CHAPTER 13
HEALTH INSURANCE

Although the health insurance industry started in the latter part of the 1800s, it did not boom until the 1940s. Today most people realize the need of health insurance due to the escalating cost of care. In the year 2008, the expenditures for health care were 16% of the gross national product. The United States spends more per capita than all other developed nations for medical care.

Health or disability insurance encompasses a broad spectrum of insurance plans that protect against the financial consequences of illness, accident, and disability. A health insurance provider is the source that provides the medical services such as a physician or hospital. Notwithstanding any other provision of law, and except as provided herein, any person or other entity which provides coverage in this state for medical, surgical, chiropractic, physical therapy, speech pathology, audiology, professional mental health, dental, hospital, or optometric expenses, whether such coverage is by direct payment, reimbursement, or otherwise, shall be presumed to be subject to the jurisdiction of the Department of Insurance unless the person or other entity shows that while providing such services it is subject to the jurisdiction of another agency of this or another state or the federal government. A person or entity may show that it is subject to the jurisdiction of another agency of this or another state or the federal government by providing to the commissioner the appropriate certificate or license issued by the other governmental agency which permits or qualifies it to provide those services for which it is licensed or certificated. (CIC 740) Service contractors (i.e. HMOs, PPOs) come under the authority of the Office of Managed Care.

Three categories of health insurance are medical expense coverage, disability income insurance, and accidental death and dismemberment insurance. Health insurance can be obtained through individual plans and group plans. Health insurance also is provided through state and federal government programs.

Individual plans may cover family members and are issued by commercial insurers and service organizations. These plans will require an application and normally require proof of insurability.

Group health insurance plans also are offered by commercial insurers and service organizations. Members of a specified group are covered under a master contract issued to the sponsor who may be an employer, trade or professional association, credit union, labor union, and other organization. The sponsor is the policyowner and responsible for paying the premiums. Group policies may be contributory or noncontributory, meaning the members may or may not be required to contribute to the premium payment. All members of the group will be covered under the policy and normally the group members are not required to provide evidence of insurability. The provisions and coverages of group health insurance contracts usually are more liberal than individual health policies.

Life insurance provides a sum of money upon the death of the insured and can protect those left behind from financial disaster. Likewise, health insurance provides protection just when needed—upon the illness of an insured or when an insured is disabled. Medical expense insurance provides the necessary funds to pay hospital and doctor bills when an insured is ill or suffers an accident. Disability income insurance provides a stream of income when the insured is disabled and unable to work and produce an income.

When deciding on the appropriate type of insurance coverage to purchase, all other possible sources of protection must be considered. Some of these include workers compensation

benefits for a job-related disability, benefits provided through an employer-sponsored plan, health coverage under any statutory plan, Social Security disability benefits, Medicare (if eligible), and any individual plans the insured may have.

COMMERCIAL INSURANCE PROVIDERS

Commercial insurers are stock and mutual life insurers, casualty insurance companies, and monoline companies that specialize in one or more types of disability income or medical expense policies. These insurers issue both individual and group policies.

Traditionally, commercial insurers have provided coverage on an indemnity basis. In other words, claim forms are typically completed and submitted by the participant who is then reimbursed for incurred expenses by the insurer. Once the insured is reimbursed, it is the insured's responsibility to pay the providers of medical care. The benefits may be provided on a scheduled basis (fixed dollar amounts for services as stated in the contract) or on a usual, customary, and reasonable basis (payment based on the norm for the procedure in that geographical area). The right of assignment is included in most commercial health policies. This allows the policyowner to assign the benefit payments directly to the provider of medical care.

SERVICE PROVIDERS

Service contractors provide health care plans under which heath care benefits are provided to the covered individuals instead of monetary reimbursement for health care expenses. The policyholders are referred to as subscribers and they receive medical care services in return for paying a premium. The medical care provider enters into an agreement with the service organization agreeing to provide medical services to the subscribers. The service organization pays the medical care provider directly rather than reimbursing the subscriber. The primary examples of service contractors are Blue Cross and Blue Shield, health maintenance organizations, and preferred provider organizations.

Blue Cross and Blue Shield

Blue Cross and Blue Shield have contractual relationships with hospitals and doctors. The providers (hospitals and physicians) have contractually agreed to accept certain fees to provide medical services to the subscribers. Due to this, there is no contractual relationship between Blue Cross/Blue Shield and the subscribers. Blue Cross and Blue Shield are prepaid plans in which the subscribers pay a premium, usually monthly.

Blue Cross and Blue Shield offer individual, family, and group plans. They offer a number of different health care plans, including health maintenance organizations and preferred provider organizations.

HEALTH MAINTENANCE ORGANIZATIONS (HMOs)

Due to escalating health care costs, health maintenance organizations evolved. HMOs' objectives are to contain medical costs by:

- Stressing preventive care through physical exams, well-child examinations, and diagnostic screening
- Reducing unnecessary hospital admissions
- Reducing the average number of days per hospital visit
- Reducing duplication of benefits

Besides trying to contain costs, the growth of HMOs also is attributable to the HMO Act of 1973 known as the **dual choice rule** which later was repealed in 1995. It was a federal ruling stating that if an employer (1) had 25 or more employees, (2) provided health insurance, and (3) there was a federally qualified HMO servicing the area, the employer had to offer the HMO coverage as an alternative choice to traditional health care coverage. Now the federal law requires that employers "not financially discriminate" in the amount contributed by employees toward HMOs and indemnity plans.

HMOs may either be for profit or nonprofit organizations. Organizers of HMOs include commercial insurers, governments, hospitals, unions, employers, and local communities. HMOs operate within a service area that needs to be approved by the Department of Insurance. The service area may be a city, a county, or a state. Members of the HMO must live within the service area. It should be noted that although the service area of an HMO is controlled by the Department of Insurance, HMOs come under the regulation of the Department of Managed Health Care in the state of California.

Under traditional insurance arrangements, the health care is received from the medical profession and the financial coverage comes from the insurance company. An HMO handles both the financial arrangements for the coverage and makes the health care services available. The HMO members, known as subscribers, prepay a specified amount for the coverage. Nominal co-payments are made at the time of a doctor's visit. Copayments for supplemental services are frequently more than for basic health care services.

A feature common to HMOs is that the primary care physician functions as the **gatekeeper**. The primary care physician (PCP) monitors the subscriber's health care needs. The PCP renders the necessary care to the subscriber and when needed refers the subscriber to a specialist for treatment. The PCP determines what care is needed and not needed. To contain health care costs, the PCP should not make unnecessary referrals.

HMOs are structured in different ways. The different models of operation are group model, staff model, network model, and independent practice association model.

Group Practice Model (Medical Group Model)

Under the group model arrangement, the HMO contracts with an independent medical group composed of physicians of various specializations
practicing in one facility or location. The HMO pays the medical group entity. The medical group will determine how to pay the individual physicians. Frequently, the HMO pays the medical group a **capitation fee**, a fixed monthly fee for every member (per capita) of the HMO. The group receives this fee even if a subscriber has received no services. However, the group could stand to lose money on a subscriber who makes frequent visits.

Group practice models can be either **open panels** or **closed panels.** When the medical group provides services to HMO members only, it is called a closed panel. In a closed panel, the doctors are normally salaried employees of the HMO and work at a clinic owned by the HMO. When the medical group provides services to members of the HMO as well as non-member patients, it is called an open panel. In this latter case, the doctors are not salaried employees of the HMO and treat patients in their own facilities.

The group model HMO refers members internally within the group. If an HMO member needs the services of a specialist who is not part of the group, special arrangements will be made. The HMO also contracts with area hospitals to provide necessary hospital care.

Staff Model

In the staff model, the contracting physicians are paid employees who work in a facility owned by the HMO. The HMO may own and operate its own hospital. In any case, the HMO's own employees and facilities are being used to deliver health care to its subscribers. In this type of model, there is no financial risk to the physician as he/she is a salaried employee. It is the HMO that is assuming the financial risk.

Network Model

An HMO will contract with several medical groups in the network model instead of just one as in the group model. The HMO also may contract with independent doctors to offer services to members out of their individual offices. In this type of organization, the medical group normally will be paid a capitation fee and the independent doctors may receive either a capitation fee or a discounted fee for services rendered.

Independent Practice Association Model (IPA)

The HMO contracts with individually practicing physicians to provide services to its members. As these doctors are practicing out of their own offices and independently of one another, it gives the subscribers an ability to find a doctor in a convenient location. The subscriber chooses a primary care physician who is responsible for the subscriber's care. If the subscriber is in need of a specialist's care, the primary care physician will refer to a doctor in the IPA network. The physicians of the IPA can use hospitals contracted by the HMO for needed subscriber inpatient care just as in the group model. IPAs can be structured as either open panels or closed panels.

HMOs--Basic and Supplemental Services

Services that HMOs are required to provide are referred to as basic services. Any services an HMO provides that are in excess of the basic services are referred to as supplemental services.

Basic Services are inpatient hospital and physician services, outpatient medical services, preventative health services and emergency services.

- Inpatient hospital and physician services include: At least 90 days per calendar year for inpatient treatment of illness and injury; 30 days per calendar year inpatient treatment for mental, emotional and nervous disorders (including alcohol and drug rehabilitation); hospital services including room and board, maternity care, operating rooms, intensive care, medications, anesthesia, physical therapy, x-rays, laboratory and diagnostic tests.
- Outpatient medical services include care given by a physician outside the hospital, laboratory and x-ray services, outpatient surgery, diagnostic services, and short-term physical therapy.
- Preventative health services include periodic health examinations, well child care, and immunizations.
- Emergency services must be available on an inpatient and outpatient basis 7 days a week around the clock. This also includes necessary ambulance services.

Supplemental services that may be offered by an HMO are prescription drugs, vision care, dental care, home health care, long-term care, substance abuse services, and mental health care. Subscribers who desire these services may purchase them from the HMO as an addition to their basic services.

Evidence of Coverage

An evidence of coverage must be provided to members of the HMO. The evidence of coverage will include coverages and benefits as well as exclusions, the effective date and term of coverage, a list of providers, description of service area, conditions of termination, and complaint system. This document will also contain information regarding the 30-day grace period, the coordination of benefits provision, incontestability clause, and a provision regarding the eligibility requirements for membership in the HMO.

All HMOs are required to have a complaint system to deal with coverage complaints and care complaints. Coverage complaints include grievances regarding coverage offered and denial of health claims. These complaints are reviewed internally and, if not resolved, may be referred to the Department of Insurance. Care complaints involve the quality of medical care. Medical personnel review this form of complaint.

