 percent of costs after that.

PPOs are considered to be closer to indemnity plans than managed care, since the insurance company pays discounted rates for medical services without becoming overly involved in health care decisions about the treatments rendered.

## **PPO Advantages**

PPOs are a better choice than fee-for-service plans if the insured doesn't make a lot of money but wants to have some flexibility in the choice of a physician. They are also good if the insured has built a relationship with a physician not in the network and wants to continue that relationship. The insured can still use preferred providers for other services and keep seeing the specialist.

PPOs are also good when the insured knows he or she will exceed the deductible amount. However, if the insured doesn't exceed the deductible, the insured will basically be getting no value out of the insurance because the deductible amount must come out of the insured's pocket before the insurance company starts paying.



## **Self-Insured Plans**

If claim costs are fairly consistent, your employer may consider a self-funded health care plan. With a self-funded plan your employer, not an insurance company, provides the funds to make claim payments for company employees and their dependents.

In the event that claims are higher than predicted, a self-funded health insurance plan can be backed-up by a stop-loss contract. The stop-loss contract is designed to limit your employer's liability for claims.



Generally, there are two variations of this coverage. Specific stop-loss coverage begins to apply after your medical expenses exceed a predetermined threshold such as \$5,000. Aggregate stop-loss coverage applies when your employer's liability for group insurance claims exceeds a specified amount. The insurance company will pay all claims once the specified amount is reached.

An employer self-funded plan may be an indemnity program which reimburses you for the medical care you have received. Or, your employer may provide benefits through the service plan offered under an HMO or through the insurance company's PPO network.

An insurance company may also be used for a self-funded employer to help out with needed administrative services.

Under this arrangement, the insurance company will provide claims forms, administer claims and make payments to health care providers; but the employer will provide the funds to make claims payments.

Self-insurance has four major **advantages**:

- The company can save money if actual losses are less than those predicted.
- The expense of carrying insurance may be reduced because of the elimination of administrative costs, agent commissions, brokerage fees and premium tax.
- Because the company has assumed the entire risk, there may be a greater effort on its part to seek ways to reduce claims and encourage employees to actively participate in "wellness" programs and improved lifestyles.
- The company has use of the money that would normally be held by the insurance company.

The main **disadvantages** of self-insurance include the following:

- Actual losses may be more than predicted, causing the unexpected loss of funds that were to be used for other purposes.
- Self-insured funds can't be used to buy death benefits.
- Expenses could be higher than expected if additional personnel have to be hired to administer claims, manage risk or offer employee information.
- Income taxes could be higher because the company will not be able to take premiums paid as a deduction; only the claims paid and operating expenses may be taken as a tax deduction.

As a rule, partners and sole proprietors are considered self-employed individuals, not employees, so the rules for personally-owned health insurance apply. Government allows anyone who is self-



employed to deduct a portion of their health insurance premiums. The deduction was 30 percent for tax years 1994 through 1996. Under new tax laws this deduction will be gradually increased to 80 percent by the year 2002.

If the partnership pays the premiums for medical care insurance on the partners without regard to partnership income, premiums are deductible by the partnership but are included in the partners' taxable income.

Self-insured plans are typically offered by financially strong companies who are able to deposit adequate sums of money to cover employee's medical expenses. Generally employers who install self-insured plans will use the administrative services of an insurer or a third-party administrator (TPA).

### **Third-Party Administrators**



A third-party administrator is a firm which provides administrative services for your employer or other associations having group insurance policies. The third-party administrator acts as a liaison between the insurance company and your employer in matters such as certifying eligibility, preparing reports required by the state and processing claims.



The use of third-party administrators became common in the 1990s, as a result of larger employers self-funding health benefits.



### **Small Employers**

Small employers (usually defined as those with fewer than 20-25 employees) have been especially hard hit by increases in health care insurance premiums. Because many group plans are experience rated, small employers see an immediate premium increase whenever claims are particularly high. If the average age of the participants is particularly high or if claims experience is high or if there has been even one long or catastrophic illness in a small employer plan, it can have a devastating effect, making health insurance unaffordable for the whole group.

Recent surveys by the Health Insurance Association of America (HIAA) indicate a substantial decline in the number of small firms that are able to offer health coverage to their employees. Several states have acted to ensure that health insurance coverages are available at a reasonable cost and under reasonable conditions for small employers. Among the new requirements:

- standard benefit plans that must be offered to small employers;
- maximum waiting periods for pre-existing conditions;
- the insurance company may not exclude particular individuals or medical conditions from coverage;
- insurance companies may only cancel small employer plans for nonpayment of premium, fraud, misrepresentation or noncompliance with plan provisions.

## Group Underwriting

Most people have at least a small amount of disability income insurance through benefits offered by their employers. These group disability income policies (like group life policies) are underwritten on very liberal terms.

Group underwriting usually is accomplished without any reference to an individual's medical information. Most insurance companies will require that a minimum number of employees participate in a group plan for that plan to be issued without evidence of insurability; **contributory** plans require 75% participation, while **non-contributory** plans require 100% participation. Generally, the employee is required to provide his or her address, social security number and certain work-related information.



In these situations, the underwriter and insurance company will concentrate on such group factors as occupational duties, industry type and the amounts of disability income being offered. Due to the nature or risk of an occupation, the insurance company may limit or refuse to write group disability income coverage for certain occupational groups—such as coal miners, the lumber industry, the entertainment industry, etc.

Group disability coverage usually will be limited to not more than 70% of earned income and subject to a low maximum benefit—such as \$1,000 or \$2,000 per month for a year. Because there is **no medical underwriting** involved with group cases, the underwriter's primary job is to protect against overinsurance or large amounts of coverage and adverse selection against the insurer.

**Adverse selection** occurs when an insurance policy encourages people with the highest risk profiles to use the coverage—and those with lower risk profiles to find more cost-effective insurance.

To avoid adverse selection, the underwriter may limit the amount of coverage offered, decline to write the group at all or offer the coverage on a non-occupational basis. Non-occupational coverage will not offer benefits for work-related disabilities.

## Association Underwriting

Although not group insurance, strictly speaking, association coverage has some of the same underwriting characteristics of group coverage. Association coverage might be described as individual policies administered as group insurance. If the association is to offer a guaranteed-issue plan, then there will be no medical underwriting, as all members are guaranteed the issuance of a policy.

However, most association plans require some medical underwriting or what is sometimes referred to as simplified or progressive underwriting. Association underwriting may take the form

of three or four medical questions asked of the individual. Due to the size of the association membership, relatively minor medical problems may be overlooked and policies issued. Nevertheless, even with simplified underwriting, it is possible for a member to be declined for the insurance.

In addition, the underwriting procedure is simplified by the fact that there are limits as to the amount of coverage that may be issued, as well as the length of the elimination and benefit periods. There is also no need to occupationally classify association members, as they all have essentially the same occupation, which is normally low risk.

Premiums for association types of coverage normally are banded by ages and amounts. For example, everyone between the ages of 25 and 30 pays the same premium for a 30-day elimination period and a \$1,000 monthly benefit payable to age 65. From age 31 to 35, a new band of premiums would be used.

Another underwriting consideration with regard to association coverage pertains to the place where the association member conducts his or her business. For example, an association composed of artists may be difficult to write disability coverage for because many of these artists will work out of their homes. Normally, individuals who work out of their homes cannot qualify for disability income coverage because it is difficult to determine if, in fact, they do become disabled. Their work place is also their recovery place and thus a conflict arises. Often, the underwriter simply may decline to offer this type of association any coverage at all.

## COBRA

If the insured has health insurance through the insured's employer and the insured leaves the job—whether he or she was fired or quit—the odds are that the insured will want to keep health coverage for a time.



Under the **Consolidated Omnibus Budget Reconciliation Act or COBRA**, which is part of a federal law enacted in 1986, the insured has the right to keep the insured's coverage at group rates if the insured loses the insured's group health insurance because of a reduction in the insured's hours of employment or because the insured leaves or loses his or her job—unless, of course, the insured is fired for gross misconduct. The insured also has the right to continue coverage for his or her spouse and any dependents. COBRA only applies, however, to employers with 20 or more employees, at least half of the time during the preceding year.



