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Review Notes:

Life and Health Insurance




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REVIEW NOTES: BASIC PRINCIPLES OF LIFE AND HEALTH INSURANCE

The Role of Insurance

- In general terms, **insurance** can be defined as a legal contract that transfers an uncertain risk from one party to another.
- Insurance can also be described as the transfer of risk through the pooling or accumulation of funds because it distributes one person's risk among a large number of people.
- The insured transfers the possibility of suffering a large financial loss to an insurer in return for paying a relatively small, contractually defined premium.
- Insurance helps to reduce the financial uncertainty of the policy owner that could otherwise result from future losses.
- Insurance has become an essential element of any financial planning process.

Benefits and Costs of Insurance to Society

- Insurance policies **indemnify** policyholders.
- To indemnify means to restore a person to the financial position they experienced prior to the insured loss.
- The ability of insurance to eliminate the potential cost of unexpected or untimely losses is arguably its most significant advantage.

Types of Insurance Companies

- There are many ways to classify insurance carriers, including:
  - Where the company was formed
  - How ownership is structured
  - Whether the company is authorized to conduct business in a given state, or
  - Whether the insurer is a commercial carrier or government provider

Private versus Government Insurers

- Private citizens own commercial insurers, which may be proprietary or cooperative.
- Federal and state governments also offer a variety of coverages, commonly referred to as **social insurance**.
- Federal and state-owned government insurers either:
  - Cover catastrophic perils or losses that are not insurable by commercial insurers, or
  - Cover insurable risks in competition with, or instead of, commercial insurers.
- Examples of social insurance programs include:
  - Social Security
  - Original Medicare
  - Medicaid
  - SGLI and VGLI
  - National Flood Insurance Program
  - Federal Crop Insurance Corporation

Private (Commercial) Insurance Companies

- Companies that sell more than one line of insurance are referred to as **multi-line insurers**.
- A company that only sells one line of insurance is a **monoline insurer**.
- Stock and mutual companies are both be considered commercial insurers, and, as such, both can write life, health, property, and casualty insurance.
- Regulators require companies to maintain a certain percentage of surplus revenue as reserves to pay future claims. These funds are referred to as *statutory reserves*.

Stock Companies – Non-Participating

- A **stock insurance company** is one that's owned by private investors (stockholders or shareholders).
- Stock insurers are incorporated under state laws, are structured like any other corporation, and their goal is to make profits for their shareholders.
- Typically, they're publicly traded.
- A portion of the company's profits may be distributed to shareholders as dividends.
- Stock insurers issue **non-participating insurance policies**.
- Non-participating policies don't pay policy dividends.
- Purchasing a non-participating policy does NOT give policy owners any other privileges of ownership.
- Post-tax earnings (**earned surplus**) that are retained by a company are considered equity and are owned by the shareholders.

Mutual Companies – Participating

- **Mutual insurance companies** are also organized under state laws but are owned by the policyholders.
- Policyholders have the right to vote for the board of directors.
- Mutual insurance companies are considered participating insurers because policy owners receive a share of surplus revenue in the form of policy dividends.
- Mutual insurers hold such excess earnings as a **divisible surplus.**
- Mutual insurers return this surplus to their policy owners by paying policy dividends.
- Policy dividends represent a refund of that portion of the premium remaining after a company has set aside the necessary reserves.
- In some cases, a stock company may be converted into a mutual company through a process that's referred to as *mutualization*.

Assessment Mutual Insurers

- Assessment mutual companies are classified by the method in which they charge premiums.
- Pure assessment mutual companies charge no premium in advance; instead, each member is assessed a portion of the losses that occur.
- Advance premium assessment companies charge premiums but levy assessments if the premium is insufficient.

Fraternal Benefit Societies

- Fraternal societies are not-for-profit organizations noted for their social, charitable, and benevolent activities.
- Fraternal membership is based on religion, nationality, or ethnicity.
- Fraternal societies also issue insurance covering their members.
- To be characterized as a fraternal benefit society, the organization must have the following characteristics:
  - It must be non-profit.
  - It must have a lodge system, including ritualistic work and a representative form of government.
  - It must exist for reasons other than obtaining insurance.

Reciprocal Insurers

- A reciprocal insurer is an unincorporated organization in which individual members (also referred to as *subscribers*) agree to insure one another.
- Unlike mutual or stock insurers, reciprocal policyholders don't transfer these risks to a separate corporate entity. Each policyholder individually assumes a share of the risk.
- This arrangement makes the reciprocal insurer a **risk-sharing** mechanism rather than a form of risk transfer.
- Policyholders receive policy dividends as well as their share of the company surplus (capital) if they terminate their membership.
- An attorney-in-fact handles transactions for the reciprocal insurer.

Risk Retention Groups (RRGs)

- A **risk retention group** is a specialized insurance company that's created to provide liability insurance for individuals and entities with a common bond.
- The federal law requires risk retention groups to follow the laws of their home state.
- Risk retention groups are only licensed in their state of domicile. In other jurisdictions, federal law prevails.
- Risk retention groups hold on to risks and process claims

Risk Purchasing Groups (RPGs)

- As with a risk retention group, a risk purchasing group provides insurance for individuals and entities with a common bond.
- RPGs differ from RRGs because they purchase coverage for their members from an insurance company rather than act as the insurer.
- The risk purchasing group becomes a master policyholder, and its members receive certificates of insurance.

Reinsurers and Retention Limits

- Reinsurers insure other insurance companies that seek to limit the loss they would face if a substantial claim became payable.
- The insurance company that transfers its loss exposure (risk) to another insurer is referred to as the **primary insurer** or **ceding company**.
- The portion of the risk that a ceding insurer retains is considered the net retention.

- The insurance company that accepts the risk is the **reinsurer** (also referred to as the **assuming company**).
- There are two types of reinsurance contracts:
  - When two companies arrange for an automatic sharing risk based on specific criteria, it's considered **treaty reinsurance**.
  - When a primary insurer seeks reinsurance for a specific exposure without an ongoing agreement, it's considered **facultative reinsurance**.

Captive Insurers

- A **captive insurer** is established and owned by a parent firm(s) to cover the parent's loss exposure.

Surplus Lines Insurance

- Surplus lines carriers provide types of coverage that are not available through authorized carriers.
- Consumers place the coverage through a surplus lines broker for high, substandard, or unusual risks that are rejected for coverage in the authorized market.

Lloyd's of London

- Lloyd's of London is a syndicate of individuals that individually underwrite insurance but is NOT an insurer.
- Lloyd's function is to provide coverages that may otherwise be unavailable.

Self-Insurers

- A self-insurer establishes a self-funded plan to cover potential losses.
- A self-insurer will often seek an insurance company that will provide insurance above a specified maximum loss level.

Insurer Classifications

Insurers Classified by Authorization

- An insurer with a **certificate of authority** that allows it to do business in a particular state is referred to as an **authorized** or **admitted insurer**.
- Generally, an **unauthorized (non-admitted) insurance** company is not permitted to conduct insurance operations unless it qualifies as a surplus lines carrier.

Insurer Classified According to Domicile

- A **domestic insurer** is organized and incorporated in the state in which it writes business.
  - *For example, if XYZ Insurance Company is incorporated in Wisconsin and writes policies in Wisconsin, it's a domestic company in that state.*
- A **foreign insurer** is authorized in one state but organized and incorporated under a different state's laws.
  - *For example, if XYZ Insurance Company is incorporated in Wisconsin but transacts insurance in Iowa, it acts as a foreign insurance company in Iowa.*

- An **alien insurer** is an insurer that's organized under the laws of a different nation.
  - *For example, Sun Financial Services of Toronto, Canada, is an alien insurer.*

Departments within an Insurance Company

- The **marketing or sales division** is responsible for increasing the number of prospective applicants.
- The **sales department** completes applications and conducts face-to-face appointments with prospective buyers.
- The **underwriting department** reviews applications, conducts investigations, determines whether to issue coverage, and assigns risk classifications.
- The **claims department** investigates, processes, and pays claims.
- The **actuarial department** calculates policy rates, reserves, and dividends.

Key People Within an Insurance Company

Producers

- The term **"Producer"** refers to individuals who are licensed by the state regulatory authority to solicit, sell, or transact the placement of insurance products with the buying public.
- Licensed producers act in a fiduciary capacity on behalf of both their insurers and their clients.
- The various types of producers include:
  - **Agents** represent one or more insurers under the terms of an **appointment** contract.
  - **Brokers** represent themselves and the insureds.
  - **Solicitors** are licensed in some states to represent a producer and solicit prospective applicants to meet and discuss their insurance needs with that producer.
  - **Service Representatives** work in some states under a limited authority.
    - They're insurance company employees in some states that hold a limited license.
    - They don't earn commissions for sales.
    - They're not required to be licensed unless they solicit, countersign policies, or collect premiums from policy owners.

Underwriters

- **Underwriters** identify, assess, examine, and classify the amount of risk represented by an applicant.
- Underwriters approve or decline applications and determine the cost of insurance.

Actuaries

- **Actuaries** calculate policy rates, reserves, and dividends.

Adjusters

- **Adjusters** investigate insurance claims to determine whether they should be settled or denied.
- A **public adjuster** is compensated for acting on behalf of an insured regarding the settlement of an insurance claim.

How Insurance is Sold

- Most consumers purchase insurance through licensed producers who market insurance products and services to the public.
- Typically, these producers are agents who are appointed to represent one or more insurance companies.
- Agents can bind insurance; in other words, they can commit the insurer to cover a risk exposure—at least temporarily.
- Some consumers may work with brokers who work for insureds to place coverage. Brokers are not appointed by the insurer and don't have the authority to bind coverage.
- In a sales transaction, agents represent the insurer, while brokers represent the buyer.

Career Agency System

- A **career agency** is often a branch of a major stock or mutual insurance company.
- A career agency may exist to represent an insurer in a specific geographical area or market.
- A general agent (GA) typically runs a career agency.
- The GA recruits, trains, and supervises career insurance agents.
- The GA has a vested right in any business that's written by those agents who sell for the agency.

Managerial System

- The managerial system is a form of career agency.
- The insurance company hires a salaried branch manager to run the agency.
- The branch manager supervises agents and receives a salary and a bonus based on meeting sales and recruiting goals.

Personal Producing General Agency System

- The **personal producing general agency** (PPGA) system resembles the career agency system, but PPGAs don't recruit, train, or supervise career agents.
- A personal producing general agent focuses on selling insurance in an assigned market or geographic area.
- PPGAs are generally responsible for maintaining their own offices and administrative staff.
- Agents who are hired by a PPGA are considered employees of the PPGA, not the insurer.

Independent Agency System

- The **independent agency** system is not tied to any particular insurance company.
- Independent agents represent any number of insurance companies through contractual agreements.

Other Methods of Selling Insurance

- A large volume of business is also marketed through direct selling and mass marketing methods.
- Insurance companies that use the direct selling method deal directly with consumers.
- Direct sellers use vending machines, advertisements, or salaried sales representatives who are licensed.

- Insurance is also sold through mass marketing techniques, such as over the Internet, newspapers, magazines, radio, and television ads.
- Mass marketing methods provide exposure to many consumers, often using direct selling methods with occasional follow-up by agents.

Evolution of Industry Oversight

- The insurance industry is regulated by a number of authorities, including some within the industry itself.
- The primary purpose of this regulation is to promote public welfare.

Federal Court Cases and Legislation Affecting Insurance Industry Regulation

- In the 1868 case of **Paul v. Virginia,** the United States Supreme Court ruled that the sale and issuance of insurance is not interstate commerce, thereby upholding a state's right to regulate insurance.
- In the 1944 case, the **United States v. Southeastern Underwriters Association (SEUA)**, the United States Supreme Court revisited the issue of state versus federal regulation.
  - The Supreme Court reversed Paul v. Virginia and ruled that the insurance industry is a form of interstate commerce.
  - The Court determined that the federal government should regulate insurance.
- In 1945, Congress passed Public Law 15—the **McCarran-Ferguson Act**. The McCarran-Ferguson Act created the following:
  - It called for the states to continue their regulation of the insurance industry because it was in the public's best interest.
  - It also made possible the application of federal antitrust laws so far as state laws did not regulate such activity.
  - Today, the insurance industry is both state-regulated and in conformity with federal antitrust requirements.
  - Any person who violates the McCarran-Ferguson act faces a fine of $10,000 or up to one year in prison.
- In 1970, the **Fair Credit Reporting Act** was enacted to protect privacy by requiring the fair and accurate reporting of consumer information and for insurers to inform applicants about any investigations being made
  - If insurers deny coverage or charge higher rates due to a consumer report, the applicant must receive the name of the relevant reporting agency.
  - Insurers that fail to comply are liable for actual and punitive damages.
  - The maximum penalty for obtaining consumer reports under false pretenses is a $5,000 fine and up to one year in prison.
- In 1994, Congress amended Sections 1033 and 1034 of the United States Code (USC) regarding **Fraud and False Statements.**
  - It's a criminal offense for felons who are convicted of crimes involving dishonesty or a breach of trust to participate in the insurance business without a "Letter of Written Consent" from their state insurance regulators.
  - The law makes it illegal to lie, falsify, or conceal information from a federal official.
  - Any person that engages in intentionally unfair or deceptive insurance practices is violating federal law.

  - Other violations include embezzling money, misappropriating insurance premiums, and writing threatening letters to insurance offices.
  - The punishment for violation is a fine of up to $50,000, up to 15 years in prison, and license revocation.
- In 1999, the **Financial Services Modernization Act** removed the barriers that kept commercial banks, investment banks, retail brokerages, and insurance companies from engaging in each other's lines of business.
- In 2001, the **USA PATRIOT Act** was adopted in response to the terrorist attacks of September 11 terrorist attacks. The law aims to detect, deter, and disrupt terrorist efforts and funding while prosecuting international money laundering.
- In 2003, the **Do Not Call Implementation Act** implemented the **Do Not Call Registry.**
  - The Act allows consumers to list their phones so that telemarketers (including insurers) cannot legally make solicitation calls.
  - Calls made on behalf of charities, political organizations, and surveys are exempt.

National Association of Insurance Commissioners (NAIC)

- The National Association of Insurance Commissioners (NAIC) is an industry association that consists of all state insurance regulators.
- The NAIC brings together regulators and industry personnel on committees that study various aspects of insurance practices, laws, and regulations.
- The organization has four broad objectives:
  1. To encourage regulatory uniformity among the states
  2. To promote efficiency in the administration of laws and regulations
  3. To protect policy owners and consumer interests, and
  4. To preserve state regulation of the insurance business
- The NAIC recognizes that state laws regarding insurance marketing, trade practices, and regulations may vary, but share more similarities than differences. Model Acts and Model Regulations developed by the NAIC provide a template for individual state legislators and regulators.
- The NAIC is not a regulatory organization. Instead, the models it creates provide a common framework for state officials that allow the various governing bodies to meet the specific needs of their respective jurisdictions while helping to streamline the legislative and administrative processes and helping to standardize the outcomes.

Unfair Trade Practices Act (Model)

- Most jurisdictions have adopted their own version of the NAIC model "*Unfair Trade Practices Act*."
- This Act gives the head of each state insurance department the power to investigate insurance companies and producers.
- It authorizes them to issue cease and desist orders and impose penalties.
- The Act also gives officers the authority to seek a court injunction to restrain unfair activities, such as misrepresentation and false advertising, coercion and intimidation, and unfair discrimination.

NAIC Advertising Code

- Many states also subscribe to the NAIC's Model Advertising Code, which labels certain words and phrases as misleading by their very nature.
- These misleading words or phrases can never be used in any insurance advertisement.

The National Conference of Insurance Legislators (NCOIL)

- In 1969, the **National Conference of Insurance Legislators** (**NCOIL**) was formed. The NCOIL's principal membership is comprised of state legislators from around the nation that serve on state insurance and financial institutions committees.
- As with the NAIC, NCOIL works to preserve state regulation of the industry, but it also works to educate public policymakers on related issues.
- NCOIL also writes model laws.

The National Association of Insurance and Financial Advisors (NAIFA)and The National Association of Health Underwriters (NAHU)

- These organizations created a Code of Ethics which details the expectations of agents in their duties toward clients.

Agent Marketing and Sales Practices Some standards in various states include:

- **Selling to Needs:** An ethical agent learns the client's needs and determines the best way to address those needs.
- **Suitability of Recommended Products:** Correlation between a recommended product and the client's needs and capabilities
- **Full and Accurate Disclosure:** Inform clients about all aspects of recommended products.
- **Documentation:** The ethical agent documents each client meeting and transaction.
- **Client Service:** The ethical agent knows that a sale doesn't mark the end of a relationship with a client but rather the beginning.

Producer Responsibilities:

- Provide customers with the best service possible.
- Solicit new business for their companies by helping clients acquire products from application to policy delivery.
- Guide customers to the right products that meet their needs and maintain a relationship with them.
- Build a business by keeping current customers satisfied and actively seeking referrals.