PREFERRED PROVIDER ORGANIZATIONS (PPOs)

Preferred provider organizations were developed as a compromise between traditional insurance coverage and coverage provided by an HMO. Organizers of PPOs include traditional insurance companies, Blue Cross/Blue Shield, trade unions, local groups of physicians or hospitals, and large employers. PPOs, like HMOs, are prepaid plans and both are referred to as managed care.

A PPO is made up of private physicians and hospitals in an area that have agreed to provide health services to the PPO subscribers. PPOs can operate as either open panels or closed panels. The health care providers are paid on a fee-for-service basis. The providers are willing to accept discounted fees in exchange for a guarantee of payment and the potential increase in patient load.

A PPO gives subscribers more flexibility in choice of physicians than does an HMO. When a subscriber sees a preferred provider, the cost of care will be completely covered minus a nominal copayment. If the subscriber decides to seek care from a nonpreferred provider, the benefits paid by the PPO will be somewhat reduced. Perhaps the PPO will only pay 80% of the normal fee. However, PPOs normally will pay in full for emergency services regardless of where or by whom rendered. This system gives the subscriber freedom of choice in the selection of a health care provider.

EXCLUSIVE PROVIDER ORGANIZATIONS (EPOs)

Exclusive provider organizations are a type of PPO. However, members must use particular preferred providers who are paid on a fee-for-service basis. The members do not have the great flexibility of choice of care providers as under a PPO. EPOs use the gatekeeper system in which the member selects a primary care physician who monitors the member's care and makes referrals to specialist within the network.

POINT OF SERVICE (POS) PLAN

The point of service plan (POS) is a type of managed health care system. It combines the characteristics of both the HMO and the PPO. When a subscriber enrolls, he/she needs to choose a primary care physician to monitor his/her health care. The primary care physician must be chosen from within the health care network and becomes the subscriber's "point of service". The primary care physician may make referrals outside the network with the POS paying a portion of the costs.

HMOs, PPOs, and POSs are referred to as **managed care**. Managed care refers to a system that imposes control of the use of health care services, the amount charged for services, and the access to health care providers.

SELF-INSURANCE

Instead of having an insurance policy with an insurance company, some businesses choose to self-insure health plans for their employees. This means the business will provide the money to cover the costs of their employees' medical bills. Other groups that may elect to self-insure are labor unions, fraternal associations, and co-ops. In these cases, dues and contributions from members cover the costs of medical care.

Self-insurers frequently will use an outside organization to handle the paperwork and process claims. Such an outside organization is called an administrative-services-only (ASO) or third-party administrator (TPA).

MEDICAL SAVINGS ACCOUNT (MSA)

A medical savings account is available to self-employed persons or employers who have 50 or fewer employees. The plan calls for a high deductible health plan (HDHP) to help pay for major medical expenses and the making of regular deposits into a medical savings account to cover minor expenses such as office visits. Deposits made toward the MSA are 100% tax deductible and can be used toward any out-of-pocket medical expense (e.g. premium, policy deductible, prescriptions, doctor's visits, vision or dental care, long term care). Once the yearly plan deductible has been met, the HDHP will pay any remaining covered medical expense in that year. If there are funds remaining in the MSA at the end of the year, the funds can either roll over for the following year or can be withdrawn as taxable income.

The HDHPs that qualify are those with a minimum individual deductible of $1,150 and a minimum family deductible of $2,300. The maximum out-of-pocket limits are $5,800 for an individual and $11,600 for a family. These are 2009 figures.

FLEXIBLE SPENDING ACCOUNT (FSA)

A flexible savings account can be set up through a cafeteria plan of an employer. An FSA allows an employee to set aside a potion of his/her earnings to pay for qualified expenses as established in the cafeteria plan—most commonly for medical expenses. Money deducted from an employee's pay is not subject to payroll taxes. Funds not spent during the year do not roll over to the next year. FSA are normally offered in conjunction with a traditional health plan.

HEALTH SAVINGS ACCOUNT (HSA)

A HSA based plan involves contributions to a savings account on a pre-tax basis by an employer and/or employee and is portable as the participant changes employers/plans. It is linked with a HDHP. Funds that are not withdrawn in a year can be rolled over and used in future years. Once the HSA is exhausted, there are no further tax advantages to help defray additional out-of-pocket expenses.

HEALTH REIMBURSEMENT ACCOUNT (HRA)

A health reimbursement account is established by an employer and serviced by a third-party administrator or plan service provider. Employers fund individual reimbursement accounts for their employees. These plans must be funded solely by employers. There are no limits on the employers' contributions and employers are not required to prepay into a fund for reimbursements. Instead, employers may reimburse employees' claims as they occur. Employees are reimbursed tax free for qualified medical expenses up to a maximum dollar amount for a coverage period. This plan will require a standard insurance plan—any health plan, not only HDHP.

CONSUMER DRIVEN HEALTH PLANS (CDHPs)

Consumer driven health plans refer to health insurance plans that allow members to use personal health savings accounts (HSA), health reimbursement accounts (HRA), or similar medical payment products to pay routine health care expenses directly. The associated high-deductible health insurance policy protects them from catastrophic medical expenses. It is referred to as consumer driven as the insured person becomes an active participant in controlling health costs rather than being passive and relying on the managed benefit plans. CDHPs are all about transferring the reins of health-care costs to the participating individual. By encouraging individuals to use CDHPs, it is assumed that consumers will eventually become more cost conscious which will enable them to make more cost-effective decisions about their health and health care.

OTHER HEALTH CARE PROVIDERS

Urgent care centers see patients without appointments during the day, evening, and weekend hours.

Surgicenters are sites for surgery requiring anesthesia but not requiring the patient stay overnight.

Home health care is provided by nurses and others for a patient who is able to return home but who is not yet able to fully care for his/her own needs.

Skilled nursing facilities provide transitional medical care for patients who no longer need to be hospitalized but who cannot care for themselves at home.

GOVERNMENT INSURANCE

Medicare

Hospital and medical expense insurance is provided for seniors by the federal government through the Social Security program. This is Medicare and is available to persons age 65 who are fully insured under the Social Security system, to persons who have been

receiving Social Security disability payments, and to persons suffering from chronic kidney disease.

Social Security Disability Income

Social security has a very stringent definition for disability. The individual cannot perform any substantial gainful work due to physical or mental disability and the impairment must be expected to last at least 12 months or end in death. The individual also must have earned a certain minimum number of quarters of coverage. There is a six-month waiting period before benefits begin.

Medi-Cal (Medicaid)

The Medi-Cal program is administered by the state of California under broad guidelines established by the federal government. Most other states call their programs Medicaid. The program is to provide medical care for persons of all ages who do not have the financial ability to meet the costs of necessary medical care.

The following are eligible for Medi-Cal: people 65 or older, blind, or disabled and who receive Supplemental Security Income/State Supplementary Program (SSI/SSP); people receiving Aid to Families with Dependent Children or other public assistance programs; people who are medically needy and meet the state limits for income and property; and those who are medically indigent (those who are pregnant, refugees in the country 18 months of less, those who are in a skilled or intermediate nursing facility, those who are under 21 whose needs are met by public funds).

A person can qualify for both Medicare and Medi-Cal. If so, Medi-Cal will pay the monthly premium for Medicare Part B and the person will not be billed for the Medicare coinsurance.

State Workers' Compensation Programs

All states have worker compensation laws. California law requires all employers to provide liability for workers compensation. An employer can purchase workers compensation insurance through a state run program, a private insurer, or can self-insure. The employer is responsible for work-related injuries or illnesses without regard to fault or negligence of any party. If a worker is killed in work-related accident, a burial allowance will be paid and the surviving spouse and children will receive compensation. Medical bills and costs of rehabilitation for the worker will be paid. Benefits for loss of income will be paid to the worker subject to minimum and maximum amounts.

There are two major categories of disability insurance policies: disability income policies and medical expense policies. Disability income policies usually pay a benefit monthly to a disabled insured who cannot work and earn an income. Medical expense policies cover medical bills ranging from basic policies offering minimal coverage to comprehensive policies providing extensive coverage. A wide variety of policies fall within this latter category including basic medical expense policies, major medical expense policies, comprehensive medical expense policies, and accident and sickness policies.

MEDICAL EXPENSE INSURANCE

Medical expense plans can be either a reimbursement of actual expenses or paid as fixed indemnities. A reimbursement policy will pay for expenses incurred up to a maximum benefit. An indemnity policy will pay a stated benefit amount to the insured.

BASIC MEDICAL EXPENSE

Basic medical expense plans are referred to as first dollar coverage because the insurance company pays from the first dollar of expenses incurred without requiring a deductible. These plans limit the type of coverage, the duration of coverage, and the dollar amount paid. General categories of basic medical expense include hospital expense, surgical expense, and physician's expense.

Basic Hospital Expense

Basic hospital expense policies pay for the daily cost of room and board during a hospital stay. They vary as to the daily amount paid and length of time payable. Basic hospital expense insurance will cover miscellaneous hospital charges covering such items as anesthesia, x-rays, laboratory fees, operating room, supplies, and drugs. Miscellaneous fees normally are expressed as a multiple of the daily room and board amount (e.g. 10 times room and board amount). However, some of these policies pay a stated dollar amount.

Basic Surgical Expense

Basic surgical expense policies pay for inpatient and out patient surgeon's services. Frequently included in these policies will be the services of an anesthesiologist and postoperative care. Fees can be paid according to a fixed schedule, on a usual, customary, and reasonable basis, or a relative value scale. In a fixed schedule, each surgical procedure has a dollar value assigned to it. If a surgery is not listed in the schedule, it does not mean that it is not covered. The claims department will have a complete listing of all procedures.

In the **usual, customary, and reasonable (UCR)** approach, surgical benefits are not listed by dollar amount. Instead the insurer will pay based on the amount physicians in the same geographical area normally charge for the same or similar procedure. The insurer has the right to agree or disagree as to whether a charge is usual, customary, and reasonable. This type of payment structure typically is found in major medical and comprehensive major medical policies.

Using the **relative value** scale, a set of points is assigned to each surgical procedure. The most complicated of surgical procedures will have a maximum set of points assigned to it. All other surgeries will have a relative number of points assigned based on relative difficulty compared to the maximum procedure. Each point has a dollar value. If a point is worth $10 and the procedure is assigned 100 points, the policy will pay $1000.

Basic Physician's Expense

The basic physician's expense policy pays for non-surgical physician's fees including office visits and non-surgical care by a physician while the insured is hospitalized. These policies usually pay on an indemnity basis (scheduled amount).

Other medical expenses may be included in these basic policies or as options added to the policy. Some of these coverages include maternity benefits, emergency accident benefits, in-

hospital physicians' visits, hospice care, home health care, mental and nervous disorders, and outpatient care.