How long the insured can keep the coverage depends on the insured's particular qualifying event—that is, dying, being fired, quitting. Different coverage periods follow each of these events. If the insured were fired (for anything other than gross misconduct, in which case the insured don't qualify at all), the insured, the insured's spouse and dependent children are entitled to 18 months of continuous coverage. Any other qualifying event entitles you to up to 36 months of coverage, if you decide to pay for it.

If the insured's COBRA coverage is about to expire—assuming the insured haven't taken another job in the interim that provides group health insurance—the insured can apply to the insurance company for conversion from COBRA to an individual policy. The insured must do so within 31 days of termination of COBRA.

The company is not obligated to provide the insured with an individual policy, however, if they only sell group insurance.

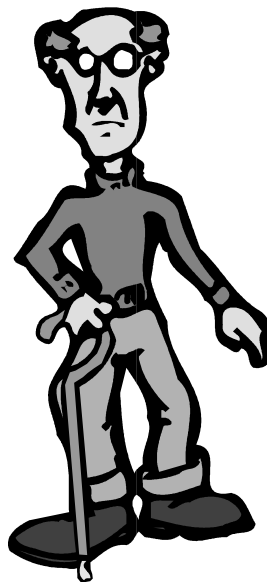
The insured's former employer will not keep paying for health insurance, either. The insured will have to start picking up the tab. The company can charge the insured 102 percent of what the coverage under the group plan actually costs (the extra 2 percent is an allowance to cover administrative costs).

Rest assured that, even with the two points, this amount is almost always less than what the insured would pay if the insured purchased individual coverage—and it is often substantially less.

By law, the insured's employer is required to let the insured know about COBRA and what steps the insured must take to retain health insurance coverage. The employer must also break down the costs for various coverages the insured may have, so the insured can choose to continue all or only some of them—for instance, the insured may decide to keep HMO coverage but give up the vision and dental plan.



**The Omnibus Budget Reconciliation Act of 1990 (OBRA 1990)** enhanced other protections for Medicare supplement consumers. Under this law, Medicare supplement insurance may not be denied on the basis of the senior citizen's health status, claims experience or medical condition during the first six months a Medicare beneficiary age 65 or older first enrolls in Part B of Medicare. This is known as the open enrollment requirement.












## Key Health Insurance Terms

Before moving on to detailed discussions of specific health coverages—we will review some of the key terms and definitions.

- **Accidental**—In a health insurance policy, accidental means unexpected cause of bodily injury. A related term—accidental means—the mishap itself must be accidental...not just the resulting injury. An example: You are chopping wood when the ax slips from your hand and cuts your foot; this is accidental means. However, if your finger gets in the way of the ax, it may not count as accidental means.
- **Accidental Death and Dismemberment**—AD&D coverage is a policy or a provision of a policy that pays either a specific amount or a multiple of a weekly disability benefit. The full coverage takes effect if the policyholder loses his or her sight—or two limbs—in an accident. (A lower amount is payable if the person loses one eye or one limb.)
- **Acute Care**—Acute Care means skilled, medically necessary care provided by medical and nursing professionals in order to restore the person to health or the ability to function. For example, acute care would be rendered to persons recovering from major surgery. **NOTE: Acute Care is NOT covered by Long Term Care.**
- **Cancelable**- This type of policy does not have a provision for renewal and allows early termination. If the insured wants coverage to continue, a new policy must be written and premiums may adjust in accordance to the insured's age.
- **Capitation**—Capitation (CAP) is the fixed amount of money paid on a monthly basis to an HMO medical group or to an individual health provider for the full medical care of an individual.
- **Closed panel**—This is a system in which insured people must select one primary care physician who will refer patients to other health care providers within the plan. This is also called a closed access or gatekeeper system.
- **Co-Insurance**—Co-Insurance is the percentage of your medical bills that you are expected to pay. Co-Insurance payments usually constitute a fixed percentage of the total cost of a medical service covered by the plan. If a health plan pays 80% of a physician's bill, the remaining 20% which the member pays is referred to as co-insurance.
- **Co-Payment**—A co-payment is the fee paid by a plan member for medical services. A co-payment would be the out-of-pocket expenses you are expected to pay, such as \$25 for an office visit or \$15 for a prescription.
- **Covered Expenses**—Health care expenses incurred by an insured person that qualify for reimbursement under the terms of a policy are, simply, covered expenses. This is an easy concept to describe in the abstract—but it can become quite complicated in a dispute.
- **Deductible**—The sum of money that an individual must pay out of pocket for medical expenses before a health plan reimburses a percentage of additional covered medical expenses is called the deductible. Deductibles for family coverage are often \$200 to \$500 per year.
  - Flat Deductible: A stated dollar amount that the insured must pay before policy benefits become payable (This is also know as "First Dollar Deductible.")
  - Corridor Deductible: Typically found in Comprehensive Major Medical policies and is the amount the insured must pay after payments under the "basic medical expenses" policy end and before the benefits under the "major medical policy" begin.
  - Integrated Deductible: Used with Supplementary Major Medical policies, but is "integrated" into the amount of benefits provided by the basic plan. Another way of looking at this is to consider the amount of expenses incurred that the

insured must share with the company under the basic plan, before the supplementary major medical benefits begin.

-  **Elimination Period**—Elimination Period (EP) means the period of time, usually expressed in days or months, at the beginning of a confinement in a long-term care facility, during which no benefits are payable. The EP could be defined as a “time deductible.”
-  **Extension of Benefits**- Termination of a LTC policy must be without prejudice for prior institutionalization, which began while the policy was in force and continues after termination. The extension of benefits may be limited by the contract’s specific benefit periods, maximum benefits, waiting periods and any other applicable policy provisions.
-  **Guaranteed Renewable**- Also allows the insured to renew the policy, and states that as long as premiums are paid the insurer must continue the coverage until a certain age, such as 60 or 65. However, premiums can be increased, but only for an entire class of insureds, not just one individual. Terms and benefits, however, cannot be changed.
- **Gatekeeper Physician**—The primary care physician who directs the medical care of HMO members is the gatekeeper physician. The primary care physician determines if patients should be referred for specialty care.
-  **Grace Period**- The period after the premium is due, though unpaid, while the coverage remains in force. The extra period is dependent on the premium mode being used. For weekly premium modes the grace period is 7 days, for monthly policies it is 10 days, and for all other modes (quarterly, semi-annually, or annually) it is 30 or 31 days. If the premium is paid during this period, full coverage remains in effect (i.e. accident and sickness), and there is no evidence of insurability required.
-  **Hospice Care**—Hospice Care refers to nursing services provided to the terminally ill. It’s offered in a hospice, a nursing home or in the patient’s home—where nurses and social workers can visit on a regular basis. The purpose of the care is to keep the patient comfortable and to enable the patient to die with dignity.
-  **Indemnity Contracts**—Indemnity Contracts are policies which provide a daily benefit, such as \$50, \$60 and \$70 per day, for each day of confinement in a hospital or long-term care facility. This method of payment can be contrasted with an expense incurred contract which reimburses for actual expenses incurred while confined.
- **Limited Health Insurance**—These special health insurance policies provided limited coverage for specific injuries or illnesses—such as travel accidents, particular diseases and hospital income.
- **Long-Term Care**—Long-Term Care (LTC) is care which is provided for persons with chronic disease or disabilities. The term includes a wide range of health and social services which may involve adult day care, custodial care, home health care, hospice care, intermediate care, respite care and skilled nursing care. LTC does not include hospital care.
- **Managed Care**—Managed care refers to a broad and constantly changing array of health plans which attempt to control the cost and quality of care by coordinating medical and other health-related services. The vast majority of Americans with private health insurance are currently enrolled in managed care plans.
-  **Morbidity**- The concept of “losses per thousand” of a given group in predicting occurrences and calculating costs in premiums.
-  **Morbidity Table**- Refers to the frequency of illnesses, sicknesses, or disabilities occurring in a given group of people over a defined period.
-  **Non-Cancelable**- This classification of policies is the most restrictive in terms of renewability. The insurer cannot cancel a non-cancelable or “noncan” policy, benefits cannot be changed, and the premiums cannot be increased under any circumstances.

