

CHAPTER 17

HEALTH INSURANCE APPLICATION, UNDERWRITING AND PREMIUMS

Insurers are concerned with morbidity in the health insurance industry. **Morbidity** is the frequency of illness, sickness, and disease. The **morbidity table** shows the number of individuals exposed to the risk of illness, sickness, and disease at each age and the actual number of individuals who incur an illness, sickness, and disease at each age. With a life insurance policy, an insurer is faced only with one potential claim per policy. However, an insurer can face numerous claims per insured on a health insurance policy. Underwriting generally is more restrictive for an individual policy than for a group policy as the chance of adverse selection is greater in an individual contract. The underwriter's function is to determine which applicants are acceptable and classify the acceptable risk in order to establish the appropriate premium.

THE APPLICATION

The application is of major importance in the underwriting process. It is the insured's request for the insurer to issue a policy. Statements made in the application are a basis for the company to issue the policy. An insurer will not issue a policy unless the application is signed by the applicant. By signing the application, the applicant is attesting the information to be correct. It should be remembered that all statements made on an application are considered to be representations. If there is an error on the application, any change made to the application must be initialed by the applicant. If the applicant makes a material misrepresentation on the application or conceals material information, it would be grounds for the insurer to rescind the contract. Applications are attached to the policy and become part of the policy.

No alteration of any written application for a policy shall be made by any person other than the applicant without his/her written consent, except that insertions may be made by the insurer for administrative purposes only and made in such manner to clearly indicate that the insertions are not to be ascribed to the applicant. The making of any other alteration without the consent of the applicant is a misdemeanor. (CIC 10382)

Section I of the application deals with personal information regarding the applicant. This includes items such as name, address, date of birth, employer's name and address, work duties, and other insurance coverages. If the policy is to cover other family members, a few questions will be asked including name, date of birth, relationship, height and weight. Section II of the application deals with medical information regarding the applicant and other family members to be covered. This information covers past medical history, current physical condition, hobbies, and moral habits (use of alcohol and drugs). There may be other questionnaires required due to hazardous hobbies and occupations. The applicant will need to sign forms authorizing the insurer to collect pertinent information from an attending

physician, credit bureaus, the MIB, investigative agencies, etc. If the applicant and the insured are different individuals, an insurable interest must exist. An insurable interest exists if the applicant would suffer a loss if the insured became ill and incurred medical expenses or if the insured were unable to work as a result of a disability. If a conditional receipt is given the applicant for a premium payment, the receipt should be signed by the agent.

Agents are important in the underwriting process as they are considered to be **field underwriters**. Agents should solicit applications that represent good business from which the insurer can profit. The agent is required to submit all applications that he/she takes. The agent represents the insurer and, therefore, must protect the interest of the insurer while serving the best interest of the applicant/client. At times agents feel in conflict with underwriting. Agents wish to sell policies in order to make commissions. Underwriting wants to insure good risks and, consequently, not all applicants will be found acceptable.

Underwriting will check to make sure that insurable interest exists if the applicant and the proposed insured are two different people. Insurable interest must exist at the time of application, but it is not required at the time of the insured's death. Third-party contracts—those in which the owner and insured are different people—will be questioned by underwriting. The applicant will bear the burden of proof to show that insurable interest exists.

Preselection activities are those that take place before an application is submitted and involve the agent's role of selecting acceptable risks. All applicants must be treated equally and fairly. Discrimination on the basis of race, age, religion, gender, or sexual preference is not allowed. Postselection underwriting activities are those that occur after an application has been submitted to underwriting for evaluation and rating.

There are a number of sources of underwriting information that underwriters can use in developing a risk profile of the applicant. The number of sources underwriting checks can vary, but usually the larger the face amount of the policy for which the insured has applied, the more comprehensive the underwriting research. Any questions raised by statements on the application that might affect insurability could trigger the use of more sources of information.