MAJOR MEDICAL EXPENSE

Major medical expense policies offer broad coverage under one policy. Using basic medical expense policies is a fragmented approach to medical care necessitating several policies that could leave a gap in coverage. Major medical policies provide more complete coverage and higher maximum policy limits. Major medical policies are sometimes referred to as catastrophic insurance as they may cover large catastrophic medical expenses. These policies cover hospital room and board, miscellaneous hospital expenses, surgery, physicians' services, transfusions, physical therapy, x-rays, laboratory services, prosthetic devices, ambulance transportation, etc. Major medical expense policies can be divided into two categories: comprehensive major medical expense and supplemental major medical expense.

Comprehensive Major Medical

A comprehensive major medical policy essentially covers all medical expenses under one policy. This type of policy will have a deductible. A deductible is a stated dollar amount of medical expenses that the insured must pay before policy benefits are paid. Deductibles may be a per cause deductible or a calendar year deductible. These deductibles apply to each covered person. Using a **per cause** deductible, a deductible must be satisfied for every separate claim. With a **calendar year** deductible, one deductible needs to be satisfied for the calendar year regardless of the number of claims submitted. Frequently major medical policies have a **carry over provision.** If the insured had no claims during the year but does have claims during the last three months of the year, these expenses may be carried over to the next calendar year and be applied to the new year's deductible.

A **family deductible** often is included. Two or three family members can satisfy the deductible for all family members thus saving the family some money. The amount above the deductible will be paid by the insurer subject to any specified coinsurance. Another situation that relates to the family is the **common accident provision**. This provision states that if family members are injured in a common accident, only one deductible needs to be satisfied.

Deductibles – please see addendum page 13-48

Coinsurance

Coinsurance is a feature of major medical policies in which the insurer and the insured share in the cost of medical expenses. After the deductible has been satisfied, the remaining expenses are shared—usually on an 80/20 basis. This means the insurer will pay 80% of covered costs and insured is responsible for the other 20%.

Consider this example. The insured has a hospital stay and all bills are covered costs and total $5,200. The policy has a $200 deductible and 80/20 coinsurance. How much will the insurer pay and how much of the bill will the insured be responsible for paying?

Total bill		$5,200	
Deductible	- 200		Remainder
$5,000			
Coinsurance	x .80		
Amount insurer pays	$4,000		
Insured's coinsurance	$5,000		
		X .20	

	$1,000
Insured's deductible	+ 200
Insured's total cost	$1,200

Stop Loss Limit

Many major medical policies have a stop loss limit which limits the insured's out of pocket expenses. Once the insured has paid a specified dollar amount toward medical expenses, there is no more coinsurance on the part of the insured. The insurance company will pay the remaining covered expenses. This protects the insured if he/she experiences a period in which there is a catastrophic illness.

Stop loss amounts can be determined in different manners according to the contract. A contract might state that the company will pay covered costs after the insured has incurred $2,000 of medical expenses. Another contract might state that coinsurance applies to the first $5,000 of medical expenses after the insured has met the deductible expense. For instance, if a policy had a $500 deductible and coinsurance of 80/20 on the first $5000 of medical bills, the insured will end up paying $1,500. That is the deductible of $500 and 20% of $5,000 which is $1,000 making a total of $1,500. After that amount, the insurance company will pay 100% of remaining covered expenses up to a stated maximum benefit.

Maximum Benefit

Major medical policies have maximum benefit amounts payable on behalf of an insured during his/her lifetime. The limits can be $1,000,000 or more. Some policies even have unlimited benefit amounts. Each member of a family has his/her own lifetime benefit amount.

Restoration of Benefits

Most major medical policies have a provision that allows for the restoration of benefits. When medical claims are paid, it reduces the maximum benefit amount available. The restoration of benefits allows for a certain amount of coverage to be restored each year to replace the coverage lost when a claim is paid. Some policies require that the insured prove insurability in order to restore benefits. Other policies have an automatic reinstatement provision that restores a specified dollar amount annually.

Pre-existing conditions

Most major medical policies will have an exclusion regarding pre-existing conditions. A pre-existing condition is one that existed prior to the effective date of the policy. The exclusion is only for a limited time after which the condition will be covered in full up to the policy limits.

Supplemental Major Medical

A major medical policy that supplements a basic policy is called a supplemental major medical policy. The basic policy covers medical expenses on a first dollar basis (no deductible) up to the policy limit. After the benefits under the basic policy have been exhausted, a

deductible must be paid. Since the deductible comes in between the basic policy and the major medical policy, it is called a **corridor deductible**. Some supplemental major medical policies have an **integrated deductible** that is integrated into the amounts covered by the basic plan. If the supplemental policy has a $250 deductible and the insured incurs $250 or more of covered expenses under the basic plan, the deductible is satisfied. If the basic policy benefits do not cover the entire deductible amount required by the major medical policy, the insured must pay the difference.

A supplemental major medical policy will have coinsurance like the comprehensive major medical policy. It will most likely have a stop loss limit and maximum benefit amounts. The supplemental policy picks up where the basic policy ends. It will cover expenses in excess of the dollar limit on the basic policy as well as expenses that are not covered under the basic plan.

LIMITED POLICIES : The following policies provide benefits for specified limited services.

Hospital Indemnity Policies

Hospital indemnity policies pay a stated dollar amount per day to the insured while confined to a hospital. The insured can use this money for anything he/she decides. The policy is not meant to cover the cost of medical care but rather to give the insured additional money while confined to a hospital. If an insured has a hospital indemnity policy that pays $100 per day and this individual is hospitalized for five days, the insured would receive $500.

Hospital indemnity polices may have benefits that pay $4,500 per month (based on a benefit of $150 per day) or even a greater amount. Benefit periods can range from six months to several years or for a lifetime.

Dread Disease

Dread disease or specified disease policies can be purchased to cover a specific disease, such as cancer or heart disease. These policies are very limited in scope. Frequently the purchaser of such a policy may believe he/she has broader coverage than what is afforded under the policy. A major medical policy could cover these illnesses plus a myriad of other problems.

A **critical illness** policy can provide a sum of money if the insured person were to have a diagnosis of a listed critical illness. This policy is not limited to one disease. These illnesses can include cancer, heart attack, stroke, multiple sclerosis, Parkinson's disease, third degree burns, and other conditions. They frequently pay in a lump sum.

Accident Only

Accident only insurance provides medical treatment for accidents. It does not provide coverage for illness contracted by the insured.

Supplemental Accident

Supplement policies provide another layer of protection on top of major policies such as health insurance. The benefits are paid directly to the insured. When an insured suffers an accident, supplemental accident insurance can cover items not covered by the primary carrier such as the deductible and other out-of-pocket expenses. In addition to this, some policies will help cover the costs of daily living expenses.

Travel Accident Insurance

Travel accident insurance covers loss from accidents while traveling. This coverage normally is limited to travel on a common carrier such as airlines, trains, or buses. Some such policies also cover the insured while in route to the airport, train station, etc.

Travel accident insurance may be offered as a benefit on either an individual or group accidental death and dismemberment policy. Air travel accident insurance providing individual, one-time coverage can be purchased from vending machines at airports.

Vision Care

Although major medical policies normally cover disease and injury to the eye, eye refraction (eye examination) and correction through the use of glasses and contact lenses is not. Vision care policies can cover eye examinations, lenses and frames, contact lenses, and other corrective items.

Vision care plans usually deliver services by using a network of eye doctors and providers of eyeglasses. The insured must use one of the specified providers. The insured will present his/her vision plan card and make a co-payment.

Dental Expense

Dental insurance may be covered under the benefits of a major medical plan or as an optional benefit on either a scheduled or non-scheduled basis. A scheduled plan has specific categories of dental treatment and dollar amounts payable for each category. Scheduled plans will pay up to the maximum stated in the schedule. Nonscheduled plans pay on a usual, customary, and reasonable basis (UCR). Dental plans also can be a combination plan covering some services on a scheduled basis and other services on a non-scheduled basis.

Dental plans can cover preventative care, restoration (filings, crowns, etc.), oral surgery, periodontics (treatment of gum problems), endodontics (treatment of problems of the dental pulp), and orthodontics.

Dental insurance plans normally have a deductible, coinsurance, and maximum amounts per calendar year (e.g. $1000). Normally only two cleanings per year will be covered. The deductible frequently does not apply to preventative care. Dental services for cosmetic reasons are excluded.

Group dental plans may be prepaid and operate in much the same way as an HMO. The plan contracts with licensed dentists to provide dental care to the subscribers in a specific service area. The dentists are paid by the pre-paid dental plan. The subscriber is responsible for copayments at the time of service. If a course of treatment is expected to exceed a specific amount, the treatment must be explained on a pre-certification form and be approved by the insurer for authorization.

When a group dental plan becomes effective, all employees must be eligible for coverage. The plan may be contributory or non-contributory. A probationary period normally applies to new employees who join the group after the effective date. Limitations may apply to employees who did not sign up for coverage when eligible but who want the coverage at a later date. These are precautions taken by the insurer to avoid adverse selection.

Prescription Drug Card

Prescription drug benefits usually are included in group health insurance policies. An individual health policy might offer this coverage as a rider. In this case, there normally is a small charge to the insured of from $2 to $5 per prescription.

Organ Transplants

More insurers are covering the cost of organ transplants as the procedures are becoming more commonplace. Usually, insurers only pay for organ transplants that are needed by insureds due to a life-threatening situation. Kidney, heart, liver, and bone marrow are some of the more commonly covered transplants.

DISABILITY INCOME

Disability income insurance provides the insured with an income after being disabled due to an accident or illness. It is probably the most overlooked form of insurance. People frequently will purchase life insurance, health insurance, and annuities and forget about disability income insurance. Statistics show that if someone is 35, there is a 45% chance of suffering a disability for at least 90 days before turning 65. Once a disability has lasted 90 days, the average length of disability is 2½ years. When someone is out of work, his/her income can end and yet everyday expenses continue. When a person suffers this form of economic death, a disability income policy can provide the needed income. When purchasing a disability income policy, a person should take into consideration all other possible sources which might provide some income. Workers compensation will pay for work related injuries and illness. Social Security Disability would pay a benefit if the person could meet the Social Security definition of total disability. The person under 65 years of age would be covered by Medicare after being on Social Security Disability for 24 months. There is the California program of State Disability Insurance into which employees are required to contribute. Employers might provide group disability insurance for employees.

BENEFIT AMOUNTS

Benefits paid by a disability income policy are in the form of monthly payments. Benefit amounts are limited and are defined in terms of the insured's earnings. The benefit ceiling will be less than the insured's regular earnings. If disability income payments were more than an insured's earnings, there would be no incentive to recover and return to work.