The rates are specified in the policy, but the insurer can use a graduated premium schedule. The term of most “noncan” policies is to age 65. This is most commonly found in disability income policies, rather than medical expense policies.

- **Nursing Home Care**—Nursing Home Care includes nursing and custodial care provided in a nursing home setting.
- **Preventive Care**—An approach to health care which emphasizes preventive measures such as routine physical exams, diagnostic tests (e.g. PAP tests), immunization, etc.
- **Primary Care Physician**—These physicians provide basic health services to their patients. General practitioners, pediatricians, family practice physicians and internists are recognized by health plans as primary care physicians. HMOs require that members be assigned to a primary care physician who functions as a gatekeeper.
- **Probationary Period**- The probationary period in a group health policy is a waiting period required before the employee or member is eligible to join the group. It applies to all of those who join the group after the policy effective date.
- **Respite Care**—Normally associated with hospice care, respite care is for the family of the patient. The patient may be admitted to a nursing home or hospice for care. This care constitutes a respite—or break—for family members taking primary care of the patient.
- **Skilled Nursing Care**—Skilled Nursing Care is daily nursing and rehabilitative care that is performed only by or under the supervision of, skilled professional or technical personnel. The care is based on a physician’s orders and performed directly by or under the supervision of a registered nurse. This care would include administering prescription drugs, medical diagnosis, minor surgery, etc.
- **Skilled Nursing Facility**—A Skilled Nursing Facility is a facility, licensed by the state, which provides 24-hour-a-day nursing services under the supervision of a physician or registered nurse.
- **Stop-Loss Provision**- The maximum amount of a claim that an insured would be required to share with the insurer.
- **Waiting Period**- The period of time that the insured will have to wait immediately after an injury or illness occurs before benefits commence or begin.
- **Waiver of Premium**- If an insured is confined to a nursing home and is receiving benefits for at least 90 days, the premiums on the policy will be waived for as long as benefits are paid.

## Medical Expense Insurance



### **Medical Expense Insurance**



The most common form of health insurance is Medical Expense insurance, designed to insure you against sickness and accidental bodily injury.

All medical expense policies are almost always subject to either a deductible or a co-insurance payment. Generally, you have to pay a certain small amount (the co-payment) each time you see a doctor or have a prescription filled and the insurer pays the rest of the money directly to the provider—if you have assigned the benefits to the provider. If you haven't "assigned" the benefits, you will have to pay the provider directly and the insurance company will reimburse you later.

If you choose a reimbursement insurance plan, you will have to pay for any medical services up front, then fill out a claim form and send it to the insurance company. The company will reimburse you for a percentage of your expenses (often 80 percent)—but only after you have satisfied the deductible.

The Medical Expense plan can give you complete freedom of choice when it comes to doctors, pharmacies and hospitals. Or it can attempt to limit you to a preferred provider organization (PPO). In this case, it would provide a list of "preferred" doctors and hospitals. If you go to a doctor or hospital that is not on the list, the insurance company will penalize you by reimbursing a smaller percentage of your medical expenses. If you see a preferred provider, you will get the full reimbursement percentage.

If your regular doctor and your neighborhood hospital are on a list of preferred providers, it often is beneficial to go with a PPO program—instead of a full freedom of choice plan—because you'd be paying less to go where you planned to go already.



## Coverage Provisions and Underwriting

There are some notable differences between individual and group policies in how coverage is handled and in the underwriting procedure.

Deductible, Co-Payment, Reimbursement Insured employees with dependent coverage must meet the deductible before expenses will be covered. But, plans typically include some type of family deductible in order to limit a family's exposure for health care expenses.



A family deductible is usually some multiple of the individual deductible, often two or three. For a family deductible to be satisfied, the combined expenses of covered family members are accumulated. Some plans require that at least one family member satisfy the individual deductible before the family deductible can be met.



Co-insurance is a feature typically found in group health plans. It sets the percentage of covered expenses that the employees and the health plan will pay. The most common coinsurance level is one in which the employee pays 20% of the expenses and the insurance company pays 80%.

A covered expense is an eligible expense under a group health insurance plan. It is an expense that will be reimbursed in whole or in part. An example: Most health plans, consider doctors' visits a covered expense. That is, any doctor's fee the insured incur up to the amount provided by the insured's plan.

However, just because an expense is covered does not mean that the coverage is unlimited. Both basic and comprehensive plans have limits on the amount of expenses for which they will reimburse. In addition, the insured usually have to pay some form of deductible and coinsurance before they will reimburse the expenses.

Insurance companies limit covered expenses in a number of ways. Example: The insured's insurance company can cap allowable payments for a certain procedure or service (i.e., a surgical schedule). Some insurers also restrict covered expenses by limiting the number of visits or days for home health care or skilled nursing care or by establishing a reasonable and customary charge.

## Types of Medical Expense Plans

There are two types of **Medical Expense plans** (Basic and Major Medical) and two types of **Major Medical Expense plans** (comprehensive and excess). The Basic Medical Expense policy offers primary protection for sickness and accidental injury while Major Medical Expense offers catastrophic coverage. Of the Major Medical Expense policies, one offers comprehensive protection so that basic coverage and extended health care benefits are integrated. The other is a supplement and provides excess coverage over the basic hospital/physician/surgical expenses. It basically "wraps-around" the primary policy and provides additional expenses.



## **Basic Medical Expense Policies**

Basic Medical Expense policies cover one of three expenses and include: hospital, physician and surgical expenses. You can purchase only one or a combination of expense coverages. The hospital expense coverage includes room and board, including intensive care, operating room fees, lab fees and other necessary services and supplies. Rooms are limited to semi-private and, telephone and television charges are not covered.

Surgical expense coverage includes any doctor's fees related to surgery and coverage for various types of procedures based on the company's surgical schedule (the maximum amount payable for particular operations). While physicians expense is for any treatment by a physician not related to surgery.

Basic Medical Expense policies are usually written with deductibles ranging from \$100 to \$500 per calendar year. Once the deductible is met, the insurer pays the remaining costs in full, up to the policy limits. In contrast, Major Medical Expense insurance is aimed at catastrophic medical expenses.

Introduced nationally in 1951 by insurance companies, today virtually every health insurance company offers this policy. It's intended to cover serious illnesses and accidents that end up costing you thousands and thousands of dollars. As a result, they come with very high deductibles but also, very high limits. Sometimes up to \$1million, which can mean a lot if you need a bone marrow transplant or cancer treatments over an extended period of time. They generally also have a co-insurance clause, meaning you must pay a portion of the covered expenses, usually 20 percent and then the insurance company pays the remaining 80.

## **Major Medical Expense Policies**

The most common variation on indemnity health coverage is the major medical policy. This coverage focuses on hospitalization costs, rather than health care costs in general. And it uses deductibles and absolute dollar limits differently than traditional indemnity insurance.

Major medical can be sold on an individual and group basis. It provides benefits up to a high limit for most types of medical expenses incurred, subject to a large deductible. The contract may contain limits on specific types of charges, like room and board and a co-insurance clause.

These policies usually pay covered expenses whether an individual is in or out of the hospital. Another name for this type of contract is a catastrophe policy.

In other words, the major medical approach to hospitalization coverage is designed to provide the insured with protection against catastrophic expenses that are a genuine risk in today's world.

The insured needs to think of major medical as an approach because there are a lot of expenses that the plans don't cover. And the insured is going to have to fund those expenses somehow—either with out-of-pocket payments or some kind of supplemental insurance. We'll consider the options in this chapter.

Major medical plans can be thought of as consisting of a bag of money, containing \$1 million, \$2 million, \$5 million or an unlimited amount. The money is to be used to pay for covered medical



expenses, either as an inpatient or as an outpatient. The only limitation is how much money is in the bag.

Unlike a traditional indemnity policy with benefit amount limitations, major medical insurance is designed to provide a large sum of money from which to pay covered medical expenses.

**Major medical plans** are characterized by the following:



- deductibles,
- coinsurance,
- stop-loss provisions

We will consider each of these items in some detail.