ATTENDING PHYSICIAN'S STATEMENT

The underwriter may wish to request additional information from the applicant's physician. This is to obtain more specific details regarding a medical problem including test results, treatment of injury or illness, hospitalization, and any treatment recommended but not yet received.

MEDICAL INFORMATION BUREAU (MIB)

The Medical Information Bureau is a non-profit organization supported by member insurance companies. It has approximately 700 member companies that represent most of the life and health companies transacting insurance in the U.S.A. The member companies have agreed to report information to this bureau if an applicant for insurance has been found uninsurable or has been special rated. The purpose of the MIB is to protect the member insurance companies against fraud on the part of applicants. The insurer who receives a report from the MIB will compare this information with information provided by the applicant in the application. If the information in the report and application are not consistent, the insurer will seek further information. The MIB does not have information on the majority of applicants for life and health insurance as the only reason it would have information is if someone applied for insurance and was found to have a condition significant to health or longevity. Some of the conditions that can be reported include height and weight, blood pressure, EKG readings and x-rays. Some non-medical information that can be contained in the report includes hazardous hobbies and a bad driving record. Member companies do not report information as to claims made on life, health, and disability insurance.

Applicants must be informed in writing that the insurer may report health information to the MIB. Information is shared only with other member companies. Applicants will have to sign an authorization form allowing for this sharing of information. An individual can request a report from the MIB to see if there is any such information. A one-page request form will need to be completed. Medical information will be disclosed only to the applicant's physician who is in a better position to evaluate the medical facts. The applicant has a right to request incorrect information be corrected. Insurance companies are not supposed to deny coverage based solely on information obtained from an MIB report. Obviously it could be a substantiating factor in finding a risk unacceptable.

An individual may contact the MIB at the following address:

Medical Information Bureau
P.O. Box 105, Essex Station
Boston, MA 02112
(617) 426-3660
www.mib.com

THE FAIR CREDIT REPORTING ACT OF 1970

The Fair Credit Act of 1970 applies to financial institutions, including insurance companies, that request inspection and credit reports. Some of the more salient points of this act include:

- The right to be notified in writing that a report has been requested. The applicant must be notified that he/she can request disclosure of the scope and nature of the investigation.
- The right to receive the names of all people contacted by the credit bureau.
- The right to be told the name and address of the credit reporting agency if insurance/credit was denied on the basis of the information in the report.
- The right of the applicant to receive from the consumer reporting agency, not the insurer, disclosure of the information in the report. The Fair Credit Act does not require that the reporting agency give the consumer the actual file, but must disclose the nature and substance of the report.
- The right to dispute incorrect information in the file. The credit agency must reinvestigate the disputed matter. If the disputed information is not accurate or cannot be verified, it must be deleted. If the problem is not settled after reinvestigation, the consumer may file a statement of no more than 100 words regarding the matter.

It is a good idea to check credit reports for inaccuracies yearly. Under the Fair and Accurate Credit Transactions Act, everyone is entitled to a free credit report annually from each of the three main credit bureaus. The free credit report does not come with a person's credit score. The fee to receive the credit score is approximately \$6 apiece from each credit bureau. Following are the addresses and phone numbers of these three bureaus.

Equifax
P.O. Box 105873
Atlanta, GA 30348
1-800-685-1111 or www.equifax.com

Experian
P.O. Box 2104
Allen, TX 75013-2104
1-888-397-3742 or www.experian.com

Trans Union
P.O. Box 390
Springfield, PA 19064-0390
1-800-888-4213 or www.transunion.com

RISK FACTORS

Many risk factors are considered when issuing a policy but some of the most important are physical condition, moral hazards, and occupation.

Physical Condition

Physical condition is of great consequence and refers to the applicant's current state of health and past medical history. Obviously, an applicant who enjoys good health and who has had no health problems in the past is a good risk to insure.