Benefit payments will be based on a percentage of the insured's earnings or could be a flat amount. Under the percentage method, all sources of disability income will be taken into consideration. In other words, the various sources integrate the benefits they will pay. If a policy stated it would pay 60% of earnings, it would coordinate with other sources of income to make certain that the insured did not receive more than 60% of income. Some policies may pay a benefit that varies with length of disability. A policy could pay 100% of income for the first month of disability and reduce the amount for following months to a lower percentage rate (i.e. 60%-70%). This percentage method normally is used in group disability income plans.

A flat benefit amount method pays a specified payment if the insured becomes totally disabled. Limits of payments will be based on current income. This flat benefit amount typically is payable regardless of other sources of income. The flat benefit amount normally is found in individual plans.

DEFINING DISABILITY

In order to receive benefits, the insured must meet the definition of total disability. The term *total disability* will be defined in the policy and different companies will define the term differently. Most policies define total disability in terms of the insured's work activity. The insured's ability to do his/her own occupation or any occupation for which qualified.

Own occupation defines total disability as the insured's inability to perform any or all of the duties of his/her own occupation as a result of sickness or accident. This simply means the insured can no longer perform the job he/she was doing at the time of disability. This is the most advantageous definition for the insured. Such a policy also will carry the most expensive premium payment.

The own occupation policy may use the definition of own occupation for a certain length of time (e.g. 2 years to 5 years). After that amount of time, the qualifying definition can be changed to any occupation.

Any occupation defines total disability as the insured's inability to perform the duties of any occupation for which the insured is reasonably qualified by education, training, or experience. This is a more restrictive definition of total disability and is less favorable to the insured. A surgeon may no longer be able to perform surgery due to damage to one hand, but he still could function as a general practitioner. The surgeon would not qualify for benefits under the any occupation definition.

Permanent/Temporary Disability

A permanent disability is one that reduces or eliminates the ability of the insured to work for the remainder of his/her life. A temporary disability leaves the insured unable to work while recovering from the illness or injury. However, the insured is expected to make a full recovery from the temporary disability.

Presumptive Disability

Many disability policies will state that a presumptive disability classifies as a total disability. Presumptive disabilities involve extreme losses and automatically qualify the insured for total disability benefits regardless of whether the insured can work or not. Presumptive disabilities are loss of use of any two limbs, total and complete blindness, and loss of speech and hearing.

Another criterion for presumptive disability is the loss of earnings test. If the insured is working after such a disability and he/she suffers a loss of income that falls below a certain percentage of pre-disability earnings, the insured is considered to be totally disabled and eligible to receive full benefits even if working and earnings continue at this lower level.

Injury or Illness

Some policies may further break down whether a disability is covered based on if it is caused by an accident or illness. In these cases the policies may be referred to as a total accident (injury) policy or a total sickness policy. Today most polices cover disabilities caused by either an accident or sickness.

Another matter to consider is the manner in which the policy defines the cause of the injury. Policies that use the *accidental means provision* are concerned with the cause of the

injury. The injury must have been caused by an unexpected, unforeseen event not under the control of the insured. Policies that use the *accidental bodily injury provision* are concerned with the result of the injury. The injury has to be unexpected and accidental.

If a person were to jump off a ski jump and suffer an injury, it would not be covered if the policy used the definition of accidental means. After all, the jump was intentional. If the policy used the accidental bodily injury provision, the injury would be covered as the resulting injury was unintentional and accidental.

Most policies use the accidental bodily injury provision. It is less restrictive than the accidental means provision.

Non-disabling Injuries

An insured could suffer an injury that does not qualify for income benefits under the disability income policy. Some of these policies pay a medical expense benefit that pays for the cost of treatment for the non-disabling injury. Normally the benefit is limited to a percentage of the monthly income benefit.

Partial Disability

A partial disability can be defined as the insured's inability to perform one or more important duties of his/her own occupation or the inability of the insured to work on a full-time basis. It is typical for disability income policies to make a provision for partial disability whether it is incorporated into the policy or added as a rider to the policy. Some policies may require that the insured originally suffer a total disability and then recover to the extent that he/she is partially disabled. The insured who is partially disabled can then return to work and perform some of the duties of his/her occupation or return to work on a part time basis. This shortens the length of time for total disability payments and protects the insured as he/she feels able to return to work knowing that all disability income benefits will not cease. A partial disability benefit normally pays 50% of the full disability income benefit.

Residual Disability

Some policies provide for residual disability benefits. An insured may be able to return to work, but due to the disability he/she cannot earn as much as prior to suffering the disability. A residual disability benefit is based on the percentage of income that the insured has lost due to the disability. For instance, an insured was receiving $1,000 a month disability payment due to a total disability. Eventually this insured recovered to the extent that working part time was possible, but the insured was now receiving $500 a month for the part-time work. The insured would receive $500 a month from the disability policy due to the residual disability. This benefit payment would be adjusted downward monthly to reflect any increase in earned income.

Recurrent Disability

A disability sometimes may appear to be over, but the disability recurs later due to the original sickness or accident. If the reoccurrence happens within 90 days to six months (whatever the time stipulated in the policy) after the insured has returned to work, it would be considered a recurrent disability (a continuation of the first disability). The recurrent disability would not require a new elimination period.

If the policy stipulated reoccurrence had to take place within six months and the insured had returned to work for seven months before suffering an additional disability, the second disability would be considered a new disability with a new elimination period.

Delayed Disability

A person could suffer an accident and have a delayed disability. At first the injury did not seem severe, but after awhile the individual became totally disabled. Most policies will pay disability income benefits to the insured if the disability occurs within a specified amount of time such as 20, 30, 60, or 90 days.

POLICY PROVISIONS

Probationary Period

The probationary period is the time that must elapse after the effective date of a policy before benefits are payable. The probationary period ranges from 15 to 30 days. The reason for the probationary period is to avoid adverse selection for the insurer by excluding pre-existing sicknesses from coverage. The probationary period only applies to sickness and does not apply to accident. A person could be aware of a potential sickness disability, but an accident disability cannot be anticipated or predicted.

Elimination Period

The elimination period is a waiting period after an insured suffers a covered disability until benefits become payable. It can be thought of as a deductible in time. In some disability income contracts, the elimination period may apply only to disabilities caused by an illness and not to disabilities caused by an accident.

Elimination periods range from 30 days to one year. An insured will need to determine how long he/she can go without an income. The longer the elimination period, the lower the premium.

Benefit Period

The amount of time for which benefits will be paid is the benefit period. Benefit periods can range from one year to age 65. The longer the benefit period, the higher the premium.

A short-term disability income policy typically pays benefits for six months. If a policy pays benefits for two years or longer, it is normally considered long term. A long-term policy may pay benefits to age 65 for illness and for life for disabilities due to injury. Most short-term policies cover non-occupational disabilities. Most long-term policies cover both occupational and non-occupational sickness and injuries. Occupational benefits will be reduced by any benefit amounts received through other sources such as workers compensation and Social Security.

EXCLUSIONS

Common exclusions in disability income policies include losses arising from war and military service, attempted suicide, overseas residence, piloting a private plane or being a crew member in a private plane, and injury sustained while committing a felony.

OPTIONAL DISABILITY POLICY RIDERS AND BENEFITS

Rehabilitation Benefit

If a disability income policy contains a rehabilitation benefit, it will provide coverage for physical therapy and vocational training besides paying disability income.

Waiver of Premium Rider

The waiver of premium rider allows the insured to waive premium during a period of total disability. The insured will have to be disabled for a time specified in the policy, normally three to six months. Most insurance companies will return any premium paid during the waiting period to the insured if the disability extends beyond the waiting period.

The waiver of premium rider normally ends upon the insured reaching a certain age, such as 60 or 65. The additional premium charged for the rider ends when the rider terminates.

The waiver of premium rider usually is included in policies that are guaranteed renewable or non-cancelable.

Return of Premium Rider

The return of premium rider actually refunds premium to the insured if he/she is not disabled. It may refund all the premiums paid if there are no claims or it may refund a portion of premium if claim costs do not exceed a specified percentage of the premiums paid.

This is a costly rider. If the insured should become disabled, he/she would receive the exact same benefits under the disability income policy. The insured would have paid a lot of additional premium for benefits he/she would not receive.

Cost of Living Adjustment Rider

The cost of living adjustment rider helps the insured keep up with inflation. Normally the benefit amount will be adjusted to changes in the Consumer Price Index. The insured's monthly benefit will be adjusted annually while receiving benefits.

When the disability ceases, the insured has the right to decide to maintain the policy at the new increased benefit amount and pay a higher premium, or the insured may decide to allow the policy to return to its original amount and keep the same lower premium.

Guaranteed Insurability Rider (Automatic Increase Option)

The guaranteed insurability rider (guaranteed purchase option) allows the insured to purchase additional amounts of disability income coverage at specified intervals until obtaining a certain age (e.g. 50) without proof of insurability. The rate charged for the additional coverage will be based on the insured's attained age at the time of the additional purchase. The insurance company will require the insured to show proof of increased income to purchase the additional disability income in order to avoid overinsurance.

Social Insurance Supplement Rider

The social insurance supplement rider or Social Security rider provides additional income payments to an insured when his/her social insurance benefits have not started, have been denied, or are being paid at a lesser benefit than anticipated. The benefits expected by the insured must be reasonable and reflect his/her earning level. The insured must apply for social benefits. When these benefits are received, the social insurance supplement rider will pay the difference between the expected benefit stated in the policy and the actual benefit paid.

Social insurance benefits include those received from workers compensation, Social security disability, and any local or state program.

Accidental Death and Dismemberment (AD&D)

The accidental death and dismemberment rider pays a death benefit if the insured dies as a result of an accidental bodily injury. The insured should designate a beneficiary to receive this amount referred to as the *principal sum*. If the insured suffers a dismemberment, he/she will receive a payment (called the *capital sum*) according to a schedule in the policy. This lump sum payment for dismemberment can be used for rehabilitation and training for a job for which the insured is suited.

Hospital Confinement Rider

Disability income policies have an elimination period. However, the hospital confinement rider pays the regular total disability benefit to the insured while confined to the hospital during the elimination period. The benefit is paid only as long as the insured is hospitalized. If the insured had a disability income policy with a 30-day elimination period that paid $1,500 a month and he/she were hospitalized for three days, the rider would pay 3/30 or 1/10 of the monthly benefit or $150.