## **Deductibles**

The deductible associated with a major medical policy has essentially the same function as it does for any other kind of insurance—whether health or car or homeowners. For example, the insured is responsible for the first \$100 of medical expenses related to a hospital visit; then the insurance company pays the excess covered medical expenses.

Most major medical plans will offer a variety of deductibles from \$100 to \$1,000...or even higher. Some high-risk policyholders—usually people with histories of health problems—pay as much as \$5,000 or \$10,000 deductibles. This is truly catastrophic coverage.

The deductible may be expressed as a calendar year deductible or as a per cause deductible. A calendar year deductible means that the insured satisfies the deductible once in a calendar year.

A per cause deductible is similar to the deductible found in the auto policy. Each time the insured dings a fender, the insured is responsible for a deductible. A per cause deductible basically states that each medical claim the insured incurs will have a deductible requirement. Thus, if the insured had three claims, three deductibles would need to be satisfied before the insurance company would begin to pay benefits.

Example: If Bill has three separate medical claims in a given year and his Allstate policy contains a \$250 per cause deductible, then he must satisfy three separate deductibles before Allstate will pay his claim. If his policy with Allstate contains a calendar year deductible, he only has to pay one deductible to cover the entire year.

Another version of the calendar year deductible is the family deductible. Most plans will specify an individual deductible such as \$250 and a family deductible equal to two or three times the individual deductible.



So, if the plan had an individual deductible of \$250 and a family deductible of \$750, after the family incurred expenses totaling \$750, there would be no further deductibles for the balance of that calendar year.

Most of the major medical plans contain a deductible carryover provision. If the insured hasn't incurred any claims or received any benefits from the plan, expenses incurred in the last three months of a calendar year may be applied toward the New Year's calendar deductible.

In this case, if Bill has no claims in most of 2002 but does incur \$100 of covered medical expenses in November 2002, he can apply that \$100 toward the annual deductible for 2003. Deductibles do have a large affect on the cost of major medical plans. A plan with a \$100 deductible will cost considerably more than a plan with a \$1,000 deductible. So, if the insured wants to save premium dollars, select a plan with a higher deductible—it will reduce the cost of the premium.



### **Co-Insurance Provisions**

Once the deductible is satisfied, the major medical insurance company will then pay for covered medical expenses, on a co-insurance basis.



**Co-insurance requirements** are typically expressed as 80 percent to 20 percent, 70 percent to 30 percent, 60 percent to 40 percent, etc. So if the insured has a plan with an 80 percent to 20 percent co-insurance requirement, the insurance company will pay 80 percent of the covered expenses following the deductible and the insured is responsible for the additional 20 percent of the expenses.

Just as **deductibles** affect the cost of a plan, so too will co-insurance. An 80/20 percent co-insurance provision will carry a higher premium than a 70/30 percent or 60/40 percent co-insurance feature. If the insured needs to keep the insured's premium low, buy a policy with a high deductible and a low coinsurance provision such as 60/40 percent.

This is another mechanism that insurance companies can use to limit the impact of insureds who have histories of health problems. If the insured has had heart bypass surgery and beaten a mild case of skin cancer, the insured may have to settle for a major medical policy includes a high deductible—say, \$5,000—and a heavy co-insurance split—say 60/40 percent.



### **Stop-Loss Provisions**

The co-insurance requirement continues until the insured reaches the policy's stop-loss point. The stop-loss is the point at which the insurance company begins to pay 100% of a claim. Without a stop-loss, the insured would be responsible for 20 percent of an indefinite amount such as \$100,000 or even \$1 million.

The **stop-loss amount** will vary. It could be reached at \$2,500, \$5,000 or \$10,000 of covered expenses. For example, a plan with a \$250 deductible and an 80/20 % co-insurance split on the next \$2,500 of covered expenses would result in a total out-of-pocket expense to the insured of \$750—the \$250 deductible plus 20 % of \$2,500. The stop-loss provision establishes the maximum out-of-pocket expense to the insured to be equal to the deductible plus the insured's co-insurance amount.

The out-of-pocket maximum is a major consideration when the insured is shopping for a policy. Regardless of the size of a potential claim, the most that the insured will have to pay out of the insured's own pocket is the deductible and the co-insurance amount up to the stop-loss.

The stop-loss point is also a contributing factor in the policy's premium. **The higher the stop-loss—the lower the premium.** A stop-loss at \$2,500 will cost more than a stop-loss at \$10,000. Thus, if the insured wants to keep the premium as low as possible, the formula becomes:

High deductible + low co-insurance + high stop-loss = lowest possible premium

The following encapsulates the major medical concepts we've considered so far.

Deductible	Must be satisfied before any benefits are paid.
Co-insurance	The insured pays a small part of the claims.
Stop Loss	The insurer pays 100% when stop loss is reached.



**"Mrs. Stalnaker?! Neal Haggerty, Unity National Health Insurance. Put down the cheesecake now, or we'll double your premium!"**

## **Comprehensive Medical Expense Policies**

As we've already seen, major medical coverage is considered hospitalization insurance. It doesn't cover all medical expenses—the way that traditional indemnity coverage does. What does the insured do about these other expenses? Paying for them out-of-pocket is the simplest option. But the insured needs to be cash-rich to do this. So, most people will look for some kind of insurance to add on to their major medical.

In some cases, the answer may be to buy a comprehensive medical expense plan. This kind of insurance adds coverage for basic—and not necessarily hospital-related—medical expenses to the major medical coverage.

The comprehensive plan consists of a block of first dollar (also known as "basic") benefits followed by a deductible and a typical major medical plan. This plan might specify that 100 percent of the first \$5,000 or \$10,000 of reasonable and customary expenses will be covered. Once this bundle of basic benefits is exhausted, the insured must satisfy a deductible, usually referred to as a corridor deductible and then the major medical benefits are activated.



All of the provisions common to a basic hospitalization plan as well as the provisions and concepts related to major medical plans, i.e., deductibles, coinsurance, stop loss, etc., are found in this type of plan.

A regular major medical plan will do essentially the same job as the higher-priced comprehensive plan, unless the claim is relatively small (\$10,000 or less). The first dollar benefits will cover the relatively small claim without any deductible or coinsurance.

In small claim situations, the extra premium for the comprehensive plan has to be weighed against the likelihood of a small claim of a few thousand dollars. By today's health care costs, it is difficult to spend a few days in a hospital, have surgery and not incur expenses exceeding \$10,000.

Comprehensive plans vary, but generally cover the same kinds of services. Some of these include:

- professional services of doctors of medicine and osteopathy and other recognized medical practitioners;
- hospital charges for semiprivate room and board and other necessary services and supplies;
- surgical charges;
- services of registered nurses and, in some cases, licensed practical nurses;
- home health care;
- physical therapy;
- anesthetics and their administration;
- x-rays and other diagnostic laboratory procedures;
- x-ray or radium treatment;
- oxygen and other gases and their administration;
- blood transfusions, including the cost of blood when charged;
- medicine requiring a prescription;
- specified ambulance services;
- rental of durable mechanical equipment required for therapeutic use;
- artificial limbs and other prosthetic appliances, except replacement of such appliances;

- casts, splints, braces and crutches;
- rental of a wheelchair or hospital bed.

## Other Options

If insurance companies consider you uninsurable—because of your age or a pre-existing condition—you probably are qualified for a state-sponsored health insurance program. These programs should be used as a last resort, because they typically offer only limited benefits, are expensive and usually include a waiting period before the benefits kick in and you are covered. But at least they're there, if you need them. You can find out about these plans by calling your state insurance department.

If price is the problem when it comes to securing insurance, you may qualify for Medicaid. It provides medical assistance to low-income families and individuals of all ages. (Your county's Social Services Department can fill you in on the eligibility requirements.)

If you are an employer who can't afford to offer your workers coverage through normal channels, you also may be able to get help from your state.

For instance, in California, companies with three to 50 full-time employees are eligible for the **Health Insurance Plan of California (HIPC)**, a state-sponsored pool. It guarantees coverage to your workers in any one of 20 different health plans offered through insurance companies or HMOs at more favorable rates.

Most small employers also cannot be refused coverage because of the medical history of one or more of their employees. This is known as a guaranteed issue. (Some individual plans also are available on a guaranteed-issue basis, although they will have higher premiums.)