Rating Services

- Rating services help to publicize the financial health of insurers.
- The financial strength (solvency) and stability of an insurance company are two vitally important factors.
- The PRIMARY purpose of a rating service company (e.g., A.M. Best) is to determine an insurer's financial strength.
- Financial strength can be evaluated by examining a company's reserves and liquidity.
  - **Reserves** are the accounting measurement of an insurer's future obligations to its policyholders. They are classified as liabilities for the insurance company.
  - **Liquidity** indicates a company's ability to make unpredictable payouts to policy owners.

- In generic terms, insurance is defined as the transfer of risk from one party to another in exchange for a fee (premium) by means of a legal contract.
- Insurance spreads each insured's risk of loss across many people participating in an insurance company's risk pool by paying a premium.
- Insurance reduces financial risk and spreads the risk of loss from one individual to many.

Principle of Indemnity (Indemnification)

- Operating on the "**Principle of Indemnification,**" the goal of an insurance carrier is to "restore" insureds to their original financial position following losses.
- The same principle stipulates that insureds will not profit or gain by their losses. In other words, they will not receive more than they lost.
- Most accident, health, property, and casualty insurance contracts are all contracts of **indemnity**.

Law of Large Numbers (Spread of Risk)

The **law of large numbers** holds that, based on experience, the greater the number of homogenous loss exposures, the more likely the overall likelihood of loss can be predicted.

- The law of large numbers does NOT predict whether an individual suffers a loss.
- The law of large numbers helps predict the losses that those in the risk pool will suffer in the aggregate.

> *For example, let's assume that a carrier insures one million people against accidental death. In this case, the carrier is more likely to accurately predict the number of accidental deaths than a company that insures only 1,000 people against the same peril.*

Adverse Selection

- **Adverse selection** is defined as the tendency for higher-than-average risks to seek out insurance more frequently than those who are lower risk.
- If an insurer suffers a financial loss due to adverse selection, it has inaccurately calculated the risk of loss and consequently charged inadequate premiums. Companies must avoid adverse selection to be profitable and stay in business. Sound and competent underwriting may reduce the chance of adverse selection.

Perils, Loss, and Hazards

Perils (CAUSES of Loss)

- A **peril** is the immediate and specific cause of a loss. Each line of insurance covers a different set of perils and losses.
- Accident and health insurance policies cover losses that are caused by illnesses and accidents.

- For life insurance and annuities, the primary covered peril is death.
- Life insurance protects against premature death.
- Annuities protect income when a person's life span is greater than the statistical average, and the insured would otherwise outlive his assets.

Named Perils versus Special (Open) Perils

- Insurance contracts that cover **Specified** or **Named Perils** will individually list perils that they cover.
- If a loss is caused by a peril that's not listed within the insurance policy, then the loss is not covered.

> *For example, an accidental death and dismemberment policy only covers certain losses, and only those due to accidents. By naming and defining specific causes of loss, a named-peril policy defines covered losses narrowly.*

- Insurance contracts that use a **Special** or **Open Peril** definition of covered causes of loss offer insurance that protects against a broad spectrum of potential losses. These policies start by stating that they cover all direct causes of loss and then list any excluded perils.
- Any peril that's not explicitly excluded is covered.

> *For example, an individual disability income policy covers losses due to either illnesses or accidents. They also cover job-related losses as well as those that are not.*

Loss

- A **loss** is defined as an unintended and unforeseen reduction or destruction of financial or economic value.
- A loss can also be defined as either an accident or an occurrence.
- An **accident** is an unforeseen, unexpected, unintended, and sudden event, which occurs at a specific time and specific place.
- An **occurrence** is any event that causes a loss. Occurrences include accidents, illnesses, and losses that are caused by repeated or continuous exposure to conditions over time.

[EXAM TIP: Every accident is an occurrence, but not every occurrence is an accident.]

Direct Loss

- A **Direct Loss** results when a person is hurt, killed, or property is damaged or destroyed.
- The peril is the proximate cause of the direct loss.

Indirect Loss

- An **Indirect Loss** is also referred to as a "**Consequential Loss"** because the loss results from a direct loss.

> *For example, if an individual suffers an injury that causes her to be disabled for six months, her injury is a direct loss. The individual's loss of income, which occurs because the injury results in her inability to work, is indirect.*

Loss Exposure

- Loss exposure is the risk of a possible loss. Basically, any situation that presents the possibility of a loss.

Homogeneous Exposure Units

- Homogeneous exposure units are similar objects of insurance exposed to the same group of perils.
- A loss exposure consists of loss exposure units.

Hazards

- A **hazard** increases the possibility that a loss will occur.

  Examples of hazards include icy roads, driving while intoxicated, and improperly stored toxic waste.

- There are three types of hazards—*physical hazards, moral hazards,* and *morale hazards*.

Physical Hazards

- **Physical hazards** are physical or tangible conditions existing in a manner that makes a loss more likely to occur.

  Poor health and ice on roads are examples of physical hazards.

Moral Hazards

- **Moral hazards** make a loss more likely to occur due to the dishonest character of the insured.
- Properly defined, a moral hazard occurs when the insured is much more intentioned and conscious of participating in wrongdoing that's more likely to lead to a loss.

  For example, a dishonest person is more likely to lie to their insurance company, both on an application and when submitting a claim.

  Negative habits such as drug use, alcohol abuse, and smoking are commonly associated with moral hazards.

Morale Hazards

- **Morale hazards** arise from a state of mind related to the indifference of an insured to whatever loss may occur.
- The insured unintentionally creates a loss situation because he doesn't care about loss prevention since the property is insured.

Risk

- **Risk** is defined as the potential or uncertainty for loss.

Types of Risk

Speculative Risk

- Speculative risks are not insurable because they offer the opportunity for gains as well as losses.

Pure Risk

- Pure risks are insurable because there's only the potential for loss, not gain.

Elements of an Insurable Risk

- In general, insurable risk must include the following elements:
  - **An insurable loss must be due to chance (accidental),** which means that the cause must be outside of an insured's control. This characteristic helps insurers avoid adverse selection.
  - **An insurable loss must be definite and measurable**, which means that the time, place, and amount are known.
  - **An insurable loss must be predictable**, which means that the probability of loss in the future can be calculated. There must be a sufficient number of homogeneous loss exposure units to do so.
  - **An insurable loss cannot be catastrophic**, which means that a loss cannot be too big or uncertain to calculate. The loss exposure must be reasonable.
  - **The loss exposure to be insured must be substantial.**
  - **The premium cost must be economically feasible;** it must be small relative to the covered loss exposure.

Insurance Risk Classifications

- Typically, an insurer will place a risk into one of the following three classifications:
  - **Standard risks** are considered to have an average potential for loss.
  - **Substandard risks** have a higher-than-average potential for loss. Substandard risks may either pay a higher premium for coverage or be declined altogether.
  - **Preferred risks** are judged to be a better than average risk for an insurance company because they have a lower-than-average potential for loss.

Risk Management

- The process of analyzing exposures that create risk and designing programs to handle them is referred to as **risk management**.
- Risk may be reduced or managed by purchasing an insurance contract.

Methods of Handling Risk

- **Risk avoidance** means eliminating an activity or condition that exposes a person to a type of loss or specific perils.
- **Risk reduction** is the process of taking deliberate actions to reduce the likelihood or severity of a loss.
- **Risk retention** is a conscious strategy of maintaining reserves to address the risk of losses.
- **Risk transfer** features a legal contract that transfers risk from one party to another. In general, insurance contracts are risk transfer arrangements. They transfer the risk of loss defined in the policy to the insurer in exchange for a known fee or premium.
- **Risk-sharing** spreads risk among multiple parties. Each party assumes a portion of the risks covered by the arrangement, such as with **reciprocal insurance companies**.

Risk Pooling

- **Risk pooling** spreads risk by distributing the cost of possible losses over a large number of individuals. It transfers risk from an individual to a group.

Reinsurance

- Reinsurance is defined as the transfer of risk from one insurer to one or more other insurers.

Prevention

- Another risk management tool that's available is loss prevention. Loss prevention involves taking actions to eliminate damage or loss.

General Law of Contracts

- Insurance contracts are binding legal agreements between two parties—a policyowner and insurer. In most cases, the policyowner is also the insured. Some life insurance policies are not owned by the person being insured.
- If an insurance exam asks for the identity of the party that enters into an agreement with an insurance company when buying a policy, the proper answer is "the policyowner," even if "the insured" is also given as a choice.
- The only time "the insured" is the correct answer is when "policyowner" (or "policyholder") is not given as a possible answer.
- The beneficiary is not a party to the contract.
- The following four essential elements must be contained in every contract for it to be legally valid and binding (enforceable). We can remember them using the mnemonic "C.L.O.C.".
    1. Competent parties
    2. Legal purpose
    3. Offer and acceptance
    4. Consideration
- The four elements can be remembered using the mnemonic "C, L, O, C."

Competent Parties

- The parties to the contract must be legally competent and must possess the capacity to make binding agreements.
- The parties must be mentally sound, sober, of sufficient age, and not disqualified on other legal grounds.
- Individuals that may be barred from entering into a legally binding contract include:
    - Minors as defined by state law
    - Insane or mentally incompetent individuals
    - Individuals who are under the influence of alcohol or drugs at the time of application
    - Persons who are forced or coerced into a contract
    - Enemy aliens
    - Convicts (based on state law)

Legal Purpose

- For a contract to be enforceable, the contract must have a **legal purpose**. The object of the contract and the reason for the parties to enter into the agreement must be legal.

Offer and Acceptance

- Both parties to the insurance contract must agree to the contract terms before they become valid and in-force.
- The first party that commits to the contract is offering to enter into a legally binding agreement.
- The second party's commitment is legally considered an acceptance of the offer.

- An **offer plus an acceptance** is often referred to as the **agreement**.
- When the applicant for an insurance policy submits a completed application and pays the initial premium, she's making an offer. When the insurer issues the policy as requested, it accepts the offer.
- If a consumer submits an application without an initial premium, the consumer is NOT making an offer because no transaction can be completed without the payment of the initial premium. Instead, the consumer is asking the insurer to make an offer by issuing a policy. The consumer accepts the offer by paying the initial premium.

Consideration

- For any agreement to be binding, both parties must provide each other with some item of value, which is the definition of "consideration."
- An applicant's **consideration** is the premium paid and the representations (i.e., statements) made.
- The insurer's consideration is the promise to pay legitimate claims.
- Consideration is the binding force of any insurance policy.

Special Features of Insurance Contracts

Aleatory Contract

- An insurance contract is an **aleatory contract** because one party may recover more in value than he has paid.
- The value of the policyowner's potential benefit (i.e., claim payment) is generally higher than the value (i.e., premium) that's received by the insurer.
- There's no guarantee that the insured will receive a benefit. Performance is based on an uncertain future event involving unequal bargaining value.

  For example, an individual who has a disability insurance policy will collect benefits if she becomes disabled. However, if no disability occurs, benefits are not paid.

  Another example illustrating the aleatory nature of insurance contracts is a life insurance policy that pays out a $20,000 death benefit after only $100 of premiums were collected.

Contract of Adhesion

- Insurance policies are contracts of adhesion.
- They're contracts that are prepared by only one of the parties—the insurance company.
- There's no negotiation regarding the terms. The insurer sets the terms, and the applicant can either "take it or leave it."

Ambiguities in a Contract of Adhesion

- In any contract of adhesion, the party that dictates the contract terms must make those terms clear.
- The doctrine regarding ambiguities in a contract of adhesion favors the party that did not create the contract terms. When it comes to insurance policies, the courts will rule in favor of the insured.

Doctrine of Reasonable Expectations

- The **doctrine of reasonable expectations** stipulates that an insurance contract may be interpreted by a "reasonable" consumer to mean what the producer or insurer has indicated it means or what he has interpreted or expected it to mean.

Unilateral Contract

- Insurance policies are unilateral contracts because only the insurer makes an enforceable promise.
- Insurers promise to pay benefits upon the occurrence of a specific event, such as death or disability.
- The applicant makes no promise to continue the policy and can cancel it at any time.
- The insurer's promise remains in force as long as the policyowner pays the required premium.

Personal Contract

- Most forms of insurance are **personal contracts** because they're non-transferrable.
- Insurance contracts always insure a person, even when they insure property. A homeowner's policy doesn't merely cover a house; it also covers the person who owns the house. When the person sells the house, the coverage cannot be transferred to the new owner.
- Life insurance is an exception to this rule. **Life insurance is NOT a personal contract.**
- Life insurance contracts can be treated as financial assets. They can be used collateral for loans and can be sold to third parties under the terms of a viatical or senior settlement.

Conditional Contract

- Insurance policies are conditional contracts because the insurance company's performance is contingent on the occurrence of uncertain future events.
- The insurer must only fulfill its promise to pay if a covered loss occurs while the policy is in force.
- The insurer's obligations under the contract are conditioned on the performance of specific acts by the insured or the beneficiary. For example, the insured must provide notice of claim and proof of loss.

Valued Contract or Indemnity Contract

- Insurance policies indemnify an insured in one of two ways. Some policies have a fixed value, while others have benefits that are tied to the loss of assets, income, or health.

Valued Contracts

- A **valued contract**, such as life insurance, pays a stated sum regardless of the actual loss incurred.

Indemnity Contracts

- An **indemnity contract** pays an amount which is equal to a loss that's identified in the policy.
- Some contracts of indemnity are reimbursement policies that directly reimburse the insured for claim-related expenses.
- Other indemnity contracts define their benefits as a certain amount of money per day, week, or month to offset a loss of revenue (as in a disability policy) or some portion of periodic expenses (such as long-term care).

Insurable Interest

- Insurable interest can be defined as the kind of financial interest a person must have in themselves or another person to purchase legally enforceable insurance coverage.
- Most policies require insurable interest to exist at the time of purchase and at the time of claim.
- For a life or health insurance contract, insurable interest is only required at the time of the application. Insurable interest doesn't need to exist at the time of claim.
- To have "an insurable interest" in oneself or another person, an individual must have a reasonable expectation of benefiting from the other person's continued life. Conversely, she will suffer a financial loss if the person becomes ill, suffers an injury, or dies.

Negotiating and Issuing Insurance Policies

- An **insurance policy** is a written contract in which one party promises to compensate another against loss from an unknown event.
- A **policy rider** or endorsement is a legal attachment which amends a policy.

Utmost Good Faith

- **Utmost good faith** means that the policyowner and the insurer both know all of the relevant information that's material to the agreement. The critical concept is full disclosure.

Reasonable Expectations

- The Doctrine of **Reasonable Expectations** is the legal principle which stipulates that the terms of contracts should be interpreted as may reasonably be expected when ambiguous.

Warranty

- A **warranty** is a statement that's guaranteed to be true in every respect. It becomes part of the contract and can be grounds for revoking the agreement if found to be untrue.

Representation

- A **representation** is a statement which is made by the applicant and is considered to be true and accurate to the best of the applicant's belief.
- A false statement made by an applicant that would influence an insurer in determining whether to accept the risk is considered a **material misrepresentation**.

Concealment

- **Concealment** is defined as the failure or neglect by the applicant to disclose a known, material fact.
- An insurance company has the right to rescind the insurance contract in response to either an intentional or unintentional concealment.
- The insurer must prove the concealment exists and that it's material to the insurance policy.

Void versus Voidable Contracts

Void Contracts A **void contract** is one that has never really gone into effect because it lacks one of the four essential elements of a contract.

- *For example, if a life insurance applicant asks his friend to impersonate him during a medical exam in hopes of qualifying for coverage, any resulting policy would be void. It would never be in effect because the insurance company doesn't have the right person's consideration. Also, it doesn't have medical data about the applicant which is necessary to underwrite the policy.*

Voidable Contract A **voidable contract** is an agreement that's legitimately in force, but then one of the parties violates a condition of the policy.

- The injured party may have the right to terminate the agreement.

Cancellation Cancellation occurs when one of the parties voluntarily terminates an insurance contract.

Fraud

- Fraud is an intentional misrepresentation regarding a claim or policy application that a consumer makes to obtain benefit payments or policy coverage under false pretenses.
- Life insurance contracts cannot be voided after they have been in force for two years. After two years, the policies become incontestable.
- Guaranteed renewable health insurance policies usually have two or three years, depending on state law. After this time, they also become incontestable.
- The ability of insurers to void other health insurance policies due to fraud is not necessarily limited. This will be addressed in the section titled "Time Limit on Certain Defenses."

Parole Evidence Rule

- The **parole evidence rule** limits a contract to its written terms. Oral statements that are made before the formation of a contract are not admissible in court unless they become part of the written contract.

Waiver

- A waiver is the voluntary surrendering (giving up) of a known right.
- A waiver is also defined as "the deliberate, voluntary, or intentional abandonment of a known right by an insurer."
- One example of an insurer waiving a right occurs if an incomplete application is mistakenly accepted. Once the policy is issued, the insurer cannot contest a later claim based on the missing information.

Estoppel

- Estoppel requires an insurer to abide by misleading or incorrect statements that are made by one of its agents, even if it can demonstrate that the governing policy form contradicts the agent.
- Under certain circumstances, this legal principle prevents the insurer from escaping the consequences of its agent's actions as long as they were within the scope of the agent's authority.