BUSINESS USES OF DISABILITY INSURANCE

Key Person Disability

Key person disability insurance will replace income lost due to disability of a key employee. A key employee is a person essential to the smooth running of a business. The benefit from the key person disability insurance can be in the form of salary continuation. In other words, the benefit is paid directly to the disabled key employee. The business will free up money in this way allowing it to replace and train a new employee.

Key person disability insurance can pay the benefit directly to the business. The funds from the policy help to protect the company should it suffer a loss of income due to losing a key employee.

Disability Buy-Sell

Business partners may wish to purchase disability insurance to fund a buy-sell agreement. Should a partner become disabled, the disabled partner might want to dispose of his/her interest in the business. If the remaining partners cannot afford to buy out the disabled partner's interest, the business may have to be liquidated. A disability buy-sell insurance policy will provide the needed funds to buy out the disabled partner.

Business Overhead Expense (BOE)

Business overhead expense is a policy sold to business owners to cover routine overhead and wages if a business owner becomes disabled. Such a policy is not meant to cover costs such as new inventory and capital goods. It is meant to keep the business afloat until the recovery of the business owner.

Reducing Term Disability

A business might have long-term financial commitments that require regular payments. If a business owner or key employee were to be disabled, the business might experience a loss of revenue making these financial obligations difficult to meet. To cover decreasing financial obligations, decreasing term insurance can be used. The amount of insurance decreases as the loan amount decreases.

GOVERNMENT DISABILITY PROGRAMS

The federal Family and Medical Leave Act (FMLA) and California's Family Rights Act (CFRA) entitles eligible employees working for covered employers to take unpaid, job-protected leave for up to 12 workweeks in a 12 month period. The leave may be taken for the birth, adoption, or foster placement of a new child, to care for a seriously ill child, parent, or spouse, or for the employee's own serious health problem.

California's Paid Family Leave is a component of the state's unemployment compensation disability insurance program (SDI) and is funded through employee contributions. It provides up to six weeks of wage replacement benefits in a 12-month period. SDI also provides benefits for workers who need time off due to their own non-work-related injuries, illnesses, or conditions, including pregnancy. A new mother can apply for Paid Family Leave insurance benefits as soon as she recovers from the pregnancy-related disability and is no longer in receipt of State Disability Insurance benefits.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

Accidental death and dismemberment insurance (AD&D) is a limited policy as it only pays for death due to an accident and not from natural causes. An accident is an unexpected and unforeseen event that generally results in an injury. AD&D also pays a benefit to the insured for a dismemberment. Dismemberment has to do with loss of sight or limb. Loss of limb means the severance of a limb at or above a major joint by which the limb is attached to the body. Loss of an arm would be severance at or above the elbow or shoulder. Loss of sight means the complete and permanent loss of sight. The eye does not have to be removed. Typically any medical expenses are not included in AD&D policies although some may pay a medical reimbursement benefit up to a stated amount.

Capital Sum/Principal sum

The benefit amount paid to the insured for dismemberment is called the **capital sum**. Policies will state the benefit amount to be paid for different types of dismemberment. Generally, the full capital sum will be paid if the insured suffers a double loss such as both arms or an arm and sight in one eye. Lesser benefit amounts may be paid for a single loss such as one arm. Some AD&D policies will pay the full capital sum for complete and permanent loss of hearing.

The amount paid for accidental death is referred to as the **principal sum**. The policyowner should name a beneficiary to receive the death benefit. As in life insurance policies,

the policyowner may name one or more primary beneficiaries, contingent beneficiaries, and tertiary beneficiaries.

Some accidental death and dismemberment policies pay double, triple, or quadruple the principal sum if the insured dies due to specific circumstances. If a policy pays double the face amount, it is called double indemnity. If the policy pays three times the face amount, it is referred to as triple indemnity.

Time Limits

An insured might not die immediately as the result of an accident. Most policies state that the death must occur within 90 days of the accident for the benefits to be paid. Some companies pay benefits after the 90-day period has ended if the insured suffers a total and continuous disability from the date of the accident. An insured might fall off a ladder, strike his head, and end up in the hospital in a coma. He might not regain consciousness and subsequently die. If the policy contained the total and continuous wording, the death benefit would be paid.

Accidental Means vs. Accidental Results

An accidental death and dismemberment policy makes a distinction between injuries caused by accidental means and those due to accidental results. If a policy uses accidental means, both the cause and the result must be unintentional. Most policies use the accidental results definition that states only the resulting injury must be unintentional. If a roofer jumps off a ladder and is injured, it would not meet the definition of accidental means as the roofer deliberately jumped off the ladder. However, the roofer would be covered under a policy using the accidental results definition—the resulting injury was unintentional.

Other Types of AD&D

AD&D can be purchased by an individual as a single policy or as part of a disability income policy. It is frequently utilized in group life and health insurance and pays whether the injury is occupational or non-occupational.

A *limited risk* policy states a specific risk that will be covered by the policy for death or dismemberment. Travel accident insurance is a limited risk policy as it only covers travel accidents that occur within a specified period of time.

A *special risk* policy covers unusual risks. A ballet dancer might wish to insure her legs. This would not be a covered risk under accident and health policies, but it could be covered under a special risk policy.

HEALTH INSURANCE POLICY PROVISIONS

UNIFORM POLICY PROVISIONS

The National Association of Insurance Commissioners developed the Uniform Individual Accident and Sickness Policy Provision Law. All states have adopted this law in principle but most states have modified the law to some extent. The purpose of the law was to make for a certain degree of uniformity of all individual health insurance contracts. Insurance companies are not required to use the exact wording of the uniform policy provisions. They are allowed to reword the provisions as long as the wording is not less favorable to insureds.

There are 12 mandatory provisions and 11 optional provisions. This chapter will summarize these provisions.

TWELVE MANDATORY PROVISIONS

Provision #1: The Entire Contract

The policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. Therefore, the entire contract is the policy, the application, and any riders or endorsements. Nothing can be incorporated by reference. No change in the policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed or attached to the policy. No agent has authority to change the policy or to waive any of its provisions.

Provision #2: Time Limit on Certain Defenses

There are two paragraphs in this provision having to do with the incontestability of a health policy after it has been in effect a certain period of time, usually two years.

Paragraph A states that after two years from the date of issue of the policy, no misstatements, except fraudulent misstatements, made by the applicant in the application for the policy shall be used to void the policy or to deny a claim for loss incurred or disability commencing after the expiration of such two-year period. Fraudulent statements on a health insurance application are grounds to contest the policy at any time. However, if the policy is guaranteed renewable, it cannot be contested for any reason after the contestable period expires.

Paragraph B states that no claim for loss incurred or disability commencing after two years from the date of issue of the policy shall be reduced or denied on the grounds that a disease or physical condition, not excluded from coverage by name or specific description effective on the date of loss, had existed prior to the effective date of coverage of the policy. In other words, the insurance company cannot deny a claim or reduce benefits on the basis of a preexisting condition after the expiration of a two-year period unless the preexisting condition is specifically excluded in the policy.

Provision #3: Grace Period—7, 10, or 31 Days

The **grace period varies according to premium payment frequency**. The grace periods are as follows:

Weekly-premium policies-----7 days
Monthly-premium policies---10 days
All other policies----------31 days
(quarterly, semi-annual,
and annual payments)

The policy is in force during the grace period and claims submitted during the grace period will be covered.

If a policy contains a cancellation provision, the grace period is subject to the cancellation provision. If the company is not going to renew the policy, it must give not less than

five days written notice prior to the premium due date to the insured of the company's intent not to renew the policy beyond the period for which the premium has been accepted.

Provision #4: Reinstatement

If the premium on the health policy is not paid by the end of the grace period, the policy will lapse and coverage will terminate. If the insurer or its agent accepts the delinquent payment and no reinstatement application is required, the policy is reinstated automatically upon receipt of the premium due. If the insurer requires an application for reinstatement and issues a conditional receipt for the premium paid, the policy will be reinstated upon approval of such application by the insurer or, lacking such approval, upon the 45th day following the date of such conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of the application.

Once a policy is reinstated, there is a 10-day waiting period for sickness coverage. There is no waiting period for accident coverage.

Provision #5: Notice of Claim

Written notice of claim must be given to the insurer within 20 days after occurrence or commencement of any loss covered by the policy or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured to the insurer or its authorized agent shall be deemed notice to the insurer.

If the insured suffers loss of time on account of disability for which indemnity may be payable for at least two years, the insured shall give notice to the insurer once every six months of the continuance of the disability except in the case of legal incapacity.

Provision #6: Claim Forms

The insurer, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proof of loss. If such forms are not furnished within 15 days after giving notice of loss, the claimant shall be deemed to have complied with the requirements as to proof of loss upon submitting written proof covering the occurrence and the character and extent of the loss.

Provision #7: Proof of Loss

Written proof of loss must be furnished to the insurer within 90 days after the date of loss or after the insurer becomes liable for periodic payments (disability income benefits). Failure to furnish proof within 90 days shall not invalidate nor reduce any claim if it was not reasonably possible to give such proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

Provision #8: Time of Payment of Claims

With the exception of claims involving periodic payments over time, the insurer must make payment immediately after receiving notification and proof of loss. Payments on disability income policies must be made at least monthly.

Provision #9: Payment of Claims

The payment of claims provision states how and to whom payments are to be made. Indemnity for loss of life is payable to the beneficiary designated. If there is no beneficiary, the payment will be made to the estate of the insured. Any other accrued indemnities unpaid at the insured's death may, at the option of the insurer, be paid either to the beneficiary or to the estate. All other indemnities are payable to the insured.

This provision has two optional paragraphs. The first paragraph, called the *facility of payment* clause, allows the insurer to pay up to $1,000 in benefits to a relative or individual who is considered to be equitably entitled to payment. The second paragraph allows the insured to have medical benefits paid directly (assigned) to the provider of care.

Provision #10: Physical Exam and Autopsy

The insurer at its own expense shall have the right to examine the insured at reasonable intervals during the period of a claim. The insurer may pay to have an autopsy performed to determine the exact cause of death where it is not forbidden by law.

Provision #11: Legal Actions

This provision sets the time limit for bringing suit against the insurer. No action at law can be brought to recover on the policy prior to the expiration of 60 days after written proof of loss has been furnished. This gives the insurer time to investigate a claim and determine its validity.

No suit can be brought after the expiration of three years after the time written proof of loss is required to be furnished.

Provision #12: Change of Beneficiary

This provision applies to health or disability policies that include a death benefit. Unless the insured makes an irrevocable beneficiary designation, the right to change beneficiaries is up to the insured. The consent of the beneficiaries will not be requisite to surrender or assignment of the policy or to change beneficiary designations.