If an applicant has been treated for chronic conditions, this could result in higher than average claims experience for the insurer. Some of these conditions are high blood pressure, heart problems, ulcers, back problems, and hernias. Extreme obesity also is of great importance in determining risk.

Moral Hazard

An applicant's habits and lifestyle are of consequence when determining insurability. Heavy drinking and the use of drugs present a moral hazard. A poor credit rating also represents a moral hazard. When issuing a disability income policy, underwriters need to be wary of potential malingerers as such persons will pretend to be disabled in order to collect insurance benefits.

Occupation

Occupation is of significant importance in underwriting. The hazards presented in a job affect the possibility for accident and injury. Occupations are classified based on frequency and severity of injuries and length of disabilities.

A heavy equipment operator or roofer presents much more of a risk than does an office worker or an accountant. There are a few professions that are not insurable such as a stunt pilot.

As mentioned in an earlier chapter, the optional change of occupation provision allows for adjustments to be made. If an insured changes to a more hazardous occupation, the benefits will be reduced. Conversely, if the insured changes to a less hazardous occupation, the insured will return any excess unearned premiums.

OTHER RISK FACTORS

Other risk factors include age, sex, medical history, and avocations (hobbies).

Age affects risk as the older one becomes the higher the risk to the insurer. Accidents become more extreme and illnesses more fatal. Most individual health policies limit coverage to a certain age such as 65.

Likewise, **sex/gender** has a bearing on insurability. Women put in more claims on health insurance than do men. Men present a lower rate of disability than do women, except at the upper ages.

An applicant's personal and family **medical history** is indicative of possible future impairments and thus represents a risk factor. Normally, underwriters cannot turn down a risk based on an applicant's blindness, deafness, genetic characteristics, current pregnancy, marital status, or sexual preference.

An applicant's **avocations** can increase the likelihood of suffering an injury or disability. Hobbies such as scuba diving, sky diving, motor racing, hang gliding, and mountain climbing are considered risky and must be considered in determining insurability.

CLASSIFYING RISKS

After the underwriter has reviewed all pertinent information, there are four ways to classify the applicant. The underwriter could rate the applicant as a preferred risk, a standard risk, or a substandard risk. The underwriter also could find the applicant uninsurable.

A **standard risk** falls within the company's normal guidelines. A standard risk reflects normal exposures and will be insured at standard rates and premiums.

A **preferred risk** presents a reduced risk of loss and will pay a lower premium. To be a preferred risk an individual must be in excellent health, exercise regularly, not smoke, not have a hazardous job or hobbies, and meet certain weight limitations.

A **substandard risk** reflects an increased risk of loss. An individual may be found to be a substandard risk based on physical factors, occupation, or hobbies. If an underwriter finds an applicant to be a substandard risk, the underwriter will charge a higher premium, make use of a restrictive rider, or limit the type of policy issued.

A restrictive or impairment rider excludes coverage from losses resulting from physical impairment or chronic conditions. Using such a rider, the policy can be issued at standard rates. If the substandard rating is based on job, hobbies, or physical condition, a higher premium will be charged either for a few years or permanently. If a limited policy is issued, it could provide a lower amount of protection, provide a shorter benefit period, have a longer waiting period, or exclude specific kinds of illness or perhaps be an accident only policy and not cover illness.

If the underwriting department finds a risk to be uninsurable according to its guidelines, the applicant will be turned down for coverage.

No insurer issuing or providing any policy of disability insurance covering hospital, medical, or surgical expenses shall engage in the practice of postclaims underwriting. Postclaims underwriting means the rescinding, canceling, or limiting of a policy due to the insurer's failure to complete medical underwriting and resolve all reasonable questions arising from written information submitted on or with an application before issuing the policy. (CIC 10384)

Starting in 2014, health plans cannot deny coverage or charge more for insurance because of a person's health, past medical problems, or gender. However, insurers can raise premiums by up to 50% for people who smoke. Also starting in 2014, insurers can charge older people no more than three times the amount charged younger adults. Currently, companies can charge older people up to 10 times what is charged younger people.