- Estoppel applies when ALL of the following elements are present:
  - An agent is acting within her authority.
  - The agent makes an inaccurate representation on behalf of the insurance company.
  - A consumer relies on the information being correct.
  - When a circumstance arises that tests the validity of the questionable representation, the insurance company refuses to honor the agent's words.
  - The insurer's decision causes financial harm to the consumer.

The Law of Agency

- Insurers grant agents the authority to sell, solicit, and negotiate contracts of insurance, and bind them on their behalf.
- When acting within the scope of their authority granted, an act of the agents is an act of the principal.
- The relationship between an agent and the company represented is governed by agency law.

Principles of Agency Law

- The four essential principles of agency law include:
  1. Acts of an agent are equal to the acts of the principal.
  2. Under law, a contract that's completed by an agent is also completed by the principal.
  3. Payments that are received by an agent for the principal are received by the principal.
  4. If an agent knows it, it's presumed that the insurance company does as well.

Agent Authority

- "Authority" is what an insurer grants a licensee to transact insurance on its behalf.
- In reality, an agent's authority can be quite broad.

Express Authority

Express authority is the agent's authority which is expressly granted in his agency contract.

- The principal deliberately gives this authority to one or more agents.
- For example, an agent has the express authority to bind coverage for applicants on behalf of the company.

Implied Authority

Implied authority describes the authority we assume an agent needs to transact the principal's business as expressed in the contract.

- Implied authority is incidental to express authority.
- Implied authority encompasses the little things an agent needs to do to accomplish the tasks expressly assigned to him under the terms of his agent contract.

Apparent Authority

Apparent authority is the appearance of authority regardless of whether it actually exists.

- Apparent authority relies on the perception of an agent's authority based on the actions, words, or deeds of the principal.

Brokers versus Agents

- Insurance producers may be agents or brokers.
- An agent has an agent's contract, while a broker has a broker's contract.
- In a sales transaction, agents represent the insurer, but brokers represent the buyer (or applicant).
- A broker cannot bind coverage; however, an agent can.

Agent versus Solicitor Authority

- Some states license **solicitors**.
- Solicitors have the authority to seek out insurance applicants for a company, but don't have any authority to bind coverage on behalf of a company.
- Solicitors arrange for prospective clients to meet with an agent.
- Agents are authorized to handle all of the necessary steps of an insurance sale, from solicitation to sales to taking and binding an application.

Agent as a Fiduciary

- An agent is a fiduciary because an agent holds a position of financial trust and confidence as it relates to both consumers and insurers.

Other Legal Concepts Related to Insurance

Subrogation

- Subrogation is the insurer's right to pursue liable third parties for amounts that are paid out in claims which are made by the insured.

Tort Law

- A tort is a wrong against an individual as opposed to a crime, which is a wrong against society.
- Torts are adjudicated in civil court, rather than a criminal court.
- Civil courts also judge cases involving contracts, which fall under contract law.
- Torts most often occur when one individual wrongs another individual by failing to act in a reasonable or prudent manner. This is referred to as **negligence**.
- There are several types of negligence, including:
  - **Simple negligence** is a failure to act (or not act) in a reasonable or prudent manner.
  - **Gross negligence** results from a reckless disregard for the need to act reasonably.
  - **Willful and wanton negligence** combines a reckless disregard for reasonable standards of care and an awareness that harm will probably occur.

Errors and Omissions (E&O) Insurance

- Insurance agents need errors and omissions (E&O) liability insurance, which covers injuries resulting from an error that's made in rendering or failing to render professional services.

Typical Losses Covered Under an E&O policy, typical losses that are covered for the producer include:

- Not effecting insurance coverage or a policy change when requested
- Administrative and premium calculation errors
- Misstating insurance coverages, or not explaining policy provisions properly
- Incorrectly identifying client loss exposures, or failing to recommend coverages
- Forwarding inaccurate or incomplete information about a client to a carrier
- Improperly handling a claim

Typical E&O Exclusions Intentionally harming a person is always excluded in any liability insurance policy, which includes:

- Criminal, illegal, or dishonest acts
- Malicious acts
- Libel and slander
- The intentional violation of any law, regulation, statute, or ordinance

General Concepts of Life Insurance

Types of Life Insurance Policies

Industrial life insurance issues small face amounts, such as $1,000 or $2,000. Premiums are paid weekly and collected by debit agents. They were designed for burial coverage.

Group life insurance is written for members of a group, such as a place of employment, association, or a union. Coverage is provided to the members of that group under **one master contract**. The group is underwritten as a whole, not on each member. Typically, group life insurance doesn't require evidence of insurability and is cheaper than individual life insurance.

Ordinary life comprises several types of individual life insurance, such as temporary **(term)** and permanent **(whole)**.

Term life insurance gives a person the most considerable amount of coverage for a limited period. Term insurance is only in effect for a limited period because it has a TERMination date. Term insurance is an inexpensive type of insurance, which makes it an attractive option for policies with a significant face value. Term life is the CHEAPEST type of pure life insurance due to the fact that it has a termination date and doesn't have any cash value. Term life insurance will ALWAYS be cheaper than a whole life policy with the same face value. It provides pure death protection since it only pays a death benefit if the insured dies during the policy term.

Level term insurance, also referred to as level premium level term, requires a fixed, low premium in exchange for level protection that lasts a specified period. For example, if a person needs life insurance that provides coverage for the remainder of her working years and wants to pay as little as possible, she will need Level term.

Level term life insurance is often renewal and convertible. For example, a person has a 10-year renewable and convertible term policy. At the conclusion of the 10 years, the policy terminates, or she can renew it. If she renews it, the premium price will go up, and she will have the policy for another 10 years. This cycle can continue until she's too old to renew it or it's too expensive. All TERM insurance has a final TERMINATION date after which it can no longer be renewed. If the policy is CONVERTIBLE, a person can CONVERT it to whole life (think, rent to own) at any time. Whenever a person renews or converts ANY insurance, she doesn't need to worry about her health (i.e., her insurability is locked in). However, the price will always rise because her current (attained) age is used for your new policy. Term life insurance is typically thought of as "renting." The concept is that a person has a roof over her head, but the price of renting is going to rise until it no longer makes sense to continue renting or, at some point, the rental contract is TERMINATED, and she gets kicked out.

Premiums are initially higher for non-renewable level term insurance than renewable term life insurance because they're level throughout the policy period. However, with renewable term insurance, the premiums will increase at each renewal and eventually exceed those of standard level term insurance.

Decreasing term life insurance provides an **annually decreasing face amount over time with level premiums.** A decreasing term policy is a type of life policy with a death benefit that adjusts periodically (according to a schedule) and is written for a specific period. Decreasing term policies are generally written for the **protection of a mortgage or other debt** that typically decreases over time until it's paid off. For example, a 15-year decreasing term policy could protect a 15-year mortgage. As the mortgage balance reduces each year, the face value of the insurance policy will adjust accordingly to match. After the mortgage is paid off, the insurance policy will expire.

Credit policies are typically purchased using a decreasing term life insurance policy, with a term that's matched to the length of the loan period and the decreasing insurance amount matched to the declining loan balance. Since credit life insurance is designed **to cover the life of a debtor and pay the amount due on a loan if the debtor dies before the loan is repaid**, credit policies can only be purchased for up to the amount of the debt or loan outstanding. For example, if a person wants an insurance policy to protect a $20,000, five-year auto loan, he could use a five-year decreasing term life insurance policy with an initial face value of $20,000. He will pay the same level premium every month for the five-year term of the policy. The face value will start at $20,000 and change according to a schedule (the auto loan). After five years, the car will be paid off, and the insurance policy will no longer be needed.

Increasing term life insurance provides **an increasing face amount** over time based on specific amounts or a percentage of the original face amount.

Convertible term life insurance policies have a provision that allows the policyowner to **convert the term insurance into a permanent insurance policy without proof of insurability.** For example, John took out a low-cost term life insurance policy when he was young to take advantage of his excellent health. Knowing that the policy would eventually terminate, John wanted the option to convert the policy to a permanent one for final expense benefits when his finances improve. The conversion privilege of a group term life policy allows an individual to leave the group term (temporary) plan and convert his insurance to an individual (permanent) policy without providing evidence of insurability.

Term life insurance policies are typically converted using the insured's attained (current) age, not the age of the insured at the time of the original application. The insured's age is a primary factor for calculating premium costs. Therefore, using the insured's current (attained) age will result in higher premiums than using the insured's original age. For example, a $25,000 policy on a healthy seven-year-old boy will cost substantially less than a $25,000 policy on a 57-year-old man.

Whether converting an individual or group term insurance policy, the insured's insurability is guaranteed. However, the cost of the policy will be based on her current (attained) age, not the age when she applied for the original term policy. Convertible term insurance allows the insured to enroll in temporary coverage and later change it to permanent coverage without insurability (good health). However, the premiums will increase due to using the insured's attained age.

Renewable term insurance guarantees the insured the right to continue term coverage after the expiration of the initial policy period **without proving insurability.** When a term policy is renewed, the insured is not required to prove insurability. However, the premium price will rise because the insurance company will use the insured's current or attained age to determine the new premiums. If a customer wants coverage at the lowest possible cost that was good for a limited period but offers the ability to continue the coverage after the expiration, the customer will want a renewable term policy.

Annual renewable term coverage provides a level face amount that renews annually. This type of coverage is guaranteed renewable annually without proof of insurability.

Whole life insurance provides a permanent death benefit for the entire life of the insured, but it also provides living benefits in the form of cash values and policy loans. Whole life insurance typically has a level premium and matures once the insured attains the age of 100.

Advantages of whole life insurance:

- Covers the entire life of the insured
- Living benefits – cash value and policy loans
- Fixed premiums

Drawbacks of whole life insurance:

- Protection is more expensive than term insurance because of the policy's living benefits
- Premium paying period may extend beyond the income-earning years

Whole life is often compared to BUYING (e.g., BUYING a house). The idea is a person can pay off a house slowly or quickly; however, regardless of how it's paid, once it's paid for, the person owns the house. There are several types of whole life. All whole life policies have the same types of benefits. The only difference in "types" of whole life is how the policy is paid. All whole life policies last until death or to the age of 100, have a fixed premium, and offer level benefits with cash value accumulation regardless of how it is paid.

Types of whole life insurance include:

- **Straight life:** This is basic whole life insurance with a level face amount and fixed premiums that are payable over the insured's entire life, or to the age of 100 (maturity of policy).
- **Limited Pay Whole life:** This is whole life insurance in which the insured is covered for her entire life, but premiums are paid for a limited time. As the premium payment period shortens, the total cost for the insured decreases, and the policy's cash values increase faster. For example, under a life paid-up at age 65 policy, premiums are only paid until the insured is 65 years old. With a 20-pay life policy, the insured only pays for 20 years. All policy provisions and insurability being equal, a 40-year-old insured would pay more for the 20-pay life than she would for a paid-up at age 65 policy. Additionally, her cash value would accumulate at a faster rate. Both of these policies are in effect until the insured's death or until she reaches the age of 100.
- **Single premium whole life:** Allows the insured to pay the entire premium in one lump-sum and have coverage for her entire life.
  - An immediate non-forfeiture value is created
  - Immediate cash value is created
  - A large part of the premium is used to set up the policy's reserve
- **Modified whole life:** This type has low premiums in the early years and jumps to a higher premium in the later years but remains fixed after that. Premiums increase just once.
- **Graded whole life:** Under a typical graded premium life insurance policy, the premium increases yearly for a stated number of years, then remains level. Premiums continue to stay level for the remainder of the policy. For example, a policy can start low in a graded whole life insurance policy and increase a small amount every year up until the fifth year, then it will level off for the remainder of the policy.

Special Use Policies

In addition to the basic types of life insurance policies, there are a number of "special use" policies insurance companies offer. Many of these are a combination (or package) of different policy types and are designed to serve a variety of needs.

Family plan policies are designed to insure all family members under one policy. Usually, the family head is covered by permanent (whole life) insurance, and the spouse/children are included on the same policy as level term life riders (family term riders).

The term coverage on the spouse and children is typically convertible to permanent coverage without evidence of insurability as long as it's "attached" to another person's policy. Think sidecar on a motorcycle. Riders must RIDE on something.

Family plan policy example:

- **Husband –** Whole Life Policy
- **Wife (spouse) –** Term Policy which is convertible without proof of insurability
- **Children –** Term Policies which are convertible (typically at the age of 18 or 21) without proof of insurability; premium remains the same regardless of the number of children

Family income policies combine whole life insurance and decreasing term insurance. It provides monthly income to a beneficiary if death occurs during a specified period after the date of purchase. If the insured dies after the specified period, only the face value is paid to the beneficiary since the decreasing term insurance expired. Income needs typically DECREASE over time because the household debt shrinks.

Family maintenance policies combine whole life insurance and level term. They provide income to a beneficiary for a selected period if an insured dies during that period. At the end of the income-paying period, the beneficiary also receives the entire face amount of the policy. If an insured dies after the end of the selected period, the beneficiary receives only the face value of the whole life policy. Maintenance "maintains" the family using level term insurance. This means that the family will receive a benefit for a preset number of years after the insured's death.

Multiple protection policies pay a benefit of double or triple the face amount if death occurs during a specified period. If death occurs after the period has expired, only the policy face amount is paid. The period may be for a specified number of years (e.g., 10, 15, or 20 years) or to a specified age (e.g., the age of 65). These policies are combinations of permanent insurance and level term insurance.

Joint life policies cover two or more people. The age of the insureds is averaged, and a single premium is charged. It uses permanent insurance (as opposed to term) and pays a death benefit when one of the insureds dies. The survivors then have the option of purchasing an individual policy without evidence of insurability. The premium for a joint life policy is less than the premium for separate, multiple policies. ONE policy covers two. This is similar to a "joint account" with a bank – one account (or policy, in this case) for two people.

A variation of the joint life policy is the joint and survivor policy, or a "**survivorship life policy**" (it can also be referred to as a "second to die" policy). This plan also covers two lives, but the benefit is paid upon the death of the last surviving insured. Compared to the combined premium for separate life insurance policies on two individuals, the premium for a survivorship life policy is lower.

Juvenile Insurance is life insurance written on the life of a minor. The adult applicant is typically the premium payor until the child comes of age and can take over the payments.

Credit life insurance is designed to cover the life of a debtor and pay the amount due on a loan if the debtor dies before the loan is repaid. It's issued in an amount that's not to exceed the outstanding loan balance and is generally paid entirely by the borrower. A decreasing term policy is most often used.

Non-Traditional Life Policies

Interest-Sensitive Whole Life: Interest-sensitive life insurance (current assumption whole life insurance) is a type of whole life insurance in which the cash value can increase beyond the stated guarantee if economic conditions warrant. It also allows the insured to increase the face amount or use the extra cash value to lower future premiums. Premiums can vary to reflect the insurer's changing assumptions concerning its death, investment, and expense factors. CAWL (current assumption whole life) policies are almost always an MEC due to accelerated premiums.

Adjustable life policies are distinguished by their **flexibility** from **combining term and whole life insurance into a single plan.** The policyowner determines how much protection is needed and how much premium he's willing to pay. Adjustable life insurance allows a person to vary his coverage as his needs change without requiring evidence of insurability. Consequently, no new policy needs to be issued when changes are desired. Adjustable life has all the usual features of whole life insurance.

Universal life is a variation of whole life insurance and is **characterized by considerable flexibility.** Changes may be made with **relative ease by the policyowner** with these flexible-premium policies. Investment gains go toward the cash value. Unlike whole life (with its fixed premiums, fixed face amounts, and fixed cash value accumulations), **universal life allows its policyowners to** determine the amount and frequency of premium payments, which will adjust the policy face amount. Essential characteristics of a universal life policy are flexible premiums, flexible benefits, no minimum death benefit, and cash value withdrawals. Cash value accumulations are subject to a **minimum interest guarantee.** Any surrender charges of a universal policy must be disclosed.

Equity Index Universal Life insurance (EIUL) is a permanent life insurance policy that allows policyholders to tie accumulation values to a stock market index, such as **the S&P 500.** Indexed universal life insurance policies typically contain a minimum guaranteed fixed interest rate component and the indexed account option. Indexed policies give policyholders the security of fixed universal life insurance with the growth potential of a variable policy linked to indexed returns. The potential extra interest is based on the investments of the company's general account.

Modified Endowment Contracts (MECs) are policies that are overfunded, according to IRS tables. Policies that don't meet the **seven-pay test** are considered MECs and will lose favorable tax treatment. The seven-pay test is a limitation on the total amount a person can pay into a policy in the first seven years of its existence. The test is designed to discourage premium schedules that result in a paid-up policy before the end of a seven-year period.

For example, if the yearly premium is $500, over seven years, the total amount paid would equal $3,500. If a person paid $3,501, the policy has exceeded the 7-pay test and is no longer a life insurance contract. Instead, it will be taxed as an investment.