ELEVEN OPTIONAL PROVISIONS

The following eleven optional provisions may or may not be included in a policy. Insurers may use any of them that they choose. However, provision #3 (Other Insurance in This Insurer), provisions #4 (Insurance with Other Insurer), and provision #5 (Insurance with Other Insurers) are rarely used as they deal with overinsurance but have proved to be ineffective.

Provision #1: Change of Occupation

This provision is included in many disability income policies as the risk involved in an occupation affects the chances of an insured being disabled. The change of occupation provision states the changes that may be made to premium rates or benefits payable if an insured changes occupations. If an insured changes to a more hazardous occupation, the insurer will reduce benefits to whatever the premium would have purchased at the higher risk occupation. If the insured changes to an occupation classified by the insurer as less hazardous, the insurer will reduce the premium rate accordingly and will return the excess pro rata unearned premium from the date of change of occupation or from the policy anniversary date immediately preceding receipt of such proof, whichever is the more recent.

Provision #2: Misstatement of Age

If the age of the insured has been misstated, all amounts payable shall be adjusted to the amount the premium paid would have purchased at the correct age. It makes no difference whether the misstatement was intentional or unintentional. The insurer will adjust benefits based on the correct information.

If an insured understated his/her age, the insured was paying too low a premium and benefits paid would be reduced. If an insured overstated his/her age, the insured was paying too high a premium and the insurer could increase the benefit amounts.

Provision #3: Other Insurance in This Insurer

If an insured has more than one policy of a similar type with an insurance company, the insurer can limit the amount of benefits that will be paid under all contracts. Any insurance over the specified amount is considered to be void and the insurer will return the premium paid for these benefits to the insured or the insured's estate.

Another way an insurer can handle such a situation is to limit coverage to one policy selected by the insured, the beneficiary, or the administrator of the insured's estate. The premium for all the other policies will be refunded.

Provision #4: Insurance with Other Insurer

If an insured has coverage with another insurer providing benefits for the same loss on an expense-incurred basis, the amount payable will be prorated in cases where the company accepted the risk without being made aware of the other existing coverage. Any excess premium will be refunded to the policyowner.

Provision #5: Insurance With Other Insurers

If the insured has coverage with other insurers providing benefits for the same loss on other than a expense-incurred basis, the liability of the company will be for such proportion of the indemnities of which the insurer had notice that bear to the total amount of all indemnities. Any excess premium will be returned to the policyowner.

Provision #6: Relation of Earning to Insurance

If an insured has several disability income policies and the benefits from all policies exceed the insured's monthly earnings at the time of disability or the average monthly earnings for the two preceding years, the insurer is liable only for a proportionate amount of benefits as the insured's earnings bear to the total benefit under all contracts.

The monthly benefit amount cannot be reduced to less than $200 or the sum of the monthly benefits specified in the coverages, whichever is less.

Provision #7: Unpaid Premium

Upon the payment of a claim under the policy, any premium due and unpaid may be deducted from the sum payable to the insured or beneficiary.

Provision #8: Cancellation

The insurer may cancel the policy at any time by giving five days written notice to the insured. After the policy has been continued beyond its original term, the insured may cancel at any time by written notice to the insurer with the cancellation effective upon receipt of notice or at a later date as specified in the notice. Cancellation of a policy shall not effect any pending claim.

A policy cancelled by the insurer will be cancelled on a pro rata basis—all unearned premium will be returned to the policyowner. If the insured cancels a policy, it will be cancelled on a short rate basis—unearned premium minus company expenses will be returned to the policyowner.

Provision #9: Conformity with State Statutes

Any provision of the policy which, on its effective date, is in conflict with the statutes of the state where the insured resides will be amended to conform to the minimum requirements of state statutes.

Provision #10: Illegal Occupations

The insurer shall not be liable for any loss that was caused by the insured's commission of or attempt to commit a felony. The insurer also is not liable for a loss caused by the insured's being engaged in an illegal occupation.

Provision #11: Narcotics

The insurer shall not be liable for any loss sustained by the insured while under the influence of alcohol or narcotics. An exception to this rule involves an insured taking narcotics under the advice of a physician.

OTHER HEALTH INSURANCE PROVISIONS

Policy Face

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

Insuring Clause

The insuring clause essentially is the insurer's promise to pay benefits under the conditions stipulated in the contract. It identifies the insurer and the insured and states the type of loss covered by the contract.

Consideration Clause

Legal contracts require consideration. In health insurance, the insurer agrees to provide the benefits stated in the contract. The consideration given by the insured is premium payment and the statements made in the application. A copy of the application will be attached to the policy. The consideration clause will state the amount and frequency of premium payment.

If the applicant submits a signed application without premium payment to the insurer, the policy lacks consideration and is not a valid contract.

Free-Look Provision

When a policy is delivered to the insured, he/she has the right to look over the policy and decide whether or not to keep it. The free look is 10 days. However, seniors have a 30-day free look. If the policy is not wanted for any reason, the policy may be returned for a full refund of premium. If the policy is returned during the specified period, the insurer is not liable for any claim originating during the free-look period.

Renewability Provisions

Health policies have to be renewed periodically. The policyowner always has the right to cancel a policy or allow it to lapse by failing to make premium payments. If a policyowner wishes to cancel a policy during the policy term, he/she is entitled to receive the unearned premiums. The policyholder pays in advance for insurance coverage, but the insurer does not earn the premium until coverage is provided. If an individual paid the annual premium for 12-months coverage and cancelled the policy after three months, he/she would be entitled to receive the premium paid in advance for the nine months for which no coverage will be provided. When the policyholder cancels the policy, the insurer returns the unearned premium on a short rate basis. The insurer deducts an amount to cover its expenses and returns the remainder to the insured. When a company cancels a policy, it will return all of the unearned premium to the insured which is referred to as a pro rata cancellation.

Whether an insurer may refuse to renew a policy depends upon the renewability provision in the policy. The more favorable the renewability provision is to the insured, the higher the premium. The less favorable the renewability provision is to the insured, the lower the premium. The renewability provisions can be classified into five types.

1. Cancelable

A cancelable policy can be canceled by the insurer at any time by giving written notice to the insured. Any premiums paid in advance must be refunded to the policyowner. If an insurer cancels a policy in the midst of a claim, the company is responsible for the claim. A cancelable policy allows the insurer to increase premiums.

. 2. Optionally Renewable

In an optionally renewable policy, the insurer has the option to renew or not renew for any reason. The insurer also may terminate the policy on any premium due date or anniversary date of the policy. If the insurer chooses to renew, the premium may be increased for a class of insureds.

3. Conditionally Renewable

In a conditionally renewable policy, the insurer may terminate coverage but only for specific conditions stated in the policy. These reasons cannot be based on the insured's health. Some reasons could be loss of employment or reaching a certain age. Premiums may be increased on the policy's anniversary date for an entire class.

4. Guaranteed Renewable

The insured is guaranteed the **right to renew** this policy at each renewal date until reaching a certain age (e.g. 65). The insurer cannot change the terms of this contract, but the insurer **may change the premiums** for an entire class of insureds.

5. Non-cancelable

A non-cancelable (noncan) policy **cannot be canceled** for any reason other than non-payment of premium. **Premium rates cannot be changed** either. The rates are specified in the policy. Noncancelable policies normally can be renewed until age 65. This type of provision commonly is found in disability income policies.

Conversion Privilege for Dependents

When dependents are covered under a family policy, they have certain rights of conversion when they are no longer eligible under the family plan. Dependents include the insured's spouse, insured's children, insured's dependent parents, and anyone else for whom dependency can be established. Eligibility can end due to death, divorce, or a child reaching a certain age. Children are not eligible after age 19 or after age 23 unless a full-time student. Some companies are raising the age for full-time students. These dependents have the right to convert to an individual plan without evidence of insurability as long as the conversion is done within 31 days.

Benefit Payment Clause

The benefit payment clause defines the type of benefits provided by the contract and under what circumstances they will be paid. Contained in this clause are specific benefit amounts, the elimination period, and the duration of benefits.

There are certain minimum mandated benefits that are required by state law to be included in certain types of policies. These mandated benefits normally apply to individual and group health policies written on an expense-incurred basis and to service plans such as Blue Cross and Blue Shield. Coverage for newborn children and coverage for emotional, mental, and nervous disorders are examples of these mandated benefits. There are some benefits that must

be provided as optional coverages including obstetrical services and treatment for alcohol and drug dependency.

Exclusions

Exclusions are provisions in insurance policies that state what will not be covered under the contract. Common exclusions in health policies include:

- War and acts of war
- Self-inflicted injuries
- Aviation as a pilot
- Military service
- Overseas residence
- Foreign travel
- Committing or attempting to commit a felony

Pre-existing Conditions

A pre-existing condition is a condition for which the insured was treated or sought advice within a stipulated time period before making application for an insurance policy. A pre-existing condition can be excluded from coverage. Depending on the pre-existing condition the insurer may:

- Decline coverage
- Use an impairment rider excluding a specific condition
- Temporarily exclude the condition
- Rate the insured as a substandard risk

A pre-existing condition disclosed on the application form may be covered. The insurer can review the medical information and decide to either cover the condition or exclude it.

Non-occupational Coverage

A non-occupational policy will cover the insured only while not working (such as covering an injury at home). Any losses due to an occupational cause will not be covered. Injuries due to work will be covered under workers compensation insurance.

An occupational policy will cover losses due to work or due to any other type of loss.

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.

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)

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 to 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. 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 than 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. A new policy might exclude coverage for pre-existing conditions or there might be a new waiting period established. Another thing to consider is that the new policy might have a new contestable period.

If either a group or individual policy is replaced, any ongoing claims must be covered under the new contract. Consequently, this overrides any exclusion regarding pre-existing conditions. This legislation is referred to as **no-loss-no gain**.

GROUP HEALTH INSURANCE

Whereas the greatest amount of life insurance is individual policies, most people in the U.S. have health coverage through a group policy. In an individual policy the contract is between the insurer and the policyowner, but in group insurance the insurance contract is between the insurer and the sponsoring organization. Some sponsors for group insurance include employers, trade associations, labor unions, multiple employer groups, creditor-debtor groups, and lodges. For an association to obtain group insurance, it must be a natural group and have been in existence a certain period of time, usually two years.

In group insurance the sponsor is issued a **master policy.** Individuals covered under the group policy do not receive a copy of the master policy but receive a **certificate of insurance** and an outline describing benefits. The master policyholder is responsible for applying for the coverage and providing information to the insurer about the group. The master policyholder owns the policy and is responsible for making the premium payment to the insurer.

In general, benefits provided under group contracts are more extensive and have higher benefit maximums than do individual policies. The cost for insuring someone under a group plan is less than insuring a person under an individual policy due to decreased administrative and selling expenses. Group insurance provides benefits to people who might not be able to afford the coverage on their own. Dependents may be covered under a group health policy.