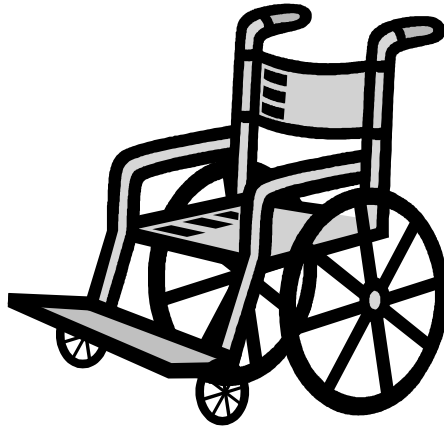


### Methods Used to Contain Medical Insurance Cost

In order to control escalating costs associated with health care, many insurers are implementing methods to reduce and minimize cost while giving insureds options for medical care and treatment. These methods are being widely recognized and approved as methods to control medical claims expenses. The primary purpose of these provisions is to assist policyholders in the utilization of their policies by maintaining cost effectiveness. Listed below are the most commonly used methods.

1. Second surgical opinion: Used to reduce unnecessary surgical operations.
2. Utilization Review: Used by insurers and employers to evaluate the appropriateness, necessity, and quality of health care being provided to an individual.
3. Pre-certification Provision/Authorization: Both the patient and the physician will know how much of a claim will be paid prior to the treatment being delivered. This allows the insurer to review the appropriateness of the procedure and the estimated length of the hospital stay.
4. Concurrent Review: The insurer monitors the progress of the insured's hospital stay to make sure everything is going as planned.
5. Ambulatory Outpatient Care: The procedures and the diagnostic testing and treatment being performed are on an "outpatient" basis, which eliminates the cost involved in an "inpatient" hospital stay.

## Disability Income Insurance



### Disability Income Insurance



People will insure their home, their cars, their things, but they'll often forget to insure the asset that pays for all of these—their ability to earn money.



The average American is **more than twice as likely to become disabled than to die during his or her working life.**

If your client has a family, he probably has life insurance to protect them in case he dies. But what if he doesn't die? What if he suffers a stroke and can no longer work? What if he's diagnosed with a debilitating illness?

If he had died, his life insurance would pay off. His family would also probably get Social Security survivor's benefits and they might be able to sell any assets he had.

But if he lives and can no longer earn a living, what will happen? Will he be able to pay his bills? Will his family suffer? He may live for many years totally disabled—and, therefore, unable to generate an income to pay for the higher medical and living expenses caused by the disability.



In the United States, **the most common cause of mortgage foreclosures is the disability of the borrower.**



## Types of Disability



### Total Disability

The definition of disability used in the contract determines whether a person is actually eligible for benefits. Most contracts will only pay for total disability. There are three definitions used in contracts for total disability.



1. The inability to work at ANY SUBSTANTIAL GAINFUL OCCUPATION. Example: Someone is NOT eligible to receive disability benefits if he/she can earn a paycheck from ANY job that exists in the economy. (This is social security's definition)



2. The inability to perform the duties of ANY OCCUPATION FOR WHICH THE INSURED IS REASONABLY SUITED BY EDUCATION, TRAINING, OR EXPERIENCE. Example: If a person can be placed in another position in a related occupation or field, then he/she may NOT qualify for benefits; this is also known as the "any occupation" definition, and is more restrictive for the insured.



3. The inability to engage in his/her OWN OCCUPATION. Example: If someone is unable to work at the job, occupation, or position held at the time of the disability occurred, he/she will qualify for disability income. This definition provides the most coverage.



### Partial Disability

The definition of partial disability is the inability of the insured to perform one or more of the regular and important duties of his/her occupation. It results in a loss of a PERCENTAGE of normal working hours. Example: A disabled employee who is working part time and receiving lost income benefits under his/her long term disability benefits.



### Temporary Disability

A person is disabled on a "temporary" basis when he/she is unable to work at all while recovering from an illness or injury; FULL RECOVERY IS EXPECTED.



### Permanent Disability

A person is disabled on a "permanent" basis when he/she has been injured or sick and is NOT EXPECTED TO HAVE A FULL RECOVERY.

To sum up the types of disability, there are four levels-of-severity of a disability. These are listed from most severe to least severe.

1. Permanent Total
2. Permanent Partial
3. Temporary Total
4. Temporary Partial

## The Odds of Becoming Disabled

If your clients are like most people, they think disability won't happen to them. But it could. In fact, a person is more likely to become disabled than to die at almost any age.

The following chart shows that **the risk of becoming disabled during peak earning years** is substantial—especially for people age 50 and younger. And as you get older, the duration of the average disability increases—as do the chances that you will never totally recover.

By the time you're 50, if you've got a disability that has lasted more than 90 days, odds are it will take you more than six years to recover. For most people, who work for a living, this kind of downtime is catastrophic.

### The Probability of Disability Compared to Death at Specific Ages

Age	Number per 1,000 disabled	Number per 1,000 dying	Probability of disability compared to death
32	6.87	1.74	4 to 1
37	7.75	2.27	3.5 to 1
42	9.46	3.39	2.8 to 1
47	12.00	5.00	2.4 to 1
52	15.78	7.36	2 to 1

Source: Commissioner's Individual Disability Table and Commissioner's Standard Ordinary Mortality Table

Do you really need to worry about protecting your income? Consider how much you could earn between now and age 65, if you are the age listed in the left most column below:

### Potential Earnings to Age 65

Starting at This Age and...	...At these Monthly Incomes, Earning Potential Will Be.....			
	\$2,000	\$4,000	\$6,000	\$8,000
25	\$960,000	\$1,920,000	\$2,880,000	\$3,840,000
30	840,000	1,680,000	2,520,000	3,360,000
35	720,000	1,440,000	2,160,000	2,880,000
40	600,000	1,200,000	1,800,000	2,400,000
45	480,000	960,000	1,440,000	1,920,000
50	360,000	720,000	1,080,000	1,440,000

Your ability to earn an income could generate more than \$1 million in an average lifetime. And the chart above doesn't include things like pay raises or cost of living increases.

As you get older, the duration of the average disability increases—as do the chances that you will never totally recover. By the time you're 50, if you've got a disability that has lasted more than 90 days, odds are it will take you more than six years to recover. For most people, who work for a living, this kind of downtime is catastrophic.

If you don't have disability income insurance, you have to rely on other resources to help offset the effects of a disability. What sorts of other resources?

- Cash Savings
- Investments
- Business Assets
- Government Programs
- Borrowing

How long will your savings last? And how liquid are your investments or business assets? If you have an art collection or a car collection, it might take months or years to find the right buyer at the right price—and the same goes for a business. What are you going to live on in the meantime?

And who is going to loan you enough money to cover your costs during an extended disability? Certainly not a bank, since you have no way of repaying the loan if you aren't earning a living. (On the other hand, if you can rely on a rich relative who loves you dearly, you may not need disability income insurance.)

What about programs through work? If you're an employee, there may be some work-related benefits available from a group disability plan, a salary continuation plan, employee stock plan, workers' compensation, etc.

But group disability benefits are of short duration—a year or less—and cover only a percentage of lost income. These fixed and capped benefit plans also tend to discriminate against higher-paid employees.

For example, a group plan might provide benefits equal to 60 percent of your pay, up to a maximum benefit of \$2,000 per month (\$24,000 annually). This may prove to be an adequate benefit if you earn \$40,000 or less per year. But for people earning more, the disability benefit is still limited to \$24,000 per year. If you earn \$60,000 annually, then your disability benefit would cover only 40 percent of your ordinary pay.

An important point about group benefits or work-related plans is that you merely "rent" this coverage. Benefits are available on the condition that you continue to be an employee. If you terminate employment, your disability benefits also are terminated. If a disability strikes between jobs, no work-related benefits are provided.

## Workers' Comp and Social Security



Workers' compensation provides another source of disability income benefits—but only if your accident or sickness is job-related. Falling out of bed in the morning and breaking your arm does not constitute a workers' comp claim. Slipping on a wet floor at the job site and breaking your arm also is a workers' comp claim.