- If withdrawn before age 59 1/2, there's a 10% penalty.
- Taxation only occurs when cash is distributed.
- Funds that are withdrawn from an MEC are subject to last-in-first-out (LIFO) tax treatment, which assumes that the investment or earnings portion of the contract's values is withdrawn first (making these funds fully taxable as ordinary income).
- Penalties and taxes may be assessed on premature distributions (i.e., policy loans) from a modified endowment contract (MEC).

Variable Insurance Products

Due to the transfer of investment risk from the insurer to the policyowner, variable insurance products are considered both securities contracts and insurance contracts. A producer is required to register with the National Association of Securities Dealers to sell variable products.

Variable whole life insurance was created to help offset the effects of inflation on death benefits. Variable whole life insurance is permanent life insurance with many of the characteristics of traditional whole life insurance. The main difference between traditional whole life insurance and variable whole life insurance is how the policy's cash values are invested. With traditional whole life insurance, these values are kept in the insurer's general accounts and invested in conservative investments that are selected by the insurer to match its contractual guarantees and liabilities. With variable life insurance policies, the policy values are invested in accounts that are separate from the insurer's general accounts. These accounts allow the policyowner the option to direct the investment choice and offer common stock, bond, money market, and other securities investment options. Values that are held in these separate accounts are invested in riskier, but potentially higher-yielding, assets than those held in the general account. The primary characteristics of a variable life policy include fixed premiums, a guaranteed minimum death benefit which fluctuates over the minimum, and cash values which fluctuate and are not guaranteed.

Variable universal life (VUL) life insurance combines all the characteristics of universal life and variable life. In a VUL, the cash value can be invested in various separate accounts, similar to mutual funds. The choice of which of the available separate accounts to use is entirely up to the contract owner. The **'variable'** component in the name refers to the ability to invest in separate accounts whose values vary because they're invested in the stock and bond markets. The **'universal'** component in the name refers to the flexibility the owner has in making premium payments**.** Variable universal life insurance provides the policyowner with flexible premiums, adjustable death benefits, a guaranteed minimum death benefit. It gives the insured growth potential for higher returns and the potential for loss. Evidence of insurability can be required for an individual who's covered by a variable universal life policy when the death benefit is **increased.**

REVIEW NOTES: LIFE INSURANCE POLICY PROVISIONS, OPTIONS, AND RIDERS

Standard Life Insurance Provisions

Entire Contract:

- The entire contract includes the actual policy and the application.
- It states that nothing outside of the contract (the contract includes the signed application and any attached policy riders) can be considered part of the contract.
- It also assures the policyowner that no changes will be made to the contract or the waiver of any of the provisions after it has been issued, even if the insurer makes policy changes that affect all policy sales in the future. However, this doesn't prevent a mutually agreeable change or modification of the contract after it has been issued.
- Any change to a policy must be made with the approval of an executive officer of the insurance company whose approval must be endorsed on the policy or attached in a rider.
- The **execution clause** states that the insurance contract will be executed when both parties (the insurer and the policyowner) have satisfied the conditions of the contract.
- The **privilege of change clause** (or policy change provision) outlines the conditions under which the company will allow the policyowner to change the policy's coverage.

Insuring Clause (or Insuring Agreement):

- The insuring clause is the insurer's basic promise to pay specified benefits to a designated person in the event of a covered loss.
- This is the part of the insurance policy that identifies the specific type of benefits or services that are covered by the policy and the circumstances under which they will be paid.
- The purpose of this clause in an insurance policy is to specify the scope and limits of the coverage provided.
- Any promises that the INSURER makes will be in the INSURING clause.

Consideration Clause:

- A policyowner must pay a premium in exchange for the insurer's promise to pay benefits.
- A policyowner's consideration consists of completing the application and paying the initial premium.
- The amount and frequency of premium payments are contained in the consideration clause. For insurance, the insurance company exchanges the promises in the policy for a two-part consideration from the insured.
- Consideration is an exchange of an item of value on which a contract is based.
- An insurance contract is valid only if the insured provides consideration in the form of the initial full minimum premium required and the statements that are made in the application.
- The applicant states, "Please CONSIDER me for insurance. Here is my completed application, my initial premium, as well as how much money and how often I agree to pay. Please CONSIDER me!"

Incontestable Clause:

- In a life insurance contract, this is the clause that prohibits the insurer from questioning the validity of the contract after a certain period has elapsed.
- The period is typically two years from the policy's issue date. Since state requirements may be different, they will be covered in the state law portion at the end of the course.

Physical Exam and Autopsy:

- The physical exam and autopsy provision entitles a company, at its own expense, to make physical examinations of the insured at reasonable intervals during the period of a claim, unless it's forbidden by state law.
- Only the state can forbid an autopsy. A person (and her family) gives up her right to refuse when she applies for insurance.

Misstatement of Age or Sex:

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

Owner's Rights Provision

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

Assignment Provision

- The **assignment clause or provision** is the right to transfer policy rights to another person or entity. The new owner is referred to as the assignee.
- An **absolute assignment** occurs when the assignee receives full control of the policy and the rights to the policy benefits from the current policyowner. Under an absolute assignment, the transfer is complete and irrevocable, and the assignee receives full control over the policy and full rights to its benefits.
- A **collateral assignment** is the partial and temporary transfer of rights to another person or entity. Collateral assignments are typically intended for securing a loan with a creditor. A collateral assignment occurs when the policy is assigned to a creditor as security or collateral for a debt. If the insured dies (or possibly becomes totally\permanently disabled), the creditor is entitled to be reimbursed out of the benefit proceeds for the amount owed. The insured's beneficiary is then entitled to any excess of policy proceeds over the amount due to the creditor.

Free Look:

- Once the policy is delivered, the policyowner is permitted a certain number of days to look over the policy and, if dissatisfied, return it for a refund of all premiums paid.

Grace Period:

- The grace period is a specified period after a premium payment is due, during which the protection of the policy continues despite the fact that the payment for the renewal premium has not yet been received.
- The policyowner is given a number of days after the premium due date and, during this time, the premium payment may be delayed without penalty, and the policy continues in force.
- If the insured dies during the grace period of a life insurance policy before paying the required annual premium, the beneficiary will receive the face amount of the policy less any required premiums.
- The purpose of the grace period is to give the policyowner additional time to pay overdue premiums.

Reinstatement:

- The reinstatement provision allows the policyowner to reinstate a policy that has lapsed as long as the policyowner can provide proof of insurability and pays all back premiums, outstanding loans, and interest.
- Most states allow reinstatement for up to three years after a policy has lapsed. However, for some states the reinstatements are from five to seven years.
- This provision specifies that if an insured fails to pay a renewal premium within the time granted, but the insurer subsequently accepts the premium, coverage may be restored.
- Under certain conditions, a policy that has lapsed may be reinstated.
- Reinstatement is automatic if the company or its authorized agent accepts the delinquent premium, and the company doesn't require an application for reinstatement. If it takes no action on the application for 45 days, the policy is reinstated automatically.
- To reinstate any policy, a person needs a reinstatement application, statement of good health, and payment of all back premiums.

Provisions and Options Related to Cash Value

Non-Forfeiture Options

- When a policyowner decides he doesn't want his life insurance policy any longer, he has the option to surrender his policy. If there's cash value remaining, the policyowner must use one of the following non-forfeiture options:
  - **Cash Surrender:** Allows the policyowner to receive the policy's cash value and, at this point, the policyowner no longer has coverage. Typically, the maximum length of time a life insurance company may legally defer paying the cash value of a surrendered policy is six months (delayed payment provision).
  - **Extended Term Option:** Permits the policyowner to use the policy's cash value to buy level, extended term insurance for a specified period. No premium payments are made. The coverage provided with the extended term non-forfeiture option is equal to the net death benefit of the lapsed policy.
  - **Reduced Paid-Up Option:** The policyowner pays no more premiums, but the face amount is decreased.
- *If the insured is closing her account (surrendering her policy), the insurance company is questioning what it should do with her cash (so that she doesn't forfeit it).*

Policy Loan Provisions:

- Policies that have cash value also have policy loan and withdrawal provisions. These policies must begin to build cash value after a certain number of years. In most states, the period is three years.
- Policy loans (with interest) cannot exceed the guaranteed cash value, if so, the policy is no longer in force.
- The policyowner has the right to the policy's cash value.
- Policy loans are not taxable.
- At time of the insured's death, any loans (with interest due) will be deducted from the insured's policy proceeds.

Automatic Premium Loans:

- This provision allows the insurer to automatically use the policy cash value to pay an overdue premium. Therefore, it allows the insurance company to deduct the overdue premium from an insured's cash value by the end of the grace period if a payment is missed on a life policy.
- There's no cost associated with this provision.
- The automatic premium loans provision is similar to using a savings account for overdraft protection, but there's no fee. Instead, there's simply interest charged for borrowing the funds. If the loan is not repaid, interest is added to the loan.
- Outstanding loans are subtracted from any death benefit or cash surrenders if they're not paid back first.
- The insurance company can AUTOMATICALLY take out a LOAN for the insured against his CASH VALUE to cover his PREMIUM in the event the company doesn't' receive his payment.
- Automatic premium loans can continue for as long as the insurer doesn't receive payment and the policyowner has cash value remaining in the policy. Once all of the cash value is gone, if the policyowner doesn't start paying, the policy will lapse.
- The automatic premium loans function in the same manner as any other cash value loan.

Provisions and Options Related to Policy Proceeds

Beneficiary Designation:

- This is where the policyowner indicates who's to receive the proceeds.

Change of Beneficiary:

- The policyowner may change the beneficiary designation at any time unless a beneficiary has been identified as irrevocable.

Settlement Options:

- The methods by which the policy proceeds can be paid out or settled.
- Typically, the beneficiary chooses the settlement option at the time of the insured's death.
- The **spendthrift clause** stipulates that the policyowner may select a settlement option at the time of application.

Accelerated Benefits Rider:

- This rider allows the insured to receive a portion of the death benefit prior to death if the insured has a terminal illness and is expected to die within one to two years. Regardless of the amount withdrawn in an accelerated death benefit, it will decrease the death benefit when death occurs.

- For example, an insurance company may know that a person is going to die soon, which means it's going to be paying out the benefit soon. To make things a little easier and less stressful, the company will give the insured some of the proceeds NOW and deduct from what would go to the beneficiary upon the insured's death.

Long-Term Care Rider:

- A **long-term care rider** is a type of accelerated benefits rider that will pay a benefit if the insured is permanently confined to a nursing home and requires long-term care or is unable to perform two or more activities of daily living.
- Activities of daily living (ADLs) include eating, dressing, bathing, toileting/continence, walking/ambulation, transferring, or taking medication.

Provisions and Options Related to Policy Dividends

Dividends:

- Participating policies pay dividends to policyowners if the company's operations result in a divisible surplus.
- Dividends are a return of overcharged premiums and are therefore not taxable.
- Insurers typically pay dividends on an annual basis.

Dividend Options:

- The following dividend options are available to policyowners for settling dividend payments:
  - **Cash Option**: The insured simply takes the cash.
  - **Reduced Premiums Option**: Reduces premium payments by having the insurance company retain the money and charge less the following year.
  - **Accumulate Interest Option**: Allows dividends to accumulate interest. Interest is the only part of a potential dividend for which the policyowner may be taxed.
  - **Paid-Up Additions Option**: Purchases single payment whole life coverage.
  - **One-Year Term Option**: Purchase one-year term protection.
- Unlike non-forfeiture options, the policy remains active when a dividend option is selected.

Life Insurance Policy Riders

Waiver of Premium Rider:

- This rider allows the policyowner to waive premium payments during a disability and keeps the policy in force; it doesn't provide cash payments to the policyowner.
- The disability must be total and permanent and must have sustained through the waiting period (either 90 days or six months).
- After a certain age (typically the age of 60 or 65), the waiver of premium rider is void, unless it's currently in use.
- The waiver of premium covers the PRIMARY INSURED, not any additional insureds.
- This provision does NOT provide income and is NOT a loan. Instead, the insurance company is "waiving" the premiums" and treating it as if the insured made the premium payments each month.

Accidental Death Benefit Rider (Double Indemnity):

- This rider may be added to a permanent or temporary life insurance policy.
- It pays an additional sum to the beneficiary if the insured dies due to an accident.
- The amount paid is a multiple of the policy face amount, such as double or triple the original benefit. This is truly the cheapest way to add a large amount of coverage for a specific period.
- Provides an additional amount of insurance that's typically equal to the face amount of the base policy if the cause of death was the result of an accident.

Accidental Death and Dismemberment Rider:

- This rider may be added to a permanent or temporary life insurance policy, and it pays benefits for dismemberment and accidental death.
- It pays a principal sum (face amount) for loss of both hands, both arms, both legs, or loss of vision in both eyes.
- Pays capital sum (half of face value) for loss of one foot, one hand, one eye, etc.
- One foot and one hand = 100% face value.

Guaranteed Insurability Option Rider:

- This rider allows a policyowner to purchase additional life insurance coverage at specified dates without providing evidence of insurability.
- It also includes specific events (e.g., marriage or birth of a child) without requiring the proof of insurability.
- The benefit is typically allowed every three years, up to the original face amount of the policy.
- This feature is also referred to as the *future increase option*.

Cost of Living Rider:

- This rider allows the policy face amount to be adjusted to account for inflation based on the Consumer Price Index (CPI).

Payor Provision (Rider):

- The payor provision is typically attached to juvenile policies to protects the insured in the event that the PAYOR dies or is disabled.
- With this provision, if the adult premium payor of the juvenile policy dies or becomes disabled, the premiums will be waived until the child reaches a specified age (e.g., age 18, 21, or 25).
- This provision is also referred to as the *payor clause*.

Term Rider:

- A term rider allows an applicant to have excess coverage by adding an additional term rider to her primary policy.
- A term rider is an economical way to add a large amount of additional insurance to a permanent life insurance policy.
- Term riders covering the life of the insured can be level, increasing, or decreasing term.

Return of Premium Rider:

- This rider returns the total amount of premiums paid into the policy, in addition to the face value, as long as the insured dies within a specific period that's specified in the policy.
- It also returns premiums to the living insured at the end of a specified period as long as the premiums have been paid.

Other Insureds Provisions:

- Other insured or dependent riders may be added to a primary policy to cover a spouse or "another insured," children, or adopted children.
- Family plan policies typically cover the family head with permanent insurance, and the coverage on the spouse and children is term insurance in the form of a rider.
- A term rider for other insureds is always level term.
- Adding a term rider is cheaper than having every family member obtain their own policy.
  - *For example, the primary policy may be on a father, but the mother and the children are riding on (attached to) the father's policy as term riders. Term riders allow for additional family members to be covered under one policy by attaching everyone to the primary policy.*

Child Term Rider:

- A child term rider is a life insurance product that rides on the primary parent's policy and covers the lives of the children.
- The child term rider is typically one flat premium, regardless of the number of children covered.
- Remember, a child term rider pays a benefit to the beneficiary (parent) if the child dies; it doesn't pay the child.

Spousal Term Rider:

- A spousal term rider is a life insurance product that rides on the primary policy and covers the life of the primary insured's spouse.
- Remember, a spouse term rider pays a benefit to the beneficiary (primary insured) if the spouse dies; it doesn't pay the spouse.

Common Exclusions or Restrictions

Exclusions:

- An exclusion is a feature of a life insurance policy stating that the policy will not cover certain risks.
- Exclusions and restrictions are situations or conditions which are not covered or are covered with substantial limits.
- The exclusions section is NOT included in the policy face (i.e., the first page of an insurance policy).

War or Military Service

- The insurer will not pay the claim if the insured dies or is injured while in active military service or due to an act of war.

Aviation

- The insurer will not pay the claim if the insured dies due to involvement with aviation. Typically, this is limited to high-risk aviation (e.g., stunt pilot, instructor/student pilot, or a military pilot).
- Although uncommon, it may also exclude the period during which insured is serving as a pilot or crew member of an aircraft.

Hazardous Occupation or Hobby

- If the insured dies as a result of a hazardous occupation or hobby, the insurer will not pay the claim.
- To deny the claim, the activity or occupation for which the claim is being denied must be explicitly excluded in the policy (i.e., part of the entire contract).
- The **change of occupation provision** allows the insurer to reduce the maximum benefit payable under the policy if the insured switches to a more hazardous occupation or reduce the premium rate charged if the insured changes to a less hazardous occupation.

Criminal Activity

- Losses due to injuries that are sustained while rioting, **committing a felony**, or attempting to do so, also may be excluded.
  - **Illegal Occupation**: This provision specifies that the insurer is not liable for losses that are attributed to the insured's being connected with a felony or participating in an illegal occupation.
  - **Intoxicants and Narcotics**: The insurer is not liable for any loss that's attributed to the insured while intoxicated or under the influence of narcotics.

Suicide Clause:

- The policy will be voided and therefore no death benefit will be paid if the insured commits suicide within one to two years from policy issuance. The primary purpose of a suicide provision is to protect the insurer against the purchase of a policy by a person who's contemplating suicide.

REVIEW NOTES: LIFE INSURANCE PREMIUMS, PROCEEDS, AND BENEFICIARIES

Purpose of Premiums

- The insurer receives a premium from a policyowner in exchange for insurance protection. The premium is part of the policyowner's consideration or the "binding force" in the contract, which cements the agreement between the insurer and policyowner.