There is no individual selection as to coverage under a group health policy. Benefits are predetermined by the employer in conjunction with the insurer.

ELIGIBILITY

For a group policy to be issued, the group must be formed for some reason other than to purchase insurance. This is referred to as a natural group. For instance, an employer-employee group is not formed for the purpose of obtaining insurance and, therefore, is a natural group. A "true group" is defined as one that has at least 10 members. However, California recognizes a group as having two or more members.

In group insurance the normal practice is to cover all eligible persons regardless of age or physical condition. Individuals covered under the group policy must meet certain eligibility requirements to participate in the plan. Frequently these requirements are being a full-time employee and having been employed a specified amount of time such as 90 days.

The period of time an employee must work for an employer before being covered under the group insurance is called the **probationary period**. The probationary period in a group health policy is intended for people who join the group after the policy effective date. The period of time in which to sign up for the group coverage is referred to as the **eligibility** period—normally a 31-day period after the probationary period has ended. An employee, who tries to join the group plan after the eligibility period has expired, may be subject to some individual underwriting.

CONTRIBUTORY AND NON-CONTRIBUTORY PLANS

If the employer pays the entire premium for the policy, the plan is called **non-contributory** as the employee contributes nothing. In a **contributory** plan, both the employer and employee contribute to the premium payment. In non-contributory policies, the employer must cover **100%** of eligible employees. Contributory plans require **75%** participation in order to avoid adverse selection for the insurer.

The cost of insurance paid by an employer for employee benefits is a deductible business expense on income tax returns.

UNDERWRITING CHARACTERISTICS

In group underwriting, the underwriter focuses on the group as a whole. The underwriter is concerned with the group's risk profile. There normally is no medical information asked of the plan participants. In a small group there is a much greater chance for adverse selection. One bad risk in a small group could have a great impact on claims experience. Due to this, insurers engage to some degree in individual underwriting with small groups. In this way the premium charged for coverage can be adjusted to the possible loss exposure.

An underwriter will consider a number of things when underwriting a group policy. The underwriter will take into consideration: carrier history (how often has the employer changed insurance carriers); the stability of the group; prior claims experience of the group; size and composition of the group (age and sex of group members); type of business or industry in which the group is engaged; zip code (cost of care varies in different geographical areas); and length of waiting period for loss of time benefits.

Group policies normally contain a provision excluding pre-existing conditions. This commonly is defined as a condition for which the member received treatment during the three months prior to the effective date of the group coverage. Group policies will state when a condition will no longer be regarded as pre-existing (i.e. not having received treatment for the condition for a three-month period).

CONVERSION PRIVILEGE

Group health plans providing medical expense coverage contain a conversion privilege for individuals who wish to convert their group coverage to an individual policy with the same insurer when they leave their employment. The conversion must be exercised during a 31-day period. During this conversion period, the individual still is covered under the group policy whether or not ultimately exercising the conversion privilege.

Although the individual may not be turned down for insurance coverage, the insurer is allowed to evaluate the person in order to establish an appropriate premium payment. The insurer could rate the person as either a standard or substandard risk.

POLICY REPLACEMENT:

Group Life and Disability: The provisions of this article apply to all policies of group life insurance, to all group disability policies, to any group nonprofit hospital service contract, and to any self-insured welfare benefit plan issued in this state (CIC 10128).

Definitions (CIC 10128.1)

"Carrier" means the insurance company, nonprofit hospital service corporation, or other entity responsible for the payment of benefits or provision of services under a policy.

"Dependent" shall have the meaning set forth in the policy.

"Discontinuance" shall mean the termination of a policy or the termination of coverage between an entire employer unit under a group disability policy, group nonprofit hospital service contract, or self-insured welfare benefit plan, and does not refer to the termination of any agreement between any individual member under a contract and the disability insurer, nonprofit hospital service contract or self-insured welfare benefit plan.

"Employee" means all agents, employees, and member of unions or associations to whom benefits are provided under a policy.

"Extension of benefits" means the continuation of coverage under a particular benefit provided under a policy following discontinuance with respect to an employee or dependent who is totally disabled on the date of discontinuance.
"Policy" means any group insurance policy, group hospital service contract or other plan, contract or policy subject to the provisions of this article.

"Policyholder" means the entity to which a policy or contract is issued.
"Premium" means the consideration payable to the carrier.

"Replacement coverage" means the benefits provided by a succeeding carrier.

"Totally disabled" shall have the meaning set forth in a policy.

Extension of benefits

A group policy which provides life insurance, loss of time benefits, or hospital, medical or surgical expense benefits must extend the benefits for a reasonable time after the policy is discontinued for any employees who are totally disabled when the policy was discontinued and who became totally disabled while insured under the group policy. (CIC 10128.2)

When discontinued, a group policy with both life insurance and disability benefits is considered to provide a reasonable extension of benefits if:

1. The discontinuance does not affect the disability benefit.
2. The rights of conversion apply to the amount for which the person is insured when the disability benefit ends except if that benefit is a payment of income for a specified period. Then the conversion rights apply only to any amount of insurance remaining after the income is paid.
3. The insured may convert any life insurance to which no disability benefit provision applies to an individual life policy. (CIC 10128.2.b)

A policy providing benefits for loss of time or a specific indemnity during hospital confinement is deemed to have a reasonable extension if the discontinuance does not affect the benefit provided. A policy which provides hospital, medical, or surgical benefits on an expense-incurred or service basis must extend benefits for any condition causing total disability existing at the time of discontinuance for at least 12 months after discontinuance. Any extension of benefits may be terminated when the covered employee is no longer disabled or when a succeeding carrier provides coverage without limitation to the disabling condition. (CIC 10128.2 c-d)

Level of Benefits

A carrier providing replacement coverage for hospital, medical, or surgical benefits on an expense-incurred or service basis within 60 days after the prior group policy is discontinued must cover all employees and dependents who were insured under the prior policy when it was discontinued as long as they were eligible for coverage under the previous policy. A replacement carrier does not have to provide benefits for the conditions that caused an employee or dependent to be totally disabled. (CIC 10128.3.a)

The level of benefits provided by replacement coverage cannot be lower than the benefits provided under the prior policy, minus the amount of benefits paid by the prior carrier. Benefits for an employee or dependent under a replacement policy cannot be reduced or excluded because of preexisting conditions unless they would have been excluded or reduced as preexisting conditions under the prior group policy. (CIC 10128.3.b)

A prior carrier must make available to a succeeding carrier a statement of benefits so the succeeding carrier can verify benefits to be paid. A succeeding carrier may not exclude coverage on a dependent child who was covered by a prior carrier because of the fact the insured employee does not provide primary support for the child. (CIC 10128.3.d-e)

If an employee or dependent fraudulently fails to tell a succeeding insurer about a preexisting condition, the insurer can deny benefits for the individual. However, the other employees or members of the group cannot be penalized. (CIC 10128.2.f)

All policies subject to the foregoing provisions will be construed to be in compliance with the California insurance code. (CIC 10128.4)

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

HIPAA was enacted in 1996 and affects almost all healthcare providers. This law defines that the information in client files belongs to the client and must be protected. HIPAA has made sweeping changes in the way that medical information is handled and protected.

HIPAA, in general, is designed to make health coverage more portable for individuals who change jobs or health plans by limiting the coverage exclusions that can be imposed when such a change occurs. Employers who provide health insurance for their employees are required to offer full health care coverage immediately to newly hired employees if they previously had "creditable" coverage for 12 straight months with no lapse in coverage of 63 days or more. If an individual did not have creditable coverage, the new insurer can refuse to pay for any pre-existing conditions for 12 months. However, the individual may reduce the exclusion period if he/she had group health plan coverage or health insurance prior to enrolling in the plan. HIPAA allows an individual to reduce the exclusion period by the amount of time that he/she had creditable coverage prior to enrolling in the plan and after any "significant breaks" in coverage. If the enrollee had creditable coverage for the last eight months, there would only be a four-month exclusion period. Late enrollees in group health plans might have to wait up to 18 months for coverage for pre-existing conditions.

When someone leaves a health plan, he/she should get a "certificate of creditable coverage". The certificate should list the following: coverage dates; policy ID number; insurer's name and address; and insured's name as well as any family members included under the coverage. When an entire business changes health insurance carriers, certificates of creditable coverage are not necessary as the new health insurance is issued with full **take-over benefits** for all eligible members enrolled on the date that the new insurance starts. This means all pre-existing conditions are covered immediately by the new insurance policy.

HIPAA's rules apply to every employer group health plan that has at least two participants that are current employees, including companies that are self-insured. The law prohibits group health plans and health insurers from discriminating against individuals with regard to eligibility, premiums, or contributions based on any health status related factor (e.g. a plan may not require an individual to pay a premium greater than do similarly situated individuals enrolled on the basis of any health status related factor). HIPAA's rules provide no protection if a person switches from one individual health plan to another individual health plan.

TYPES OF GROUP COVERAGE

Medical expense, disability income, and accidental death and dismemberment are available on group plans. Medical expense may be group basic medical expense or group major medical expense. The **basic medical expense** policy could be one of three types: hospital, surgical, and physician's expenses. Other group basic medical expense policies include dental and vision care, prescription drugs, laboratory services, diagnostic x-rays, and home health care. A basic medical expense policy can be limited to one coverage or a combination of several of the foregoing coverages.

Group major medical expense, like individual policies, can be either a comprehensive major medical policy or a supplemental major medical policy. Such contracts will have either an initial deductible, a corridor deductible, or an integrated deductible.

As a result of a 1979 amendment to the Civil Rights Act, group medical expense plans must provide maternity benefits. This amendment requires that groups of more than 15 members must treat pregnancy no differently than any other allowable medical expense. Different waiting periods cannot be required for maternity benefits than any other medical benefit.

A characteristic of group medical expense plans is the **coordination of benefits (COB) provision**. This is an arrangement in health insurance to discourage multiple payments for the same claim under two or more policies. If payment were to be made by several companies, this

could result in overinsurance. Overinsurance is a situation in which the benefits paid to the insured exceed the actual amount of the medical bills. Such a situation could tempt an insured to make false claims in order to profit financially. When two or more group health insurance plans cover the insured and dependents, one plan will be considered the primary plan and the others will be considered secondary plans. Medical expenses not covered under the primary plan could be covered under the secondary plan.