FACTORS IN HEALTH INSURANCE PREMIUMS

Health insurance premium rates are based on three major factors: **morbidity, interest, and expenses.**

Morbidity

Morbidity tables indicate the average number of persons at various ages that are expected to become ill or suffer an accident. Morbidity statistics also deal with the average length of time of disability. By approximating the number of persons affected and the duration of disability, insurers can determine the necessary amount of premium to charge.

Interest

A great deal of the premiums collected by an insurance company is invested to earn interest. The interest received helps to reduce the cost of insurance to policyowners. Without the interest to offset costs, policyowners would be required to pay higher premiums.

Expenses (Loading)

As all companies have overhead expenses, it is necessary for each policy to pay its proportionate share of these costs. Expenses include policy acquisition costs, administration, rent, supplies, agents' commissions, employees' salaries, etc. These expenses are loaded to the pure cost of insurance to determine actual premium payments.

OTHER FACTORS IN PREMIUM DETERMINATION

Claims Experience

Before determining an appropriate premium, insurers need to approximate the cost of future claims. One method of making such a determination is to examine claims tables based on past claims experience. Experience tables have been compiled for hospital expenses, surgical benefits, and other medical expenses. By adding a factor to account for the rising costs of medical coverage, these tables allow insurers to estimate the cost of future claims.

Benefits

A health policy may offer limited coverage or broad coverage. The type of benefits covered by a policy affect premium rate. A comprehensive major medical policy will cost more than a basic hospital expense policy. Thus, the greater the benefits provided by a policy, the higher the premium.

Age and Sex

Age has a bearing on premium as health claims increase with age. Older individuals will be required to pay higher premiums. Women under age 55 suffer more disabilities and of longer duration than do men. Premiums for women for certain health coverages are higher than are rates for men. At older ages these differences tend to level out.

Occupation and Avocations

If an individual has a hazardous job or hobbies, he/she has a higher than normal risk exposure. Therefore, a higher premium will be charged.

AIDS Considerations

State laws vary greatly in regard to using tests to detect AIDS antibodies and using such results to make underwriting decisions. In California no insurer shall test for HIV or for the presence of antibodies of HIV for the purpose of determining insurability other than in accordance with the informed consent, counseling, and privacy protection considerations of the applicant. An insurer that requests an applicant to take an HIV-related test shall obtain the applicant's written informed consent for the test. This written informed consent shall include a description of the test to be performed, including its purpose, potential uses, and limitations, the meaning of its results, procedures for notifying the applicant of the results, and the right to confidential treatment of the results. The insurer shall notify an applicant of a positive test result by notifying the applicant's designated physician. All costs of testing will be borne by the insurer.

No life or disability income insurer shall consider the marital status or known or suspected homosexuality or bisexuality of an applicant for life insurance or disability income insurance in determining whether to require an HIV antibody test of that applicant. Despite these restrictions by the CIC, a life or disability income insurer may decline a life or disability income insurance application on the basis of a positive test result using specified testing methods.

Many people with AIDS are living far longer with the introduction of powerful drugs such as protease inhibitors. However, these drugs are very expensive costing \$24,000 or more per year. If a health policy covers prescription drugs, the cost of covering individuals with AIDS will impact the overall cost of health insurance.

TAX CONSIDERATIONS

Medical Expense Insurance

An individual may make a deduction for medical expenses only to the extent that such expenses exceed 7.5% of the insured's gross income. (Starting in 2013 a tax deduction can be taken only on medical expenses that exceed 10% of the insured's gross income. This change is postponed until 2016 for taxpayers age 65 or older.) Obviously, if medical expenses are reimbursed through insurance, such expenses are not deductible. In figuring deductible expenses an individual may include prescriptions, doctor fees, hospital expenses, nursing care, rehabilitative services, dental care, and medical insurance premiums.