The intent of the workers' comp system is to make the employer liable for occupational disabilities without you having to prove that the company was at fault. Your employer either will cover such claims out of company funds or elect (as almost all do) to cover this risk by means of workers' comp insurance.

The laws—and the benefits provided—vary somewhat from state to state. But benefits are usually low—about \$300 a week at most.



You also might think you can count on Social Security disability income benefits. But it's not easy to get Social Security benefits—and they're pretty puny when they do come. To be eligible for disability benefits under Social Security, you have to be both "fully insured" and "disability insured."

Fully insured status means that you have paid Social Security taxes for 40 calendar quarters (10 years). Disability insured means that you have paid Social Security taxes in at least 20 out of 40 calendar quarters (5 out of 10 years) prior to filing a disability claim.

In addition, you must be under age 65, the disability must be expected to last for at least 12 months or end in death and the disability must satisfy the definition of total disability in accordance with the Social Security law.



Total disability is defined as the inability to engage in any substantial gainful activity by reason of a medically determined physical or mental disability relative to a person's education and prior work experience.

This means that you must be unable to perform your previous job—or any other substantial work that exists in the national economy relative to your age, education and prior work experience.

In addition, there is a five-month waiting period before any benefits can be paid. In reality, due to the waiting period and the time it takes to process an initial claim, you probably won't receive your first Social Security claim check until about a year after the onset of the disability—if you're one of the very few who qualifies to collect benefits in the first place.

## **What About Other Coverage?**

If you weren't injured on the job, some states (including California, Hawaii, New Jersey, New York and Rhode Island) provide state benefits for non-occupational disabilities. The amount of the benefits will vary. Generally, the state plan will provide 50 percent to 60 percent of your wages for a limited period of time—such as six to 12 months.

Yet another form of coverage that could kick in is Accidental Death and Dismemberment (AD&D) coverage, which frequently is provided as part of an individual or group life insurance contract. AD&D coverage pays a "principal sum" (basically, the policy's face amount) for accidental death in accordance with the policy's provisions and definition of accidental death. This same amount is paid if you lose use of both arms or both legs or if you lose vision in two eyes due to an accident. This amount usually is identified as the capital sum if the policy is paying an accidental dismemberment benefit.

What if your back gives out? Then what?

You could qualify for coverage under your long-term care (LTC) insurance—if you have it. It will pay for the care of persons with chronic diseases or disabilities and may include a wide range of health and social services provided under the supervision of medical professionals.

You also might have another insurance policy that would help out in the event of a disability. For instance, accident-only insurance provides coverage for injury from an accident—but it excludes coverage for sickness. Benefits may be paid for all or any of the following: death, disability, dismemberment or hospital and medical expenses. This is not a kind of insurance that most people need. But some, who travel often, will either buy it themselves or get it as a work-related benefit.

What about credit insurance? This policy is issued only if you are in debt to a creditor. The coverage is limited to the total amount of your indebtedness—but some insurance companies even balk at paying that. If you're given the choice of purchasing credit insurance, for the most part, you're better off spending the premium money on disability income insurance.

It is clear that most people cannot rely on any of the other kinds of insurance that they may have—or their savings or collections—to help them through a prolonged disability. Fortunately, there is a form of insurance designed to do just that. It's aptly called disability income insurance.

Disability income insurance (also referred to as loss-of-time insurance) pays you a weekly or monthly benefit for disabilities due to an accident or sickness. The primary purpose of this coverage is to replace the loss of personal income due to a disability.

Disability income policies are issued on an individual basis—or on a group basis, through an employer-sponsored plan, labor union or association. Benefits paid are in accordance with the policy's provisions and, to a degree, your loss of income.

## Figuring Out How Much You Need

Disability income insurance can enable you to pay a mortgage and other necessary expenses when a total disability due to an accident or sickness cuts off your income. But exactly how much of this insurance do you need?

To figure this out, you will need to gather some information. This includes: what you make and what you have to protect.

Usually, it's best to use a worksheet when conducting a needs analysis. (Our standard worksheet appears below.) This helps you consider problems, needs and objectives consistently. It also helps you avoid the main problem that plagues needs analysis: overlooking something.

What you make is fairly simple to calculate. It's the amount of earned income you expect to have during a specific period of time. In most cases, insurance companies calculate this number by asking what you make in salary and other earned income. A good insurance company will ask for some kind of proof of income—like an IRS W-2 form or other tax document.

**Don't fudge these numbers.** If you do, the insurance company will not have to pay you anything in the event of a claim. You'd be amazed how many people blatantly lie on their applications and then haul their insurance companies into court when they won't pay. Just in case this doesn't sound so bad, it's worth noting that the insurance company wins when you lie. And you wind up with lawyers' bills on top of everything else.

To determine your disability income insurance needs, you also need to calculate how much you need to protect. Among the most common of these issues are educational objectives for dependent children, other family needs, business objectives and retirement goals.

In greater detail, these are the factors that will impact your disability needs most directly:

- **Fixed Obligations.** Such expenses as mortgage or rent, car payments, utilities, food, installment purchases, insurance premiums, etc., must be itemized.
- **Variable Expenses.** These are the unexpected, non-fixed expenses that occur from month-to-month, such as car repairs, medical expenses, prescriptions, home repairs, etc. Try to estimate these unexpected monthly expenses to the best of your ability.
- **Added Expenses.** In addition, there are added expenses due to a person's disability—additional medication, doctors' bills, prosthetic appliances (such as braces), the rental of a hospital bed or a wheelchair, hospital bills that are not fully covered by hospitalization insurance, etc.



## Charting Your Needs

Most insurance companies use fairly standard worksheets to determine a monthly expense estimate that relates to disability coverage needs.

The worksheet below will help you add up your expenses, such as mortgage or rent, utilities, food, auto or transportation expenses, tuition or education expenses, clothing, outstanding consumer loans or installment purchases, insurance premiums, medical or dental care costs, taxes and miscellaneous expenses.

Then it will help you look at your other sources of funds in the event of a disability and consider your potential needs, should you become disabled. If the final income figure is negative, check your numbers—with an eye toward making sure that your expenses are all covered and that the non-earned income is absolutely reliable. If your final number is still negative, you don't need to worry about disability insurance—you should be thinking about retiring.

For most people, the final income figure will be positive—and probably disturbingly large. And remember, this is only a monthly number.

In order to estimate the likely total loss from a disability, refer to the disability duration chart below.

### The Average Duration of a Disability that Lasts for More Than 90 Days

Age at Onset	Duration in Years
30	4.7
35	5.1
40	5.5
45	5.8
50	6.2
55	6.6

Source: Journal of the American Society of Certified Life Underwriters

## Analyzing Coverage

Once your needs analysis is completed, you're ready to start comparing disability income policies. Once again, this process usually works better if you use a formal method of review. Let's start by explaining the variables that affect disability income insurance. The following are the items you can change to raise or lower your premium—and to suit your needs.



- The length of the **elimination period** (EP). This is the waiting period between when you make an income insurance claim and when the coverage begins. EPs work much like

deductibles in auto or homeowners insurance—the larger they are, the cheaper the coverage. If you have a substantial amount of savings that you are willing to spend to support yourself and your family in the event of a disability—or if you have a short-term disability plan through work—you can afford to select a longer elimination period.



- The length of the **benefit period** (BP). This is the amount of time that the income insurance will pay benefits. It may pay for a year, two years, five years or even for the rest of your life. The longer the benefit period, the bigger the risk the insurance company takes—so the higher your premium will be.
- **The amount of the monthly benefit.** This may be the most important factor of all. The bigger the benefit, the more costly the policy.
- The inclusion of **optional benefits.** These usually are based on your individual needs and financial goals—the subjective factors that are difficult to quantify.
- Finally, there is one other consideration that profoundly affects your rates and the amount of coverage an insurance company will provide: your **occupational classification.** We'll cover this in more detail later in this section.

## Choosing an Elimination Period



Most of these variables can be adjusted to provide for an increase or decrease in the premium and should be considered if the price of the policy is a critical factor. For instance, the elimination period is similar to a deductible—but it's a time deductible, instead of a dollar deductible. The longer the EP, the smaller the premium. The shorter the EP, the higher the premium. Thus, a plan with a 30-day EP will have a considerably higher premium than a plan with a 90- or 180-day EP.