As an example, Theo and Barbara are married and both have insurance through their own jobs and their policies also cover dependents. The primary insurance on Theo is through his own job. The insurance coverage offered by Barbara's job is secondary on Theo. Conversely, Barbara's main coverage is through her job and the coverage offered through Theo's job is secondary. If Theo becomes ill, the medical bills will be submitted to his company's insurer. The secondary insurance through Barbara's company will pay whatever the primary carrier did not pay up to its own limits.

Children could be covered by both parents' insurance. In such cases either the gender rule or the birthday rule could be used to determine the primary insurer. Using the gender rule, the father's plan is the primary carrier. This rule is discriminatory in nature. California uses the **birthday rule** which states that whichever parent's birthday comes first in the year is the primary insurer. If one parent had a February birthday and the other a July birthday, the February birthday falls first in the year and that parent's insurer would be the primary insurer for the children.

Group Disability Income Plans

In group disability income plans, the payment amount normally is based on a percentage of the employee's earnings such as 60%. These plans can be either short-term or long-term disability plans. Short-term plans can have benefit periods of short duration such as six months. Long-term plans can have benefit periods of two years or longer. If an employer were to provide both short-term and long-term disability, the short-term policy would pay first before the long-term policy would pay benefits. Frequently a long-term policy will pay benefits based on the *own occupation* definition of total disability for one or two years and, after that amount of time has elapsed, change to the *any occupation* definition of total disability.

Benefit amounts paid under a group plan usually are considered to be supplemental to workers' compensation benefits. This dovetailing of benefits is to prevent an individual from receiving more than a specified percentage of normal income.

Group Accidental Death and Dismemberment Insurance

Group accidental death and dismemberment (AD&D) insurance frequently is part of the group life insurance coverage offered by the employer. Occasionally it is offered to employees as a separate policy for which the employees pay if they wish the additional coverage.

AD&D policies pay an additional sum if the employee dies as the result of an accident. This sum is referred to as the principal sum. If the employee suffers a dismemberment (loss of limb or sight in an eye), the policy pays a capital sum.

OTHER GROUP PLANS

Multiple Employer Trusts (METs)

A multiple employer trust provides benefits to employees of two or more financially unrelated companies. The companies may employ workers from the same labor union or those

in the same industry. Employer contributions go into a common pool from which benefits are paid. Employees may transfer between employers in the fund and retain their benefits. METs have been growing as smaller employers band together to provide benefits to employees. These small firms by banding together can lower costs by taking advantage of the economies of large group underwriting.

A third party administrator (TPA) is an outside organization used to administer the managerial and clerical functions related to a multiple employer trust or self-insured employer plan.

Credit Disability

Credit disability (credit health) insurance is designed to provide monthly payments on an outstanding loan should the insured (borrower) suffer a disability due to sickness or accident.

Blanket Health Insurance

Blanket health insurance is written to cover a group of individuals who are exposed to the same risks. The individuals within the group are changing constantly and, therefore, are not named. Examples are an owner of a campground wishing to cover campers and a university wishing to cover its students.

Franchise Health Insurance

Franchise insurance (wholesale insurance) provides insurance to employees of small businesses, associations, and professional organizations. Although franchise insurance covers a group, individual policies are written on each insured person. There is no master contract issued to the sponsoring organization. Premium rates usually are discounted as a number of policies are involved. The tax implications are the same as on other group policies as explained on the next page.

TAXATION OF GROUP HEALTH BENEFITS

An employer may deduct the amount paid for group health insurance as a business expense. The employee is not taxed on these health benefits provided by the employer. Employee contributions made on a contributory plan are not tax deductible for the employee unless un-reimbursed medical expenses exceed 7.5% of the employee's adjusted annual gross income.

The amount an employer pays for group disability income insurance for employees is a tax-deductible business expense. If the employer pays the entire premium for disability income insurance, the employee will be taxed on benefits paid to him/her if the employee becomes disabled. Under a contributory policy, the portion of the benefits for which the employee paid will not be taxed; the portion of the benefits paid for by the employer will be taxable income to the employee.

GOVERNMENT REGULATIONS AFFECTING GROUP POLICIES

COBRA

The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 is a federal statute that applies to employers offering group insurance who have **20 or more employees**. If an employee is terminated for other than gross misconduct, the employee can elect to stay

under the group policy for a period of time. The coverage must be identical to that which the employee had prior to termination. The reason for this law is to provide health care coverage for the employee and dependents until employment or coverage can be obtained elsewhere. This is not the same as the employee exercising the right to convert the group coverage to an individual plan within a 31-day period.

Employers are required to inform individuals of their eligibility for an extension of benefits under COBRA. Notification must be provided when a plan becomes subject to COBRA, an employee is covered by a plan subject to COBRA regulation, and when a qualifying event occurs. Employees have 60 days to elect a continuation of benefits under COBRA or the option is forfeited.

To be eligible for COBRA benefits, the individual must be a qualified beneficiary the day before a qualifying event occurs. Qualified beneficiaries include the covered employee, covered employee's spouse, and covered employee's dependent children.

The following are qualifying events and length of time for extension under COBRA:

- Employment is terminated for other than gross misconduct—18 months (up to 29 months if disabled).
- Reduction in hours worked (resulting in termination from plan)—18 months (up to 29 months if disabled).
- Death of employee—36 months for dependents.
- Dependent child no longer qualifies as a dependent—36 months.
- Employee becomes eligible for Medicare—36 months.
- Divorce or legal separation of employee—36 months for former spouse.

The following are disqualifying events (termination of benefits under COBRA):

- The first day a premium payment is not made on time.
- The date the employer ceases to maintain group health insurance.
- The date the individual becomes eligible for Medicare.
- The first day that an individual is covered under another group plan.

CAL-COBRA

Cal-COBRA is a state law that expands the benefits under COBRA which is a federal law. Cal-COBRA applies to employers having **2 to 19 employees**. If an employee was covered under COBRA for 18 months, he/she may be able to keep health insurance through Cal-COBRA for another 18 months for a total of 36 months coverage. Employees, who are 60 years of age or older when they become eligible for Cal-COBRA and have worked for the employer for at least five years, may continue their coverage even after Cal-COBRA until they turn 65.
This rule also applies to the spouses of such employees.

If the group plan offers specialized plans, such as dental or vision coverage, they must offer them under COBRA. However, they are not required to continue these extra plans when the employee changes to Cal-COBRA.

The American Recovery and Reinvestment Act of 2009 states that former employees who were enrolled in their employer's health plan when they lost their jobs are required to pay only 35% of the cost of COBRA/Cal-COBRA coverage. Employers must treat the 35% payment as full

payment. The employers are entitled to a credit for the other 65% of the COBRA cost on their federal payroll tax return. (Note: Prior to 2009 the terminated employee could be required to pay the premium which could have been up to 102% of the normal premium. The additional 2% was to cover the insurer's administrative expenses.)

OBRA

The Omnibus Budget Reconciliation Act (OBRA) of 1989 extended the minimum COBRA continuation of coverage from 18 to 29 months for qualified beneficiaries who were disabled at the time of termination or reduction in work hours. The termination must not have been for gross misconduct and the disability must meet the Social Security definition of disability.

OBRA allows an employer to terminate COBRA coverage when coverage becomes available under another health plan as long as the other plan does not limit or exclude benefits for a beneficiary's pre-existing conditions.

OBRA also states that COBRA coverage may be terminated only because of Medicare entitlement, not just eligibility. The employer must be certain that the individual has enrolled under Medicare before terminating COBRA coverage of a beneficiary at age 65.

TEFRA

The Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 applies to employers having 20 or more employees. The act was passed to prevent discrimination in group term life insurance plans and to amend the Social Security Act and the Age Discrimination in Employment Act (ADEA).

One goal is to prevent group term life insurance plans from discriminating in favor of key employees. Key employees are those who are officers, the top 10 interest-holders in the business, individuals owning 5% or more of the business, and those owning more than 1% who are compensated $150,000 or more annually. To be non-discriminatory, the plan must benefit at least 70% of all employees or at least 85% of participating employees who are not key employees.

TEFRA amends the Social Security Act to make Medicare secondary to group health insurance plans. It also amends the ADEA by requiring employers to offer employees between the ages of 65 and 69 and their dependents the same coverage available to younger employees.

ERISA

The Employee Retirement Income Security Act (ERISA) of 1974 was intended to bring about equality in pension plans. The act's fiduciary standards benefit plan participants and beneficiaries. This act spells out the contributions that may be made to such plans as well as the benefits they may offer. ERISA requires stringent reporting and disclosure requirements for establishing and maintaining both group health insurance and other qualified plans. Annual financial reports must be filed with the IRS. Plan descriptions must be filed with the Department of Labor.

ADA

The Americans with Disabilities Act (ADA) makes it unlawful for employers with 15 or more employees to discriminate on the basis of disability against a qualified individual with respect to any term, condition, or privilege of employment. Employees with disabilities must be

given whatever health insurance the employer provides. There are certain coverage limitations allowed for mental and nervous disorders, but such limitations must apply to both disabled employees and those who are not disabled.

An employer cannot reject a person for employment on the grounds that one of his/her dependents that would be covered under the group plan has a disability.

This law forbids the exclusion or limitation of benefits for specific disabilities such as AIDS, for specific afflictions such as cancer, and for disability in general.

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.
- **Corridor Deductible**— A health insurance deductible that applies between the basic layer and the major medical layer
- **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.
- **Incontestability**—Code section 10206 (a) The policy shall provide that the validity of the policy shall not be contested, except for nonpayment of premiums, after it has been in force for two years from its date of issue; and that no statement made by any employee insured under the policy relating to his or her insurability shall be used in contesting the validity of the insurance ewith respect to which the statement was made after the insurance ahs been in force prior to the contest for a period of two years during the employee's lifetime nor unless it is contained in a written application signed by the employee.
- **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.
- **Master Policy Owner –** The owner of a group insurance policy that is issued the master policy and is responsible for applying for coverage and providing information to the insurer about the group.
- **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.
- **Pre-existing Condition -** A health or physical condition that existed prior to the effective date of a medical insurance policy. Some health and disability policies contain provisions that preclude coverage for loss arising from preexisting conditions
- **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.

Jurisdiction

Any person or other entity that provides coverage in this state for medical, surgical, chiropractic, physical therapy, speech pathology, audiology, professional mental health, dental, hospital, or optometric expenses, whether the coverage is by direct payment, reimbursement, or otherwise, shall be presumed to be subject to the jurisdiction of the Department of Insurance, unless the person or other entity shows that while providing the services it is subject to the jurisdiction of another agency of this or another state or the federal government.

A person or entity may show that it is subject to the jurisdiction of another agency of this or another state or the federal government by providing to the commissioner the appropriate certificate or license issued by the other governmental agency that permits or qualifies it to provide those services for which it is licensed or certificated.

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.