Factors in Premium Calculation

- **Mortality Factor:** A measure of the number of deaths in a given population. Mortality is based on a large risk pool of people and time. Insurance companies use mortality tables to help predict the life expectancy and probability of death for a given group.
- **Interest Factor:** Insurance companies invest the premiums they receive in an effort to earn interest. The **rate of earnings on investments** is one of the ways that an insurance company can reduce premium rates.
- **Expense Factor:** As any other business, insurance companies have operating expenses that need to be factored into the premiums being charged. The expense factor is also referred to as the **loading charge.**

Other Factors That Impact the Premium Amount

- **Age:** The older the person, the higher probability of death and disability.
- **Sex/Gender:** Women tend to live longer than men; therefore, their premiums are generally lower.
- **Health:** Poor health increases the probability of death and disability.
- **Occupation:** A hazardous job increases the risk of loss.
- **Hobbies:** High-risk hobbies also increase the risk of loss. Remember, these are typically only important at the time of application. For example, a person is obtaining life insurance and states that he's never been skydiving (which is true). Then, five years later, the person goes skydiving for the first time and dies in an accident. In this case, the insurance company will pay the death benefit.
- **Habits:** Tobacco use presents a higher risk than for non-smokers.
- **Benefits, options, and riders:** The number and types of benefits provided by a policy affect the premium rate. The greater the benefits, the higher the premium. Or, put another way, the greater the risk to the company, the higher the premium.
- **Premium mode** refers to the premium payment schedule and **permits the policyowner to select the timing of premium payments.** Options include annual, semiannual, quarterly, and monthly. The more frequently the payments are made, the more it's going to cost overall. Ideally, if a person is able to make one payment in a lump-sum to start and "pay up" the policy, she will save the most money. Also, her cash value will begin to accumulate immediately. The higher the premium payments, the quicker the cash value will accumulate. The higher the frequency of payments, the higher the total premiums.

Premium Terms and Funding

- An insurance company's **reserves** represent money that (together with future premiums, interest, and survivorship benefits) will fulfill an insurance company's obligations to pay future claims. Each state has its own reserve requirements.
- The **earned premium** (the amount of premium to which an insurer is entitled for the insurance coverage provided) and the **unearned premium** (the premium collected from the policyholder for future coverage) make up the insurer's total premium.
- **Cost basis** represents the premiums paid into the policy minus total dividends received in cash or used to offset premiums.
- **Net premium** is a premium that makes provision for mortality (death benefit) losses only while being influenced by the interest rate assumed, gender, the benefit to be provided, and the mortality rate.
- **Gross premium** is the premium charged by an insurer and is comprised of or influenced by all factors of mortality, interest, and expenses. It's the actual premium paid by the policyowner for life insurance coverage. (Gross premium = Net premium + Insurer expenses).
- **Single premium funding:** The policyowner pays a single premium that provides protection for life as a paid-up policy. Single premium funding provides for the lowest total premium and fastest build-up of cash value.
  - *For example, John, a 30-year-old non-smoker, buys a $100,000 whole life policy for one **single premium** of $70,000.*
- **Level (fixed) premium funding:** The policyowner pays more in the early years for protection to help cover the cost in later years. This allows the premiums to remain level throughout the life of the policy. The shorter the premium-paying period, the higher the periodic premiums.
  - *For example, John can buy that same $100,000 whole life policy for 10 (annual) **level premiums** of $8,000 each ($80,000 total premiums); or John can buy that same $100,000 whole life policy for 840 **level premiums** (monthly for 70 years) of $105 each ($88,200 total).*
- **Modified premium funding** is characterized by an initial premium that's lower than it should be during an introductory period (typically the first three to five years). After this time, the premium will increase to an amount that's greater than what the initial level premium would have been and then remains level or constant for the life of the policy.
  - *For example, John can buy that same $100,000 whole life policy for 36 initial **fixed premiums** (monthly for three years) of $50 each ($1,800 total introductory) and then an additional 804 **fixed premiums** (monthly for 67 years) of $110 each ($88,440 total remainder). ($1,800 introductory + $88,440 for reminder = $90,240 total).*
- **Graded premium funding** is a contract that's characterized (like modified) by a lower premium in the early years of the contract. However, premiums increase annually for the initial period. Then, it increases to an amount that's higher than what the initial level premium would have been, but thereafter remains level or constant for the life of the policy.
  - *For example, John can buy that same $100,000 whole life policy for monthly payments of $20 for year 1, monthly payments of $40 for year 2, monthly payments of $50 for year 3, monthly payments of $75 for year 4 ($2,220 total introductory), and then an additional 792 **fixed premiums** (monthly for 66 years) of $120 each month ($95,040 total remainder). ($2,220 introductory + $95,040 for reminder = $97,260 total).*
- **Flexible premium funding** allows the policyowner to adjust the premiums throughout the life of the contract.

- **Minimum deposit financing** allows the policyowner to use policy loans to pay premiums that are due each year. The policyowner only pays the difference between the premium due and the amount borrowed (plus interest on the policy loan). Depending on the type of policy, a policyowner may be able to use the policy's cash value and dividends to pay the premium.

Comparing Life Insurance Policy Costs

- The cost of life insurance is largely dependent on an individual's specific circumstances and requirements. However, cost estimates are useful so that the consumer can consider every factor when making a buying decision. A lower premium doesn't automatically equate to a lower-cost policy. To that extent, cost indexes have been developed to aid in the process of measuring an insurance policy's actual cost.
- **Surrender Cost Index:** Uses a complicated calculation formula in which the net cost is averaged over the number of years during which the policy was in force to arrive at the average cost-per-thousand for a policy that's surrendered for its cash value at the end of that period.
- **Net Payment Cost Index:** Uses the same formula as the Surrender Cost Index, with the exception that it doesn't assume that the policy will be surrendered at the end of the period. The net payment cost index is useful if a person's primary concern is the amount of death benefits provided in the policy. It helps compare future costs (e.g., 10 to 20 years) if a person continues to pay premiums and doesn't take the policy's cash value.
- The interest adjusted cost method calculates the cost of life insurance by taking into account the time value of money (i.e., the investment return on sums placed in premium dollars had these sums been invested elsewhere).
- The traditional net cost method adds a policy's premiums and subtracts both dividends (if any) and cash value.

Policy Proceeds

- **Living Benefits:** A living benefit is the option to use some of the future death benefit proceeds before death.
- **Cash Value:** The cash (equity) that accumulates and may be borrowed against, used as collateral, utilized as supplemental retirement income, or may be withdrawn for emergencies or other situations in which cash is needed.
- **Accelerated Benefit:** Allows a person who's be certified by a physician as terminally ill to access the death benefit. To be considered terminally ill, a physician must certify that the person has a condition or illness that will result in death within two years. *After the certification, the insurance company now knows that it will soon be required to pay out the benefit. As a result, it will allow the person to use some of the proceeds now and deduct it from what's paid to the beneficiary later*.
- **Viatical Settlement:** Allows a person who has a terminal illness to sell his existing life insurance policy to a third party for a percentage of the death benefit. The new owner continues to make the premium payments and will eventually collect the full death benefit. The original policyowner is referred to as the *viator*, while the new third-party owner is referred to as the *viatical* or *viatee*.
- **Life Settlement:** A life settlement is the sale of an existing life insurance policy to a third party for more than its cash surrender value, but less than its net death benefit. An insured is not required to have a terminal illness to participate in a life settlement.

- **Policy Dividends:** Dividends are a refund of a part of the premium under a mutual insurer's participating policy. The policyowner may use dividends for cash payments, to pay the insurance premium, to purchase additional paid-up whole life insurance, to purchase one-year term insurance, or as an investment to accumulate interest. Although not directly tied to the policy proceeds, dividends are still considered a living benefit.
- **Death Benefit Settlement Options:** Although customarily selected by the beneficiary, the policyowner may select a settlement option at the time of the application and may change the option at any time during the insured's life. If selected by the policyowner, the settlement option cannot be changed by the beneficiary. Death benefit settlement options include:
  - **Lump-Sum:** Death benefit is paid in a single payment, minus any outstanding policy loan balances and overdue premiums. The lump-sum option is considered the automatic (or "default") option for most life insurance contracts.
  - **Interest Only:** The insurance company holds the death benefit for a period and pays only the interest earned to beneficiaries.
    - A minimum rate of interest is guaranteed, and the interest must be paid at least annually.
  - **Fixed Period (Period Certain):** The insurer pays proceeds (including interest and principal) in minimum guaranteed dollar payments over a specified number of years.
  - **Fixed Amount:** The insurer pays a fixed death benefit in specified installment amounts until the proceeds are exhausted. The larger the installment payment, the shorter the payout period.
  - **Life Income:** This provides the beneficiary with an income that she cannot outlive. Installment payments are guaranteed for as long as the recipient lives. The amount of each installment is based on the recipient's life expectancy and the principal benefit.
  - **Joint and Survivor:** Benefits will be paid on a life-long basis to two or more people. This option may include a period certain, and the amount payable is based on the ages of the beneficiaries.

Beneficiaries

- There are very few restrictions as to who may be named a beneficiary of a life insurance policy. A beneficiary can be either specific (a person who's identified by name and relationship) or a class designation (a group of individuals, such as the children of the insured). If no beneficiary is named or if all beneficiaries die before the insured dies, the death benefit will go to the insured's estate. The policyowner is the ultimate decision-maker. However, in the underwriting process, the underwriter may consider the issue of insurable interest. Examples of who can be beneficiaries include:
  - Individuals
  - Businesses
  - Trust
  - Estates
  - Charities
  - Minors
  - Class

Distribution By Order of Succession

- **Primary:** The first in line to receive death benefit proceeds.
- **Secondary (contingent):** The second in line to receive death benefit proceeds if the primary beneficiary dies first.
- **Tertiary:** The third in line to receive death benefit proceeds. If one is not named, the death benefit will go to the insured's estate.
- **Distribution by Descent**
  - **Per Stirpes (meaning by the bloodline):** If a beneficiary dies before the insured, benefits from that policy will be paid to that beneficiary's heirs.
  - **Per capita (meaning by the head):** Evenly distributes benefits among all named living beneficiaries.

Changing a Beneficiary

- **Revocable Beneficiary:** The policyowner may change the beneficiary at any time without notifying or obtaining the beneficiary's permission.
- **Irrevocable Beneficiary:** The beneficiary cannot be changed without the beneficiary's written consent. The irrevocable beneficiary has a vested interest in the policy. Therefore, the policyowner cannot exercise certain rights (e.g., taking out a policy loan) without the beneficiary's consent.

Special Situations

- **Uniform Simultaneous Death Act:** If the insured and the primary beneficiary die at approximately the same time as the result of a common accident with no clear evidence as to who died first, the act will assume that the primary beneficiary died first. This allows the death benefit proceeds to be paid to the **contingent beneficiary(ies).**
- **Common Disaster Provision:** With this provision, a policyowner can be certain that if both the insured and the primary beneficiary die within a short period, **the death benefits will be paid to the contingent beneficiary.**
- **Spendthrift Clause:** Prevents the deceased's creditors from obtaining the death benefit and prevents a beneficiary from recklessly spending benefits by requiring the benefits to be paid in fixed amounts or installments over a certain period.
- **The facility of payment** allows the insurance company to pay all or a part of the proceeds to a person who's not named in the policy, but has a valid right. Facility of payment is often done on behalf of a minor or when the named beneficiary is deceased.

Tax Consequences of Life Insurance

- Premiums that are paid on individual life insurance policies and premiums that are paid for life insurance used for business purposes (the company's benefit) are generally not tax-deductible. However, exceptions allow premiums to be tax-deductible for:
  - Premiums on an insurance policy to benefit a charity
  - Premiums on an insurance policy to benefit an ex-spouse as court-ordered alimony
- Employer-paid premiums that are used to fund group insurance for the benefit of employees are tax-deductible for the **employer**.

- Living benefits can have tax implications depending on the situation.
- **Cash Value:** For policies that are not surrendered, the cash value grows on a tax-free basis. If the policy is surrendered for its cash value, the portion that exceeds the premiums paid is taxable. As long as the cash value remains in the policy, taxes will never be imposed on any portion, not even the amount that exceeds the cost basis.
- According to the IRS, proceeds from a policy loan don't count as taxable income. However, if a policy is surrendered or lapses, the IRS is notified of the taxable event and taxes may be required.
- **Accelerated Death Benefit:** Under a life insurance policy, when benefits are paid to a terminally ill person, the benefits are received tax-free.
- **Dividends** are received tax-free. However, if the policyowner chooses to leave the dividends with the insurance company as an investment, any interest that accumulates will be subject ordinary income tax.
- The transfer for value rule applies when a life insurance policy is sold to another party before the insured's death. For this reason, most states require a viatical settlement company or life settlement company to inform the client that the proceeds could be taxable in certain situations and it should be recommended that they consult with a tax advisor.
- **1035 Exchange:** When an existing life insurance policy is assigned to another insurer for a new contract, the transaction may be treated for tax purposes as a Section 1035 exchange. Policy exchanges that qualify as 1035 exchanges are not taxable. A Section 1035 exchange enables the postponement of tax consequences.
- Under the **Economic Benefit Doctrine,** any benefit granted to an individual that has an economic or financial value must be included as compensation for income tax purposes in the year in which the benefit is granted. Individual life insurance generally avoids this doctrine since premature death can cause a substantial risk to a surviving family.
- Life insurance proceeds that are paid to a beneficiary as a lump-sum are generally received tax-free. Additionally, proceeds pass directly to the beneficiary and are not subject to attachment by the insured's creditors.
- If death benefits are paid to a beneficiary in installments (as opposed to as a lump-sum), the principal is received tax-free and any interest received is taxable.
- Another tax cost that's typically associated with death is the federal estate tax (although most relatively simple estates don't require the filing of an estate tax return).

REVIEW NOTES: LIFE INSURANCE UNDERWRITING AND POLICY ISSUE

Purpose of Underwriting

- Underwriting is the process that's used by an insurance company to determine whether an applicant is insurable and, if the applicant is insurable, how much to charge for premiums.
- The underwriter will utilize several different types of information when determining the insurability of the individual.
- Material facts can affect an applicant being accepted or rejected.
- One of the primary responsibilities of an underwriter is to protect the insurer against adverse selection.
- The underwriter classifies each proposed insured's risk and selects only those with an acceptable risk based on the insured's underwriting guidelines.

Underwriting Process

- The underwriting process involves reviewing and evaluating the applicant's information and establishing individual guidelines against the insurer's standards and guidelines for insurability and premium rates. The larger the policy, the more comprehensive and diligent the underwriting process.
- The most common sources of underwriting information include:
  - The application
  - The medical report
  - Attending physician's statement
  - The Medical Information Bureau
  - Special questionnaires
  - Inspection reports
  - Credit reports
- Application: The application is the starting point and primary source of information that's used by an insurance company in the risk selection. Although applications differ from company to company, they all have the same general components. Insurable interest must exist between the policyowner and insured at the time that the application is made (not at the time of death/loss).
- Insurable interest exists when the death of the insured would have a clear financial impact on the policyowner.
- An application has the following three parts:
  - Part I of the application includes:
    - General information (e.g., age, date of birth, gender, address, marital status, occupation)
    - Details about the requested insurance coverage (e.g., type of policy, amount of insurance, name and relationship of the beneficiary, other insurance the proposed insured owns)
    - Other information personal information
      - Tobacco use
      - Hazardous hobby
      - Foreign travel
      - Aviation activity
      - Military service

  - Part II of the application includes:
    - Medical information and health history
    - A medical section which must be completed in its entirety for every application (depending on the proposed policy, this section may be all that's required in the way of medical information)
    - The disclosure that the individual to be insured may be required to take a medical exam or provide a blood test or urine specimen
  - Part III of the application includes:
    - The agent's report (statement) which contains the agent's observations of the applicant
    - The applicant's financial condition, character, background, the purpose of sale, and how long the agent has known the applicant.
    - (Because the agent represents the insurance company's interests, the agent is expected to complete this part of the application thoroughly and truthfully.)