An illustration of this trade-off can be seen in the following chart:

**The Premium and the Elimination Period:**  
Male, Age 45, \$1,000 Monthly Benefit Payable to Age 65

Elimination Period in Days	Annual Premium (\$)
30	690
60	550
90	495

Usually, a plan with a 60-day EP will cost approximately 20 percent less than a plan with a 30-day EP. Most insurance companies will offer elimination periods ranging from 30 days to as long as two years. Even though a savings in premium can be realized with the longer EP, it may not be in your best interest.

For example, if you choose a 90-day elimination period, you will not begin to accrue a benefit until the 91st day of a disability. However, the insurance company won't issue a claim check until the end of the month. Therefore, you'll wait roughly 120 days—four months—from the onset of the disability until you receive any benefit.

When determining which elimination period to elect, you must answer the question, "How long can I go without any income from my disability income plan?" The answer to this question will



depend on the size of your monthly income insurance need and the amount of cash savings or the size of the liquid assets you have in reserve.

Every situation is different, but you probably will end up choosing among 30-, 60- or 90-day elimination periods. A policy with no EP is usually very expensive. A policy with more than a 90-day EP usually doesn't begin paying benefits soon enough.

It's usually a mistake to assume someone who has a higher income can live with a longer EP. If you make more money, you often have bigger expenses—which puts you roughly in the same place as someone making less money. A corporate executive earning \$250,000 may not have any more liquidity than a worker earning \$25,000 per year.

The best way to be sure you can live with a longer EP is to make sure you have short-term disability insurance to cover you during the wait. This short-term coverage is what's provided by most work-related plans.

## Selecting a Benefit Period



Once you've figured out what kind of elimination period you can tolerate, you need to choose the length of time that benefits will be paid. The most common benefit periods are one, two or five years and to age 65. In some cases, a lifetime accident and/or sickness option may be included in the policy, which extends the benefit period for your lifetime.

Like the elimination period, the benefit period is a reflection of the premium you pay. The longer the benefit period, the higher the cost of the policy. Short benefit periods result in lower premiums, especially when they are coupled with long elimination periods.

The following chart illustrates this concept.

### The Premium and the Benefit Period

Male, Age 45, \$1,000 Monthly Benefit Payable to Age 65

Benefit Period	Annual Premium (\$)
1 year	255
2 years	330
5 years	510
To age 65	690
Lifetime	830

If you determine that a 30-day elimination period is adequate, then it would be reasonable to consider a two- or five-year benefit period. On the other hand, when evaluating the risk of a permanent disability the potential loss of income during a to-age-65 benefit period is controlling. Although insurance experts normally discuss disability income benefits in terms of monthly amounts, they look at the bigger picture when determining the benefit period. The potential loss of income due to a permanent and total disability can literally be in the millions of dollars.

For example, a 40-year-old earning \$50,000 per year who becomes totally disabled stands to lose more than \$1.2 million before age 65 if the disability becomes permanent.

And, as we've seen, the older you are at the onset of a disability, the more likely it is that you will not recover fully. This possibility suggests that you should get the longest benefit period possible. However, a longer benefit period leads to a larger premium.

Following an analysis of all of the facts and your needs, the deciding factor may well be the cost of the policy. In this case, ask yourself: Should you use your resources to pay for a shorter elimination period or use the premiums to cover a longer benefit period?

## Selecting the Benefit Amount

The next factor to consider is the amount of the monthly benefit. While it would be nice to make more money if you were disabled than if you were working, this is not an option. The insurance company does not want to encourage you to stay home.



The insurance company uses what are known as issue and participation limits to determine the maximum amount of monthly benefits that may be issued. (Any state laws on the subject also would come into play.) Typically, this limit will be a predetermined percentage—such as 70 percent or 75 percent of your earned income (before taxes).

Another factor that determines the amount of the benefit is the existence of any other disability income coverage in force. On the application for insurance, you must indicate the name of the insurance company and particulars regarding the additional coverage. Any other coverage will cause the amount requested to be limited.

For example, assume that Company A will issue disability coverage up to 70 percent of a person's gross earned income. In addition, it will participate with other insurance companies' coverage up to this 70 percent maximum.

Diane, a pharmacist, earns \$3,000 per month. She may purchase disability income up to 70 percent of her earned income—or \$2,100 per month. However, she indicates on her application that she has other coverage with Company X in the amount of \$1,000 per month. The maximum coverage that Company A will issue is an additional \$1,100 per month. Company A is participating with Company X and total benefits are limited to Company A's issue and participation limits of 70 percent of earned income.

A third factor that can limit a policy's benefit amount is your non-earned income. Typically, if a person has non-earned income amounting to \$15,000 or more each year, the insurer will want to reduce the benefit amount.

A high net worth also can reduce your need for disability insurance—and the insurance company's desire to provide it for you. If you're a multi-millionaire, you're basically self-insured and probably don't need disability income insurance. Your personal and/or business assets should provide plenty of protection. The insurance company is aware of this: It may decline coverage for a person with a high net worth—or offer some small token benefit.

In short, when an insurance company's issue and participation limits are 70 percent of gross earned income, this amount probably will be very close to your net income—or take-home pay after taxes. In this way, the loss is made relatively whole again. If you were to get more than the

equivalent of your take-home pay, the insurance offers you a disincentive to return to work and encourages you to commit fraud.

## Optional Policy Benefits

When you're considering an income insurance package, the final ingredient is the inclusion of any optional policy benefits. And disability income policies provide a smorgasbord of options. The ones that appeal to most people include:

**Future Increase Option.** This is important if you're under 40 years of age. It protects future insurability by providing the guaranteed right to purchase additional amounts of disability income insurance in future years. (The assumption is that you will get raises over time.) Normally, the rider is not available past age 40, although some insurers may offer it up to age 50.

This option also may be referred to as the Guaranteed Insurability Option or Guaranteed Purchase Option, since it enables you to purchase additional disability income protection—regardless of your insurability—at specified future dates.

This benefit comes with several limitations:

1. The premium charged for the future coverage will be based on the insured's age at the time of purchase—not the insured's age when the policy was originally issued.
2. The insured will be able to purchase only a specified, predetermined amount of additional disability coverage at each option date (many insurance companies limit the amount of additional coverage available to half the original amount.)
3. The insured's earned income must warrant additional coverage.

There are a specific number of option dates on which the insured may purchase additional coverage. Usually, these option dates will be every two or three years from ages 25 to 40—or, sometimes, to age 50. These dates may be arbitrarily selected by the insured's insurance company or they may coincide with the insured's birthday, marriage or births of children.

For example, George, age 24, earns \$3,000 per month and currently has a disability income policy that provides a monthly benefit of \$2,000. His company's issue and participation limits are 70 percent of monthly earnings. His policy contains a future increase option, which allows George to purchase an additional benefit of \$300 per month on his 25th, 28th, 31st, 34th, 37th and 40th birthdays—plus upon marriage and the birth of children.

George doesn't see any increase in his salary by the time he turns 25, so he's unable to exercise the \$300 option amount (\$2,300 in benefits would exceed 70 percent of his monthly salary). However, when he turns 28, George is making \$3,500 a month. He can exercise the \$300 increase (\$2,300 is less than 70 percent of his monthly salary). A year later, George gets another raise and gets married. With his salary at \$4,000 a month, he can exercise his option again—and increase the monthly benefit to \$2,600.



**Cost of Living Rider.** To protect the purchasing power of disability income benefits, many applicants add the Cost of Living Rider to their base policy. This simply states that, as a predetermined cost of living standard increases, the benefits provided by the policy will increase by a corresponding amount.

The purchasing power of fixed disability benefits may be eroded due to inflation and increases in the cost of living. To protect against these trends, most insurance companies will offer an optional cost of living benefit.