Self-employed persons have been able to deduct 100% of health insurance premiums since 2003. To qualify for this deduction, the self-employed person and spouse cannot be eligible to participate in another employer's subsidized health plan.

Disability Income Insurance

If an individual has a personal disability income policy, the premiums are not a deductible expense. However, should the insured become disabled, the disability benefits are not taxed.

If an employer pays for a group disability income policy for his employees, the premium is a deductible business expense. The employee would have to pay taxes on the benefits if he/she were to become disabled. If the employee contributes to the premium for the disability income policy, his/her benefit will be received tax free in proportion to the premium contributed.

COST CONTAINMENT

Policy Structure

One way to contain costs is to have a higher deductible. Another method is the use of coinsurance. Major medical policies use coinsurance as a means of sharing costs between the insurer and the insured. Coinsurance is normally 80/20 with the insurer paying 80% of covered costs and the insured responsible for paying the other 20% of covered costs. Still another method is the use of shortened benefit periods.

Medical Cost Management

Medical cost management makes use of mandatory second opinions, ambulatory surgery, pre-certification review, and case management.

Mandatory second opinions require an insured to obtain a second opinion before having surgeries that are not life threatening. This is to determine if there are other alternative methods of treatment. If the insured does not obtain a second opinion, benefits may be reduced.

Ambulatory surgery means that surgery is performed on an outpatient basis. This eliminates the expense of costly overnight hospital stays.

Many policies require a **pre-certification** review. This is an approval from the insurance company before being admitted to the hospital for a non-emergency. In this way the physician and the insured will know if a claim will be covered and to what extent.

Case management allows an insurer to have an active role in handling a claim that is potentially costly. A specialist for the insurer reviews a large claim as it develops in order to suggest less costly treatment alternatives.

FRAUD

Fraud is a major problem in the insurance industry and it ultimately affects everyone who has insurance by pushing the costs upward. Laboratories might bill for tests not run and hospitals and doctors might charge for services not rendered. Individuals might fake workers compensation claims. Other insureds might pretend to continue to be disabled in order to collect disability income benefits.

REPLACEMENT

When replacing an existing policy, agents need to be careful not to misinform a client about a policy's coverage. Agents need to exercise caution that the replacement is not detrimental to the insured.

If either a group or individual policy is replaced, any ongoing claims must be covered under the new contract. This legislation is referred to as **no-loss-no gain**.

REVIEW QUESTIONS

1. Which of the following persons could be rated as a preferred risk?
 - A. A physically fit non-smoker with a non-hazardous job whose hobby is skydiving.
 - B. A person who exercises regularly, does not smoke, has no hazardous hobbies and whose occupation is roofing high-rise buildings.
 - C. A non-smoking office worker who is considerably overweight.
 - D. A secretary who jogs three times a week, does not smoke, and is physically fit.

2. Which are risk factors to be considered during the underwriting process?
 - A. Age of the applicant
 - B. Avocations of the applicant
 - C. Occupation of the applicant
 - D. All the above

3. A substandard risk can be considered an insurable risk by the underwriting department.
 - A. True
 - B. False

4. Which of the following are used in determining health insurance premiums?
 - A. Mortality, interest, and expense
 - B. Morbidity, expense, and loading
 - C. Morbidity, expense, and premiums
 - D. Morbidity, interest, and expense

5. When are disability income benefits taxable to an employee?
 - A. Disability income benefits always are received tax-free by the employee.
 - B. Disability income benefits are taxable to the employee if the employee has paid for the insurance.
 - C. Disability income benefits are taxable to the employee if the employer has paid for the insurance.
 - D. None of the above.

6. A table that reflects the average number of disabilities due to sickness and accidents at various ages is a:
- A. Mortality table
 - B. Underwriting table
 - C. Medical cost management table
 - D. Morbidity table
7. Which of the following is **not** used in determining disability insurance rates?
- A. Mortality
 - B. Loading
 - C. Interest
 - D. Morbidity