- Policies below a certain face amount (e.g., $50,000, or even $100,000) will not require additional medical information, other than what's provided by the application. However, they require a medical report for further information.
- **Credit Reports**: An applicant's credit history may be used for underwriting and determines the likelihood of the premium payments being made. The Fair Credit Reporting Act (FCRA) requires the applicant to be notified in writing if a credit report will be used. The applicant must also be notified if the premium is increased because of a credit rating.
- **Warranty**: Warranties are statements that are guaranteed to be literally true. A warranty that's not literally true in every detail, even if it's made in error, is sufficient to render a policy void.
- Representations include statements made by the applicant that are substantially true to the best of his knowledge but are not warranted as exact in every detail.
- **Medical Report**: A medical report is often used for underwriting policies with higher face amounts. If the medical section's information warrants further investigation into the applicant's medical conditions, the underwriter may need an attending physician's statement (APS).
- **Inspection Reports**: This report provides information about the applicant's character, lifestyle, and financial stability. Due to their cost, inspection reports are typically only requested for more extensive coverages. However, company rules vary as to the sizes of policies that require a report by an outside agency. When an investigative consumer report is used in connection with an insurance application, the applicant has the right to receive a copy of the report.
- Companies are allowed to obtain inspection reports under The Fair Credit Reporting Act. The FCRA regulates how credit information is collected and used to protect the rights of the consumers for whom an inspection or credit report has been requested. It established procedures for the collection and disclosure of information obtained on a consumer through investigation and credit reports.
- If an insurance company requests a credit report, the consumer must be notified in writing. This report provides information about the applicant's character, lifestyle, and financial stability. When an investigative consumer report is used in connection with an insurance application, the applicant has the right to receive a copy of the report.
- **Medical Information Bureau (MIB)**: The MIB is a non-profit trade organization that maintains medical information about individuals. Information from the MIB is used by life and health insurance companies to help avoid adverse selection by applicants. It detects misrepresentations, helps identify fraudulent information, and controls the cost of insurance. Information received or released from the Medical Information Bureau about a proposed insured may be released to the proposed insured's physician. An insurance company will NOT notify the MIB if an application is declined. One of the primary purposes of the MIB report is to allow an insurer to avoid high-risk applicants.

- **USA PATRIOT Act**: The USA PATRIOT Act was enacted in 2001 and requires insurance companies to establish formal anti-money laundering programs. The purpose of the act is to detect and deter terrorism. A life insurance policy can be cash-surrendered, which can be an attractive money-laundering vehicle because it allows criminals or terrorists to put dirty money in and take clean money out in the form of an insurance company check.
- **Special Questionnaires**: These are used for applicants who are involved in particular activities, such as aviation, military service, or hazardous occupations or hobbies. The questionnaire provides details regarding the amount of time the applicant spends on these activities.
- **Fair Credit Reporting Act of 1970 (FCRA)**: The FCRA regulates the amount of credit information can be collected and protects the rights of consumers for whom an inspection or credit report has been requested. Information regarding an individual's credit standing and general reputation is contained in a consumer report. The FCRA established procedures for the collection and disclosure of information obtained on consumers through investigation and credit reports. If an insurance company requests a credit report, the consumer must be notified of this fact in writing. The applicant has the right to receive a copy of the report when an investigative consumer report is used in connection with an insurance application.

Privacy Notice

- The Health Insurance Portability and Accountability Act (HIPPA) is a privacy rule that provides federal protections for an individual's health information. Furthermore, HIPAA gives patients a variety of rights concerning individually identifiable health information. When an agent submits an application that reveals personal information regarding an applicant, the agent is responsible for providing the insurance applicant with privacy notices.
- In applicable situations, producers must also secure an HIV consent form from the applicant and communicate that blood tests may be required. In other words, despite the fact that the insurer requires a blood test as part of its regular underwriting activity, it must still secure a signed consent form which indicates to the applicant that any blood taken will be screened for HIV and that he's providing permission for such testing to be completed.
- **Applicant Ratings**: Once all of the information about a given applicant has been reviewed, the underwriter seeks to classify the applicant's risk to the insurer. This evaluation is referred to as *risk classification*.

Classifications of Risk

- Once all the information about a given applicant has been reviewed, the underwriter will utilize several different types of information in determining the insurability of the individual and the risk that the applicant poses to the insurer. This evaluation is known as risk classification. The following rating classification system is used to categorize the favorability of a given risk:
- **Preferred**: This classification is characterized by low risk and low premiums. Some of the following may result in a policy being issued with a preferred insurance premium:
  - The applicant doesn't smoke or drink.
  - The applicant has good personal/family health history.
- **Standard**: This classification is characterized by average risk with no extra ratings or restrictions. The policies will have standard terms and rates.
- **Substandard**: This classification is characterized by high risk and rated up (higher) premiums due to chronic conditions, insulin diabetes, or heart disease.
- **Declined**: This means the applicant is not insurable because the potential of loss to the insurance company is too high. The applicant has a terminal illness or too many chronic conditions.

Field Underwriting Procedures

- Field underwriting is completed by an agent. Unlike the insurer, the agent has face-to-face contact with the applicant, which can aid the insurer in risk selection. As field underwriters, agents help reduce the chance of adverse selection, assure that the application is filled out completely and correctly, collect the initial premium, and deliver the policy. Other duties include:
  - Forwarding the application to the insurer in a timely manner
  - Seeking additional information about the applicant's medical history (if requested)
  - Notifying the insurer of any suspected misstatements in the application
  - Assuring that the application is filled out completely and correctly
  - Collecting the initial premium
- In addition, agents have the responsibility and duty to solicit only profitable business. Therefore, an agent's solicitation and prospecting efforts should focus on cases that fall within the insurer's underwriting guidelines and represent profitable business to the insurer.
- Upon policy delivery, agents must deliver the life insurance buyer's guide and policy summary to the applicant. A life insurance producer may also be required to obtain a signature on a good health statement at the time of policy delivery.

Application Errors

- If an agent realizes that an applicant has made an error on an application, the agent must correct the information and have the applicant initial the changes.
- An incomplete application will be returned to the agent.
- The agent can NEVER change the application without the customer present to initial the changes.
- **Buyer's Guide**: This document provides general information about the types of life insurance policies available in simple language that can be understood by the average person. (i.e., a general description of whole life, a general description of term life, essential characteristics of variable life, etc.).
- **Policy Summary**: This provides specific information about the policy purchased, such as the premium and benefits. The policy summary allows a person to quickly identify the specific "health insurance" that she purchased (e.g., Medicare Supplement, Major Medical, Critical Illness, Long-term Care, etc.).
- **Suitability Form**: This ensures that the customer is best suited for the policy he's purchasing and help prevent the sale of unnecessary insurance. For example, a 75-year-old customer who's living off of Social Security is not suitable for a single premium deferred annuity because she would be giving up a large sum of cash that she may need to live on and could possibly not live long enough to collect on the annuity.
- **Signatures**: The agent and the applicant are both required to sign the application. If the applicant is a person other than the proposed insured (except for a minor child), the proposed insured must also sign the application. In most states, having a policyowner (applicant) who's different from the insured (parent and minor child) is considered third party ownership. For an insurance policy, once a minor reaches the age of 15, he's eligible to enter into a contract.
- If an agent fails to deliver a fully completed and accurate application, the insurance company will return the agent's application.

Premiums and Receipts

- Agents should make every effort to collect the initial premium with each application. However, if the premium is not collected with the application, the policy will not become valid until it's collected.
- Once the initial premium is collected, the agent issues a premium receipt to the applicant.

- The only time a customer will receive a receipt is if he pays his initial premium at the time of application. No receipt will be given at any other time.
- There are two types of premium receipts which determine when coverage will begin—*conditional receipts* and *binding receipts*.
  - **Conditional Receipt**: The producer issues a conditional receipt to the applicant when the application and premium are collected. The conditional receipt indicates that coverage will be effective once certain conditions are met. If the insurer accepts the coverage as applied for, the coverage will take effect from the application or medical exam date, whichever is later.
  - **Binding Receipt**: The binding receipt—also referred to as the temporary insurance agreement—provides coverage from the date of the application regardless of whether the applicant is insurable. Coverage typically lasts for 30 to 60 days, or until the insurer accepts or declines the coverage. Binding receipts are rarely used in life insurance; instead, they're often used in auto and homeowners' insurance. Under a binding receipt, coverage is guaranteed until the insurer formally rejects the application. This may also be described as the insurer being bound to coverage until the application is formally rejected. Even if the proposed insured is ultimately found to be uninsurable, coverage is still guaranteed until rejection of the application.

Effective Date of Coverage

- As described under the conditional receipt, coverage is not effective without the collection of the initial premium, approval of the application, and followed by policy issuance and delivery. If the initial premium doesn't accompany the application, the premium must be collected by the agent. In some cases, the insurer requires the agent to collect a good health statement from the insured at the delivery time. If the initial premium is not submitted with the application, the policy effective date is established by the insurer. In this case, it could be the date the policy is issued.
- Generally, for a policy to be in effect:
  - The insurer must issue the policy
  - The insured must submit the initial premiums, and
  - (If applicable) The insured must sign a statement of continued good health.
- The effective date is important for two reasons, (1) it identifies when the coverage is effective and (2) it establishes the date by which future annual premiums must be paid.
- **Backdating**: This is the process of predating the application by a certain number of months to achieve a lower premium. Listing a younger age at the time of application results in a lower premium. A backdated application results in a backdated policy effective date if it's approved by the insurer. Applications can typically only be backdated for up to six months. This process is also referred to as "saving age." In addition, the next premium is due at the backdated anniversary date.

Policy Issue

- Policy issue occurs when the insurer "approves" the application (i.e., it is "issuing the policy").
- The insurance issued contract is sent to the sales agent for delivery to the applicant. The policy is generally NOT sent to the policyowner because the sales agent should personally explain it to the policyowner.
- Technically a policy could be ISSUED and not be delivered for days or weeks later.
- **Constructive Delivery**: Policy delivery may be accomplished without physically delivering the policy into the policyowner's possession.

- Constructive delivery occurs if the insurance company intentionally relinquishes all control over the policy and turns it over to a person who's acting for the policyowner, including the company's own agent. Mailing the policy to the agent for unconditional delivery to the policyowner also constitutes constructive delivery, even if the agent never personally delivers the policy. If the company instructs the agent not to deliver the policy unless the applicant is in good health, there's no constructive delivery.
- **The Statement of Continued Good Health**: This verifies that the insured has not become ill, injured, or disabled during the policy approval process (the time between the submission of the application and the delivery of the policy), or did not submit the initial premium with the application. It's used when the applicant did not submit the initial premium with the application in such cases. Common company practice requires that, before leaving the policy, the agent must collect the premium and obtain a signed statement from the insured which attests to her continued good health. Statements of good health are also used when reinstating a policy.
- Personal delivery of the policy is a good practice since it allows the producer to explain the coverage to the insured (e.g., riders, provisions, and options). Personal delivery also builds trust and reinforces the need for the coverage. All of the following acts can be considered means of policy delivery—mailing the policy to the agent, mailing the policy to the applicant, and the agent personally delivering policy. Delivery is important since the policyowner must sign a document to indicate that the policy has been received (and the free-look period and contestable period commences).

REVIEW NOTES: GROUP LIFE INSURANCE

Principles of Group Insurance

- Unlike individual life insurance which is written on a single life, group life insurance is written on more than one life.
- Group life insurance is typically written for employee-employer groups and is most often written as an annual renewable term policy.
- An important underwriting principle of group life insurance is that the insurance must cover all or a large percentage of the persons in the group.

Contributory and Non-Contributory Plans

- Contributory – An employee group plan in which employees share the cost. The insurance company requires at least **75%** of all employees to participate.
- Non-Contributory – An employee group plan in which employees do NOT share in the cost. The insurance company requires **100%** of all employees to be eligible.

Features of Group Insurance

- Features that separate group insurance from individual insurance include:
  - With group insurance:
    - The individual is not required to provide evidence of insurability since group underwriting is involved.
    - The insureds (employees) are not policyowners and only receive a "certificate of insurance" to prove that they have coverage.
    - The employer is the policyowner and receives one master contract (policy).
  - Group insurance has lower overall costs due to lower administrative, operational, and selling expenses associated with group plans.
  - The master contract allows for the flow of insureds, or the entering and exiting under the policy as members join and leave the group.
  - Group insurance is typically issued as annually renewable level term insurance, which provides a fixed amount of coverage throughout the term of the contract.
- Although the employer is the policyowner, the employee still has an "incident of ownership" by naming the beneficiary.

Eligible Groups

- Groups must exist for a purpose other than obtaining insurance.
- Among others, group life insurance can be formed by the following organizations:
  - Single-employee groups
  - Multiple-employee groups
  - Labor unions and trade associations
  - Credit/debit groups

  - Fraternal organizations
  - Trustee groups (established by two or more employers or labor unions)

Eligibility of Group Members (Employees)

- The employee must be full time and actively working.
- If the plan is contributory, employees must approve of automatic payroll deduction.
- A new employee probationary period is typically one to six months.
- During the enrollment period, an employee has 31 days to sign up. Otherwise, he may need to provide evidence of insurability.

Classification of Risk

- Insurers require a minimum number of group members/employees to participate in a group insurance plan in order to minimize adverse selection.
- Adverse selection means that the people who are most likely to need life insurance will purchase life insurance in greater numbers than those who are in good health.
- After all necessary information is collected on an applicant, the underwriter will classify the applicant based on the degree of risk assumed.
- The following rating classification system is used to categorize the favorability of a given risk:
  - Preferred: Low risk and lower premiums
  - Standard: Average risk with no extra ratings or restrictions
  - Substandard: High risk (rated up) with higher premiums
  - Declined: Not insurable - Potential of Loss to Insurance Company is Too High
- Lower risks tend to have lower premiums.
- If an applicant is too risky, the insurer will decline coverage

How Benefits Are Determined

- Most employers will establish benefit schedules according to the following:
  - Earnings
  - Employment position
  - Flat benefit
- Conversion to an individual policy: If a member's coverage is terminated, the member and his dependents may convert their group coverage to individual whole life coverage without being required to show proof of insurability.
- Conversion Period: An individual must apply for individual coverage within 31 days after the date of group coverage termination.
- Under the group policy, an individual is covered during the conversion period.
- Group Policy Termination: If the master policy is terminated, each individual member who has been insured for at least five years is permitted to convert to an individual policy that provides coverage up to the face value of the group policy

Group Credit Life

- Group Credit Life: Group credit life policies are established by organizations (e.g., banks and finance companies) and stipulate that, if the insured dies before a loan is repaid, the policy benefits will be used to settle the loan balance.

Taxation of Group Life Insurance Plans

- For a group life insurance plan to receive favorable tax treatment, there are specific requirements to ensure that an average employee is not discriminated against in favor of higher-level employees.
- If premiums for group life insurance are **paid by the employee**, they're not tax-deductible.
- If premiums for group life insurance are **paid by the employer**, they can be deducted as a business expense.
- Proceeds from a group life policy are tax-free if they're taken in a lump-sum.
- Proceeds taken in installments will be subject to taxes on the interest portion of the installments.

Group versus Individual Insurance

GROUP	INDIVIDUAL
One master policy is issued to the group	Each covered person possesses her own policy
Covered members have the same benefits/coverages	Each person selects her benefits /coverages
Only eligible group members can apply	Any individual can apply
Group underwriting	Individual underwriting
Coverage ceases when the member leaves the group	Coverage continues as long as the premium is paid
Less expensive with few restrictions	More expensive with more restrictions

- The essentials of group versus individual forms of insurance apply to life and health insurance.

REVIEW NOTES: ANNUITIES

Purpose and Function

- While life insurance protects against the risk of premature death, annuities protect against the risk of living too long and outliving income.
- Annuities are a way of providing a stream of income for a guaranteed period.
- Simply stated, an annuity is started with a large sum of money that will be paid out in installments over a preset period or until the money is exhausted.
- The monthly amount of benefit an annuitant receives is based on factors such as principal amount, rate of interest earned by the annuity, and length of the payout period.
- The **contract owner** is the individual who purchases the annuity, pays the premiums, and has rights of ownership.
  - The owner may be the annuitant, the beneficiary, or neither.
- During the liquidation phase of an annuity contract, the income benefits that are distributed at regular intervals are normally payable to the annuitant.
- The **beneficiary** is the person who receives survivor benefits upon the annuitant's death.
- Most annuities have two phases—the *accumulation (pay-in) period* and the *annuity (pay-out) period.*
- The accumulation period may typically continue even after the purchase payments cease.
- The annuity period is also referred to as the liquidation period, annuitization period, or payout period. This is the time when the money that has accrued during the accumulation period is paid-out in the form of payments to the annuitant

Structure and Design

- **Funding Method**: When defining an annuity, (describe how it's paid for) + (describe how it pays the annuitant) SINGLE PREMIUM (the annuitant pays once) + DEFERRED (it starts paying the annuitant at least one year later).
- An annuitant CANNOT make installment payments and get paid immediately.
- Single Payment = a lump-sum payment
- Periodic Payments (Flexible Premiums) = installments paid over a period of time

Date Income Payments Begin

- **Immediate Annuities**: Purchased with a lump-sum payment, and will start providing income payments within the first year, typically starting 30 days from the purchase date. Its purpose is to provide for the liquidation of a principal sum.
  - Commonly used to structure the payment of liability insurance settlements, lottery winnings, and other large sums.
  - This type of annuity is also referred to as a *single premium immediate annuity (SPIA)*.
- **Deferred Annuities**: These start providing income payments after the first year and are typically purchased with either a single lump-sum payment (single premium deferred annuity) or from monthly payments (flexible premium deferred annuity).