Under this option, your monthly disability benefit automatically will be increased as needed, once you are on claim. Typically, this increase will occur after the insured is on claim for 12 months—and each 12-month period thereafter—as long as the insured remains on claim. Once he or she off claim, the total disability benefit reverts back to the original amount. Many insurance companies will permit a person to buy back the additional monthly benefit when coming off claim. This means your available disability benefit will be increased to include the cost of living adjustments—and the premium charged will be increased to reflect the bigger benefit.

For example, Lucy has a disability income policy with a \$1,000 monthly benefit and a cost of living benefit. She's totally disabled for five years and gets a 5% cost of living increase each year. During her time on claim, she gets a \$200 per month increase in her disability benefit. Eventually, she recovers from her disability and can return to work. When she does, she can pay a slightly higher disability premium and keep the extra \$200 a month in force.

If you buy back a cost of living increase, the additional premium will be based on your age at the time of the buy back.

**Lifetime Benefits Option.** Although it is a relatively expensive option, Lifetime Accident and Sickness has particular appeal to a person who is likely to experience dramatic increases in earnings over the years.

This option extends your benefit period from age 65 to your lifetime. This extension may apply to accident only benefits or to accident and sickness benefits.

Normally, it means that if the total disability is due to an accident and it occurs prior to age 65, benefits will be paid for the rest of your life, provided the insured remains totally disabled.

Most companies will place some time limitations for the lifetime sickness benefit. That is, the disabling sickness must begin prior to a specified age, such as 50 or 55. A policy providing lifetime sickness benefits might state, if total disability, due to sickness, begins at age 55 or earlier, total disability benefits will be paid for the lifetime of the insured. If total disability begins at age:

- 56—total benefits are paid to age 65, then 90% of the benefit will be paid for the lifetime of the insured;
- 57—total benefits are paid to age 65; then 80% of the benefit for the lifetime of the insured;
- 58—total benefits are paid to age 65; then 70% of the benefit for the lifetime of the insured; and so on.

The progression of benefits would continue in this manner until age 65. If the total disability began at age 65 (typically, the policy is not renewed past age 65), then the payment of total disability benefits would be limited to one or two years.

Example: A young physician in the first year or two of practice may not be earning a substantial amount of income, but most certainly will over his or her professional career. A career ending in disability would have a drastic effect on such a person by substantially reducing potential lifetime earnings. Extending the benefit period for life will help reduce the effect of such a loss.

The additional premium charged for most of the optional benefits described here is relatively low. Depending on the option, the additional cost would range from \$30 to \$100 annually.

## Rehabilitation Benefits

Rehabilitation benefits is an optional coverage that can be purchased with a disability income policy and an optional benefit that can be claimed under most workers' comp systems. As a result of a disability, you may not be able to return to the work you were doing before, but you may be able to work another job. However, moving to a new job or career may necessitate some vocational training.

If you elect to participate in vocational rehabilitation, total disability benefits will continue as long as you are actively participating in the training program and remain totally disabled. Some insurers may provide a lump sum payment for vocational training. Whether a lump sum or a monthly payment, this benefit enables you to take positive steps toward returning to work. Thus, this option benefits both you and the insurance company.



## Social Security and Other Riders



The Social Security Administration defines total disability as the inability to perform any substantial gainful work. In addition, the disability must be expected to last at least 12 months or end in death. Clearly, this is a very conservative definition of total disability.

As a result, the Social Security Administration denies about two-thirds of the disability claims filed each year. For that reason, many people buy special disability coverage that will take effect whenever Social Security won't.

This coverage may be called a Social Security Rider or simply an Additional Monthly Benefit (AMB) Rider. Regardless of the name, the purpose is the same—to provide additional disability income benefits during the first year of a claim, while you are waiting for Social Security to begin. These riders also are used to complement other disability income sources, such as short-term group disability benefits provided through an employer.

There are two different methods by which a rider may provide benefits:

- All or Nothing Rider. Under this concept, you will be paid a benefit if Social Security pays nothing. Conversely, if Social Security provides any benefit, then the rider pays nothing.
- Offset Rider. The benefit provided by the rider will be reduced or offset, by the amount of any benefit provided by Social Security.

The **Additional Monthly Benefit** rider also can be used to complement group disability coverage.

For example, Jack has a short-term group disability benefit through work. This provides him with a benefit of \$1,000 per month for a period of one year, after which no benefit is provided. Jack needs and can qualify for a disability income benefit of \$1,500 per month, payable to age 65. To coordinate his individual plan with the group plan, Jack should purchase a \$1,500 total disability benefit payable to age 65 with a one-year EP. This will take over when his group coverage stops. He also should buy a \$500 Additional Monthly Benefit Rider with a 30-day EP and a benefit period of one year. This will supplement his group policy.

**Hospital Confinement Rider.** Ordinarily, you have to wait until the elimination period has been satisfied to begin collecting any disability benefits. However, the hospital confinement rider will begin paying the regular total disability benefit during the elimination period, if you are hospitalized. However, the benefits will be paid only as long as you are in the hospital.

Example: Sean has a disability income policy with a 30-day elimination period and a \$1,000 monthly benefit for total disability, payable to age 65. He also has the hospital confinement option. He is hospitalized for minor surgery for a period of two days. Following the hospitalization, he returns to work within three days. Sean can claim total disability benefits for the period of two days. The amount paid will be  $2/30$  of \$1,000—or \$67.

**Non-Disabling Injury Rider.** This option does not pay a disability benefit. Rather, it provides for the payment of medical expenses incurred due to an injury that does not result in total disability. In short, it's a form of health insurance.

Example: Arthur has a disability income policy that includes the non-disabling injury benefit. He's injured in a recreational baseball game at a picnic. He is taken to the hospital for X-rays and treatment for a badly sprained ankle. He incurs medical expenses totaling \$550, but returns to work the next day. He doesn't receive any disability income benefits, but he would be reimbursed \$550 for his non-disabling injury.

This is a kind of coverage that makes most sense for people who have trouble qualifying for traditional health insurance. It is a kind of loophole for insuring medical costs.



**Waiver of Premium.** This rider specifies that, in the event of a disability, premiums will be waived retroactively to the date of the disability. The waiver usually requires permanent and total disability, though some policies allow broader claims.

A caveat: Many people assume that all forms of insurance include this kind of waiver. Unless they include it specifically, almost none do.

**Accidental Death and Dismemberment Rider.** Like stand-alone accidental death and dismemberment insurance, AD&D riders include a death benefit, which is payable in the event of death resulting from accidental bodily injury. A companion coverage is provided for loss of limbs or sight, often called dismemberment coverage.

When you buy this additional coverage, your insurance company will attach a schedule that lists various dismemberments and losses of sight for which specified sums will be paid. The sums payable usually are expressed as percentages of the death benefit limit or sometimes as percentages of a limit in the policy known as the principal or capital sum.

The intent of the dismemberment feature is to provide you with a lump sum that will help you through any period of rehabilitation or pay for training for work other than what you used to do. In some cases, however, you might be disabled for a while and—during the disability—suffer one of the losses listed in the schedule. In this situation, you would be paid disability income up to the time of the loss of limb or sight only, then you would receive the lump sum.

Most company policies provide that, even if you are not disabled after an accident, if a loss of limb or sight occurs within 90 days of the date of the accident, the sums in the schedule will be paid.

Accidental death and dismemberment coverage provides both a life insurance and a health insurance benefit. However, the life insurance benefit applies only to accidental death and is not paid for death by natural causes.



**Presumptive Disability.** This benefit usually is considered optional and provides for total disability benefits to be paid if an injury or sickness causes you the total and irrecoverable loss of:

- speech;
- hearing in both ears;
- sight in both eyes; or
- use of any bodily limb or extremity (hand, arm, leg, foot, etc.).

So, if you have a stroke and—as a result—lose the ability to speak, you have suffered a presumptive disability and would be entitled to total disability benefits for the duration of the benefit period.

Usually, the requirement that you be under the care of a physician is waived due to the nature of presumptive disabilities.

The claims process typically is simplified with presumptive disabilities. Normally, when you have a disability claim, you and an attending physician must complete a claims form periodically—every month or once a quarter—for the duration of the claim.

For a presumptive disability claim, there is a single claims form to be completed at the onset of the claim. Due to the severity of the disability, no further claims forms usually are needed.