  - For example, a fixed deferred annuity pays out a fixed amount for life starting at a future date. Interest credited to the cash values of annuities is deferred until distribution. Other characteristics of deferred annuities include:
    - When a deferred annuity is canceled during the early contract years, the insurer will generally assess a back-end load (referred to as surrender charge).
    - The "bailout" feature, which may be found in single premium deferred annuity contracts, waives surrender charges when the interest rate falls below a stated level.
    - Before a deferred annuity contract can be terminated for its surrender value, the insurer must first obtain authorization from the owner.
    - The accumulation value of a deferred annuity is equal to the sum of premiums paid, PLUS interest earned, MINUS expenses and withdrawals

Payout Options

- **Straight Life Income Payout Option**: This option pays the annuitant a guaranteed income for her lifetime. When the annuitant dies, no further payments are made to any person. This offers protection against exhaustion of savings due to longevity.
- **Fixed Amount Option**: This option provides the annuitant with a fixed payment until the contract value is exhausted, regardless of when that will be. If the annuitant dies before the contract is depleted, the beneficiary receives the remainder.
- **Cash Refund Payout Option**: This option pays a guaranteed income to the annuitant for life. If the annuitant dies before all the money is exhausted, a lump-sum cash payment of the remaining funds is paid out to the annuitant's beneficiary.
- **Installment Refund Payout Option**: This option pays a guaranteed income to the annuitant for life. If the annuitant dies before the money is exhausted, the beneficiary will continue to receive the same monthly installment payments.
- **Life with Period Certain Payout Option (Life Income with Term certain)**: This option is designed to provide the annuitant with guaranteed payments for her life or to the beneficiary for a specific period. It designed so that benefit payments will continue for a minimum number of years regardless of when the annuitant dies.
  - For example, if an annuitant selects a 20-year period certain and dies after 10 years, the beneficiary will receive payments for another 10 years.
- **Joint and Full Survivor Payout Option**: This option pays out the annuity to two or more people until the last annuitant dies. If one of them dies, the other will continue to receive the same income payments. There are two additional options made available with a joint and survivor payout:
  - *Joint and Two-Thirds Survivor*: Survivor will have payments reduced to two-thirds of the original payment.
  - *Joint and One-Half Survivor*: Survivor will have payments reduced to one-half of the original payment.

Investment Configuration

- Annuities can also be defined by their investment configuration, which will determine the amount of income the benefits pay. The two types of annuity classifications are fixed and variable.
  - *Fixed Annuities*: Provide a guaranteed rate of return. Fixed annuities credit interest at a rate that's no lower than the contract's guaranteed rate.
  - *Variable Annuity*: Doesn't provide a guaranteed rate of return because of the investment risk. The cash value is based on the results of these investment funds. A statement must be provided to the owner of the annuity at a minimum of once per year.

  - Variable annuities can be classified as either immediate or deferred. Insurers that deal with variable annuities are subject to dual regulation by the SEC and the state's Office of Insurance Regulation.
- Accumulation Units: In a variable annuity, the value of the accumulation units varies depending on the value of the securities investment that's a part of a variable annuity.
- Annuity Units: When the variable annuity is to be paid out to the annuitant, the accumulation units are converted into annuity units. These payouts can vary from month to month and will depend on the investment results. Although the number of units doesn't change, the value of each unit will change. The amount of each variable annuity benefit paid to an annuitant varies according to the market value of the securities in the separate account.
- Equity Indexed Annuities (EIAs): A type of fixed annuity that offers the potential for a higher return than a standard fixed annuity. These EIAs may be tied to the Standard and Poor's 500 Index or the Composite Stock Price Index.
- Single-Life Annuities: Characterized by having only one annuitant.
- Tax-Sheltered Annuities: Limited exclusively for employees of religious, charity, or educational groups. These annuities are also referred to as 403(b) plans.
  - Accumulation payments often come from voluntary salary reductions.
  - The annuitant may have an individual account contract
- Income Tax Treatment of Annuity Benefits: Annuity benefit payments consist of principal and interest. The portion of annuity benefits that consists of principal (premiums paid into the annuity during the accumulation period) is not taxed and may be referred to as the owner's "cost basis." The portion of the annuity benefits that's interest earned on the principal is taxable as ordinary income. Interest income must be reported for federal income tax purposes upon receiving distributions or income benefits from the contract.
- Exclusion Ratio: This is a simple way to determine what portion of each annuity benefit payment is taxable: Exclusion ratio = Investment in the contract ÷ Expected return.
- Partial withdrawal: This is when funds are taken from an annuity before age 59 1/2. The withdrawal is considered 100% interest and is therefore taxable as ordinary income.
- A 10% tax penalty is applied if a distribution is received before the annuitant reaches age 59 1/2. After this age, withdrawals don't incur the 10% penalty tax, but are taxable as ordinary income.
- 1035 Exchange: This provision applies to annuities. If an annuity is exchanged for another annuity, a gain (for tax purposes) is not realized. This is also true for a life insurance policy or an endowment contract that's exchanged for an annuity. However, an annuity cannot be exchanged for a life insurance policy.
- Qualified Annuity Plan: This plan is a tax-deferred arrangement that's established by an employer to provide retirement benefits for employees. The plan is qualified because of having met government requirements.
  - A qualified annuity is an annuity that's purchased as part of a tax-qualified individual or employer-sponsored retirement plan, such as an individual retirement account (IRA).
  - In the accumulation phase, a qualified deferred annuity may be used to fund an IRA and permit continued contributions within the maximum limits set by the IRS. IRA funds that have been annuitized no longer permit contributions.

Suitability of Annuity Sales for Senior Customers

- When making recommendations to a senior consumer regarding the purchase or exchange of an annuity, an agent must have reasonable grounds for believing that this recommendation is suitable for the senior consumer. This recommendation should be based on the facts disclosed by the senior consumer and should include an evaluation of his investments and other insurance products along with his financial situation and needs.

REVIEW NOTES: SOCIAL SECURITY

Characteristics of Social Security

- Social insurance is provided by Social Security, also referred to as OASDHI.
- Social Security is "funded" by payroll taxes that are collected from employees, employers, and those who are self-employed.
- Social Security was established to assist people who could not afford to sustain their way of life because of unemployment, disability, illness, old age, or death.
- Social Security benefits are based on how long a covered worker has worked throughout his life.
- The primary insurance amount (PIA) determines the full amount of retirement benefits for an eligible person at the age of 65.
- Benefits that are payable by Social Security are based on what an individual worker has contributed to the program.
- Social Security establishes benefit eligibility based on an "insured" status.
- Coverage does NOT guarantee benefit eligibility.
- To obtain fully insured status, a covered worker must accrue a total of 40 quarters of credit.

Types of OASDI Benefits

- Retirement benefits
- Survivors' benefits
- Social Security survivors' benefits or death benefits – These pay a lump-sum death benefit or monthly income to survivors of deceased covered workers.
- Survivors' benefits – These include a $255 lump-sum death benefit, surviving spouse benefits, child's benefit, and parent's benefit.
- A surviving spouse without dependent children is eligible for Social Security survivor benefits as early as the age of 60.
- Survivor benefits are also available to:
  - A spouse of any age who's caring for children under the age of 16
  - Children under the age of 18
  - Children under the age of 19 who are full-time students
  - Children at any age if they're disabled before the age of 22 and they remain disabled
  - A Social Security benefit of 75% of the Primary Insurance Amount (PIA) is given to an underage child of a deceased worker

Qualified Plans versus Non-Qualified Plans

- **Qualified plans** are retirement plans that meet federal requirements and receive favorable tax treatment. Qualified plans provide tax benefits and must be approved by the IRS. The plans must be permanent, in writing, communicated to employees, and cannot favor highly paid employees, executives, or stockholders.
- The two primary types of qualified plans are *defined benefit* and *defined contribution* plans.
- To comply with ERISA minimum participation standards, qualified retirement plans must allow the enrollment of all employees who are over the age of 21 who have been employed for at least one year.
- If more than 60% of a qualified retirement plan's assets are in key employee accounts, the plan is considered "top-heavy."
- Qualified plans have the following features:
  - Employer contributions are tax-deductible as a business expense.
  - Employee contributions are made with pre-tax dollars and the earnings grow tax-deferred until withdrawal.
  - In a qualified retirement plan, the annual addition to an employee's account cannot exceed the maximum limits as set by the Internal Revenue Service.
- **Non-qualified plans** have the following characteristics:
  - They're not required to be approved by the IRS
  - They can discriminate in favor of certain employees
  - Contributions are not tax-deductible (i.e., they're after-tax)
  - Interest earned on contributions is tax-deferred until withdrawn at retirement

Tax Benefits of Qualified Plans

- Employer's contributions are tax-deductible and not treated as taxable income to the employee.
- Employee contributions are made with pre-tax dollars.
- All funds grow tax-deferred and employees are only taxed at the time of withdrawal.

Withdrawals and Taxation

- Withdrawals made by the employee are treated as taxable income.
- Withdrawals made by the employee prior to the age of 59 1/2 are assessed an additional 10% penalty tax.
- Distributions are mandatory by April 1 following the year in which the person turns age 72. The failure to take the required withdrawal results in a 50% excise tax on those funds.
- Funds may be withdrawn prior to the employee reaching age 59 1/2 without the 10% penalty tax for the following reasons:
  - The employee dies or becomes disabled
  - A loan is taken on the plan's proceeds
  - The withdrawal is the result of a divorce proceeding
  - The withdrawal is made to a qualified rollover plan
  - The employee elects to receive annual level payments for the remainder of his life

- The Employee Retirement Income Security Act (ERISA) of 1974 was enacted to provide minimum benefit standards for pension and employee benefits plans, including fiduciary responsibility, reporting and disclosure practices, and vesting rules.
- The overall purpose of ERISA is to protect the rights of workers who are covered under an employer-sponsored plan.

Employer-Sponsored Plans

- **Defined benefit plans** pay a specified benefit amount upon the employee's retirement.
  - When the term pension is used, it's typically referring to a defined benefit plan.
  - In a defined benefit plan, the benefit is based on the employee's length of service and earnings.
  - Individual and group deferred annuities mostly fund defined benefit plans.
- **Defined contribution plans** don't specify the exact benefit amount until distribution begins.
  - The two main types of defined contribution plans are profit-sharing and pension plans.
    - Profit-sharing plans are a type of retirement plan that set aside a portion of the firm's net income for distributions to employees who qualify under the plan. Plans must provide participants with the formula being used by the employer for contributions. The contributions may vary on a yearly basis, and contributions and interest are tax-deferred until withdrawal.
    - With pension plans, employers contribute to a plan based on the employee's compensation and years of service; it's not based on company profitability or performance.
- **Money purchase plans** allow employers to contribute a fixed annual amount, apportioned to each participant, with benefits based on funds in the account upon retirement.
- **Target benefit plans** have a target benefit amount.
- **Stock bonus plans** are similar to a profit-sharing plan, except that the employer's contributions are not dependent on profits and benefits are distributed in the form of company stock.
- **401(k) plans** allow employers to make tax-deductible contributions to the participant, either by placing a cash bonus into the employee's account on a pre-tax basis or the individual taking a reduced salary with the reduction placed pre-tax in the account. The account's funds are taxable at the time of withdrawal.
- Tax-sheltered annuities are a particular class of retirement plans that are available to employees of specific charitable, educational, or religious organizations.
- **Simplified employee pension (SEP) plans** are basically an arrangement whereby an employee (including a self-employed individual) establishes and maintains an IRA to which the employer contributes. Employer contributions are not included in the employee's gross income. A primary difference between a SEP and an IRA is that considerably more money can be contributed to an employee's SEP plan.
- **A Savings Incentive Match Plan for Employees (SIMPLE) plan** is available to small businesses (including tax-exempt and government entities) that employ no more than 100 employees who received at least $5,000 in compensation from the employer during the previous year. An employer can choose to make non-elective contributions of 2% of compensation on behalf of each eligible employee. To establish a SIMPLE plan, the employer must not have an existing qualified plan.
- **Keogh (HR-10) plans** are for self-employed persons, such as doctors, farmers, lawyers, or other sole-proprietors. Keoghs may be defined contribution or defined benefit plans. Contributions are tax-deductible, and interest and dividends are tax-deferred.

- **IRAs** are established by individuals who have earned income and want to save for retirement.
- **Traditional IRAs** allow for an individual to contribute a limited amount of money per year, and the interest earned is tax-deferred until withdrawal. Contribution limits are indexed annually and are currently at $6,000 per year or 100%of earned income. Any person who's 50 or older may contribute an additional $1,000, thereby making her maximum annual contribution $7,000. Some individuals may deduct IRA contributions from their taxes based on their adjusted gross income (AGI), but all withdrawals are taxable as ordinary income. If an individual or spouse is not covered by an employer-sponsored retirement plan, the entire contribution is tax-deductible (regardless of AGI). Withdrawals that are made prior to age 59 1/2 are assessed an additional 10% penalty tax.
- To avoid penalties, traditional IRA owners must begin to receive payment from their accounts by no later than April 1 following the year in which they turn the age of 72.
- Funds may be withdrawn from an IRA prior to the employee reaching the age of 59 1/2 without being subject to the 10% penalty tax (however, the interest is still taxable) for any of the following reasons:
  - Death, disability, first-time homebuyers (up to $10,000 lifetime), education (no dollar maximum), health insurance premiums (if unemployed), and qualified medical expenses
- **Roth IRAs** are designed so that withdrawals are received income tax-free. Contributions to Roth IRAs are subject to the same limits as traditional IRAs, but are not tax-deductible. Interest on contributions is not taxable as long as the withdrawal is a qualified distribution. Qualified distributions must occur after five years, or due to the death or disability of the individual, or for a first-time homebuyer (up to $10,000), or having reached the age of 59 1/2.
- A rollover is the transfer of funds from an IRA or qualified plan to another.
- Rollovers are subjected to a 20% withholding tax if eligible rollover funds are received personally by a participant in a qualified plan unless the funds are deposited into a new IRA or qualified plan within 60 days of distribution.
- Funds that are transferred directly from one qualified IRA to another qualified IRA are not subject to this withholding tax. This also includes a trustee-to-trustee transfer of rollover funds instead of personally receiving the funds and then rolling them over. This election permits the participant to avoid mandatory income tax withholding on the amount transferred.
- A surviving spouse who inherits IRA benefits from a deceased spouse's qualified plan is eligible to establish a rollover IRA in their own name.
- Rollover contributions to an individual retirement annuity (IRA) are unlimited by dollar amount.

REVIEW NOTES: USES OF LIFE INSURANCE

Determining the Proper Insurance Amounts

- Human Life Value Approach: Calculates the amount of money that a person is expected to earn over his lifetime to determine the face amount of life insurance he needs, thereby placing a dollar value on an individual's life.
- Needs Approach: A method of life insurance planning that identifies the needs of an individual and their dependents. This approach determines the total funds available to a family from all sources and subtracts the amount needed to meet their financial objectives. It takes into consideration:
  - Final expense fund
  - Housing fund
  - Education fund
  - Monthly income
  - Emergency fund
  - Income needs (if disabled or ill)
  - Retirement income
  - Estate conservation (using life insurance to enable heirs to pay estate taxes)
  - "Needs" include ANY PERSON or ENTITY who's dependent on that person (e.g., child, charity, or pet)
- The needs approach to personal life insurance planning may involve creating a lump-sum to provide for such things as education, retirement, and charitable contributions.
- The needs approach to personal life insurance planning also includes the creation of an emergency reserve fund that's primarily designed to cover the cost of unexpected expenses.

Business Uses of Life Insurance

- Buy-Sell agreements—also referred to as business continuation agreements—are used to assure the business's ownership is appropriately transferred upon the death or disability of an owner or partner. Third-party ownership of life insurance policies is widely used in business insurance and estate-planning situations.

Buy-Sell Funding for Sole Proprietors

- There's a two-step business continuation plan to keep a business running after the proprietor's death, whereby the employee takes over management of the business:
  1. Buy-Sell Plan: An attorney drafts a buy-sell plan which indicates the employee's agreement to purchase the proprietor's estate and sell the business at a price that has been agreed upon beforehand.
  2. Insurance Policy: The employee purchases a life insurance policy on the life of the proprietor. The employee is the policyowner, beneficiary, and pays the premiums. Upon the proprietor's death, the funds from the policy are used to purchase the business.

Buy-Sell Funding for Partnerships

- There are two types of buy-sell agreements for partnerships:
  1. Cross-purchase plans
  2. Entity plans
- In a *cross-purchase plan*, each partner buys, pays the premiums, and is the beneficiary of a life insurance policy on each of the other partners. The amount of the policy is equivalent to each partner's share of the business. When one partner dies, each of the other partners receives the death benefit from the life insurance on the deceased partner, which is then used to purchase the business ownership of the deceased partner.
- In an *entity plan*, the partnership itself agrees to buy the deceased partner's share of the business. Entity plans are best for businesses with several partners. In this case, the business purchases, pays the premiums, and is the beneficiary of life insurance on each partner.

Buy-Sell Funding for Closely Held Corporations

- Unlike a partnership, a closely held corporation (e.g., an incorporated family business) is legally separate from its owners and exists after one or more owners dies. A closely held corporation may purchase either buy-sell plans (i.e., either cross-purchase or entity). The difference is that an entity plan is referred to as a **stock redemption plan** for closely held corporations.
- Closely Held Corporation Cross-Purchase Plan
  - Similar to partnership cross-purchase plans, a closely held corporation cross-purchase plan requires surviving stockholders to purchase the deceased stockholder's interest in the company. The deceased stockholder's estate sells the interest to the surviving stockholders. The corporation is not part of the buy-sell plan. Each stockholder owns, pays the premiums, and is the beneficiary of life insurance on each of the other stockholders in an amount that's equal to his share of the corporation's purchase price.
- Closely Held Corporation Stock Redemption Plan
  - Similar to the partnership entity plan, the corporation purchases it, is the owner, pays the premiums, and is the beneficiary of life insurance policies on each stockholder. The amount of life insurance is equal to each stockholder's share of the corporation's purchase price. When a stockholder dies, the corporation purchases, or redeems, the deceased stockholder's share.
- Key Person Insurance: The purpose of key person insurance is to prevent the financial loss that may result when an owner, officer, or manager dies.
  - It pays for finding and training a replacement if the key employee dies prematurely.
  - The company purchases, owns, pays the premiums, and is the beneficiary of the key person's life insurance policy.
  - The premiums are not deductible for income tax purposes. However, the death proceeds received by the business are not taxable.

Employee Benefit Plans

- Deferred compensation is an executive benefit that an employer can use to pay a highly paid employee at a later date, such as upon disability, retirement, or death.
- A salary continuation plan works the same as deferred compensation except that the employer funds the plan rather than the employee. The employer establishes an agreement whereby an employee will continue to receive income payments upon death, disability, or retirement.

REVIEW NOTES: INTRODUCTION TO HEALTH AND ACCIDENT INSURANCE

Covered Perils and Losses

Covered Perils

The probability or risk of getting an illness or becoming disabled (both due to accidents and diseases) is **morbidity**.

Illness (Sickness or Disease)

- A sickness (or illness) is best thought of as an internal occurrence that becomes manifest. It may have a sudden onset or develop over time.

Accidents

- An accident is an unintended occurrence resulting in a loss caused by an external source; it's fixed in time and space.

Accidental Bodily Injury or "Accidental Result" This definition stipulates that only the injury resulting from an accident must be unintentional. The activity that led to the accident may have been taken voluntarily.

Accidental Means This definition requires both the cause and the result of an accident to be unintentional.

Covered Losses

There are five distinct types of losses covered within the broad field of health insurance—*medical expense*, *disability*, *dental expense*, *accidental injury*, and *long-term care*.

Medical Expense Medical expense insurance protects against the cost of medical care by reimbursing the insured for these costs, either in full or in part. These contracts are a form of reimbursement insurance and cover one or more of the following losses:

- Hospital expenses
- Surgical expenses
- Physician expenses
- Outpatient care

Disability Disability insurance is also referred to as a loss of income, loss of time, or income replacement insurance. These contracts insure against the loss of a person's ability to earn an income.

- Policyowners can control the premium cost of a disability income plan by electing a longer **elimination period** than may otherwise be desired. Since the benefits that are received from an individually funded disability policy are income-tax-free, policies limit benefits to a percentage of a person's pre-disability gross earnings.

Dental Insurance Dental insurance is a specialized form of health expense coverage that focuses on diagnostic and preventive treatment and is designed to pay for dental care. Many dental plans provide preventive care.

Long-Term Care Long-term care insurance covers the cost of caring for individuals who have lost the ability to perform the activities of daily living (ADLs) or have suffered a cognitive impairment. Some long-term care focuses on rehabilitation, while for others, the focus is on maintenance. Long-term care insurance helps cover the cost of necessary supportive services.

Accident Insurance

- Accidental Death and Dismemberment (AD&D) insurance—a prominent type of accident insurance—pays a lump-sum benefit amount when an accident results in the insured's death or dismemberment.

Classes of Health Insurance

The "class" of insurance is another way to categorize the various kinds of health insurance policies, including:

- Individual versus group contracts
- Private versus government insurance
- Limited risk versus comprehensive policies

Individual versus Group Contracts

Individual Insurance Contracts Individual policies are issued by insurers as contracts between the insured and the company. Individuals must provide evidence of insurability because any contract is based on the individual's level of risk. Individuals have the ability to select the coverage options that best meet their needs.

Group Insurance Contracts The group health insurance contract policy is between the insurer and the group (master contract). Individual participants choose from a standardized set of coverage options that are chosen by the group sponsor. Insurers base group insurance premiums on the average level of risk in the group, which is calculated on the group's claim experience (experience rating for large groups), or the degree of risk in the group's community (community rating for small group plans). Group plans are available to employers, associations, and other organizations.

Private versus Government Insurance

Private Insurance Private insurance is purchased through private insurers. Sources include self-insured employers and associations.

Social (Government) Insurance Health insurance is also provided through state and federal government (social) insurance programs. Medicaid is available to low-income persons.

- The federal government offers:
  - Medical insurance for seniors through Medicare, and
  - Disability insurance through Social Security (OASDI)

- The **Patient Protection and Affordable Care Act (PPACA)**—also simply referred to as the **Affordable Care Act (ACA)**—created state-based and state-administered health insurance exchanges.

- **TRI-CARE** is the federal government health plan for active duty and retired service members, as well as their families, and survivors. It has three options:

1. TRI-Care Prime – which uses military treatment
2. TRI-Care Extra – which is a PPO
3. TRI-Care Standard – a fee-for-service option

Comprehensive versus Limited

Comprehensive Policies Comprehensive policies offer a broad range of coverage on an "open-peril" basis.

- For example, major medical insurance covers most recognized medical treatments unless specifically excluded.

Limited Insurance Limited health insurance policies provide limited coverage for accidents or sickness. Contracts must specify the type of accident or sickness covered, limited perils, and amounts of coverage.

- For example, an aviation policy provides benefits for accidental death or dismemberment if death or injury results from an aviation accident during a specified trip.

Limited Insurance Policy Types

Limited risk policies cover a specific risk. An example of a limited risk policy is accidental death and dismemberment contracts, which provide benefits only when covered losses occur as a result of accidental bodily injury. State insurance departments require insurance companies to include a 'Notice to the Insured' stating that the contract is a Limited Benefit Policy.

A limited risk is different from a special risk. A special risk policy covers unusual hazards that are not normally covered under ordinary accident and health insurance.

A limit risk policy covers a common risk in a limited manner. The policy may be "limited" in the perils covered (accidents or a named disease), the time frame (a specific trip), or the nature of the loss (death or dismemberment).

Accident-Only

- **Accidental death and dismemberment insurance** pays a lump-sum benefit amount in the event of accidental death or dismemberment. In general, the insured must die within 90 days of the accident for the death benefit to be paid.

Principal Sum The principal sum is the death benefit that's payable when death results from an accident. It's the policy face amount, and the maximum benefit paid.

Capital Sum The capital sum is the amount that's payable if a person suffers an accident resulting in the permanent loss of hearing, sight, or a dismemberment. The benefit is typically expressed as a percentage of the principal sum.

Specified (Dread) Disease

- **Dread disease policies** provide limited benefits for a specific disease, such as cancer or heart disease.

Critical Illness (Specified Conditions)

- **Critical illness** contracts pay a lump sum to the insured upon the diagnosis and survival of a critical illness. Benefits can be used to cover non-medical expenses. Covered conditions typically include heart attacks, strokes, organ transplants, and end stage renal failure.

Hospital Indemnity (Income)

- While the insured is confined to a hospital, **hospital indemnity insurance** policies pay a specified amount on a daily, weekly, or monthly basis directly to the insured (not the hospital). Payment is based only on the number of days confined in a hospital.

Credit Disability

- **Credit disability insurance** plans protect a lender against the disability of a borrower before the debtor pays off a debt. Credit disability insurance covers the cost of monthly debt payments while the insured is disabled. The lender or creditor is the policy owner and the beneficiary, while the debtor is the insured and typically pays the premiums. This type of contract may also be referred to as **decreasing (term) disability insurance**.

Blanket Insurance (E.g., Teams and Passengers)

- Insurance carriers issue **blanket health insurance** policies to cover group or association members who are exposed to the same risks but at different times. The circumstances are constant, but the group's composition (individuals within the group) continually changes. As with other group contracts, the group is the policy owner; however, unlike other group policies, individual enrollment is not required, and certificates of coverage are not issued.

Prescription Drugs

- **Prescription drug policies** cover the cost of prescription drugs that are not dispensed in a hospital or extended care facility. Most prescription drug policy plans have a co-payment requirement when a prescription is being filled.

Hearing Aid Coverage

- Some private health care plans cover the costs of audiological tests, hearing aid evaluation, and partial or full coverage for hearing aids.

Vision Care

- Vision care coverage typically pays the cost of eye examinations by ophthalmologists and optometrists. The cost of contact lenses or eyeglasses is often partially covered.

Short-Term Medical

- **Short-term medical insurance** policies typically last for as little as 90 days and may provide coverage for as long as 364 days (just less than one year). Short-term plans are a stripped-down version of medical expense coverage, and consumers have traditionally used these plans as **interim coverage** to bridge gaps between more robust forms of coverage. In return for a lower premium, insurance buyers must cope with many of the restrictions that are eliminated in major medical policies by the ACA. These policies may be medically underwritten and may exclude pre-existing conditions.

Dental Insurance

Most dental plans require a review of suggested treatment to ensure it's reasonable and necessary. This process is defined as a **predetermination of benefits**, **pre-certification,** or **prior authorization** of benefits. All dental plans include limitations, exclusions, and caps on annual benefits.

Other common exclusions involve:

- Cosmetic procedures unless they're due to an accident
- Services provided by governmental agencies
- Treatment that's covered by Workers' Compensation
- Duplicate dentures or the replacement of lost or stolen dentures
- Oral hygiene instructions or similar training
- Exotic procedures, such as splinting and restoring occlusion

Replacement of prosthetic appliances (e.g., retainers) is excluded for five years after the benefits are paid

Dental plans may also include limitations on benefits for dental emergency services that are offered outside the network area.

Categories of Dental Treatment

Dental insurance may be covered by a medical expense plan. These **integrated** plans include a single deductible that may be satisfied by either dental or medical expenses. Dental insurance may also be offered as a **standalone** plan. When dental coverage is offered as an optional benefit, the plan is considered **non-integrated**.

Dental plans may be either scheduled or non-scheduled:

- **Scheduled plans** organize coverage into treatment categories, with stated limits for each.
- **Non-scheduled plans** pay benefits on a usual, customary, and reasonable basis (UCR).

Most dental plans provide coverage for diagnostic and preventive treatment.

Other categories of treatment are as follows:

- **Restorative** or **Restoration Benefits** – Fillings, crowns, and other services to restore a tooth's natural function.
- **Oral Surgery** – Includes coverage for tooth extraction and surgery treating injuries, diseases, or jaw defects.
- **Endodontics** – Root canals or treatment for diseases of the dental pulp within the teeth.
- **Periodontics** – This involves care due to gum disease.
- **Prosthodontics** – This benefit covers the replacement of missing teeth, artificial dentures, and bridgework.
- **Orthodontics** – This pays benefits for corrective teeth devices, such as braces and retainers.
- **Pediatric Dentistry** – These services are for children and adolescents.
- **Oral Pathology** – This involves tissue biopsy for the treatment of oral diseases, such as oral cancer.

Employer Group Dental Expense

This coverage typically operates similarly to individual dental plans. Dental plans generally don't have a conversion privilege. Dental plans are subject to COBRA requirements.

Types of Plans

Scheduled Plans Scheduled plans provide benefits for specific services based on a published schedule. They generally contain no deductibles or co-insurance and provide first-dollar coverage.

Non-Scheduled Plans Non-scheduled plans—also referred to as comprehensive plans—include deductibles and co-insurance.

- They generally divide services into three categories:

1. Routine or basic diagnostic and preventive services – includes x-rays, cleaning, and fluoride treatment, etc.
2. Restorative services (that are not routine) – includes fillings, oral surgery, and periodontics
3. Major services – includes crowns, orthodontics, facial reconstructions, or bridgework

- Many plans cover:
  - 100% of the costs for routine care
  - 80% for restorative services
  - 50% for major services

Combination Plan These plans combine the features of the scheduled and non-scheduled plans.

- *For example, this plan may cover diagnostic and preventive services on a UCR basis but contains a schedule of benefits for other covered services.*

REVIEW NOTES: HEALTH INSURANCE PROVIDERS

Blue Cross and Blue Shield (Service Providers)

- Service providers offer benefits to subscribers for a premium.
- Benefits are in the form of services from participating providers.
- Blue Cross and Blue Shield are one of the dominant U.S. health insurers.
- Local Blue Cross and Blue Shield plans are loosely affiliated through the national association.
- The Blues provide benefits on a **service basis,** which means that they pay the provider directly for the subscriber's medical treatment.
- Some general characteristics of Blue Cross and Blue Shield include:
  - Blue Cross covers hospital expenses
  - Blue Shield covers surgical and medical expenses
- Traditional Blue Cross and Blue Shield plans are prepaid because subscribers pay a fixed monthly fee for covered medical services.
- **Participating providers** are doctors and hospitals that contractually agree to provide medical services to subscribers for specific costs.

Traditional Medical Insurance Policies (Commercial Insurance Companies)

- Consumers receive health care services from medical professionals, and insurance carriers cover the cost by reimbursing consumers.
- Consumers can use the right of assignment to assign insurer payments to the provider to avoid upfront, out-of-pocket costs.
- Since these plans indemnify the insured, they are also referred to as **indemnity plans**.
- Traditional indemnity plans are national in scope.

[EXAM TIP: Be sure to distinguish major medical indemnity plans from the Hospital Indemnity Plan that are described elsewhere.]

Managed Care – Definition and Characteristics

- Medical cost management is also referred to as **managed care**.
- It's the process of controlling how policy owners utilize policies.
- There are at least four general approaches insurers use for cost management, regardless of form or structure:
  - Mandatory second opinions
  - Precertification review
  - Ambulatory surgery
  - Case management

Medical Cost Management

Mandatory Second Opinions

- Many health policies require a second opinion before elective surgery to reduce unnecessary surgical operations.
- An insured typically pays more in out-of-pocket expenses for elective surgeries if no second opinion is obtained.

Preventive Care

- Managed care programs also help lower health costs by encouraging preventive care.

Ambulatory Surgery

- Many surgical procedures can be performed on an outpatient basis.
- Also, ambulatory surgical centers are economical venues because of lower overhead expenses.

Case Management (Utilization Review)

- Case management may also be referred to as utilization review.
- A specialist within the insurer (e.g., a registered nurse) reviews potentially large claims as she develops and discusses treatment alternatives.

Precertification (Prospective) Review

- Before admission, a prospective review involves analyzing a case:
  - To determine the necessary treatment.
  - To evaluate a patient's overall health to determine whether the requested treatment is medically necessary.
  - To help control health care costs by reducing the length of hospitalization.

Concurrent Review

- **Concurrent reviews** occur as care is being provided.
- A nurse monitors a patient's hospital stay to determine:
  - His release date
  - Whether he requires home health care, or
  - Whether a transfer to another facility (e.g., hospice center or extended care facility) is warranted
- Concurrent reviews monitor the appropriateness of care to keep costs low while providing effective care.

Retrospective Review

- A **retrospective review** is a review of medical records after medical treatment is completed.
- An insurer can use the results to:
  - Approve or deny coverage that's already been received, or
  - Review the insurance carrier's coverage guidelines

Managed Care Networks

Health Maintenance Organizations (HMOs)

- An **HMO** offers comprehensive prepaid health care services to its subscribing members.
- A distinctive characteristic of all HMOs is that, like a traditional insurer, they organize and deliver the covered healthcare services, as well as finance the cost of health care for their subscribers.
- HMOs may be sponsored by various organizations, such as employers, healthcare providers, unions, government entities, Blue Cross and Blue Shield, or insurers.

Characteristics of HMOs

- They must provide 24/7 access to their subscribers.
- HMOs must provide an open enrollment for 30 days, which allows them to advertise their plans to the public.
- The open enrollment period allows current subscribers to either continue in the HMO or choose a different provider. Also, open enrollment enables non-subscribers to join an HMO.

Federal Requirements for HMOs

- To be eligible to offer an HMO, employers must meet the following requirements and guidelines:
  - Have at least 25 employees
  - Contribute to the plan
  - Stress preventive care
  - Maintain minimum reserves
  - Employer HMOs must use community-rated premiums
  - An employer HMO cannot charge more than a commercial insurance plan

Key HMO Characteristics for Consumers

Comprehensive Care

- HMOs provide comprehensive healthcare, including:
  - Hospitalization and in-hospital services
  - Surgical and medical treatment, including outpatient care
  - Diagnostic services
  - Therapeutic services
  - Prescription drug
  - Nursing services
  - Substance abuse, and
  - Home health care
- HMOs cover the essential health services as defined in the Affordable Care Act.
- HMO services don't typically include dental coverage or vision care (corrective lens, etc.)

Prepaid Care

- Subscribers pay a fixed periodic fee.
- There are some co-payment requirements.
- Traditionally, provider compensation was capitated.
- HMOs paid providers a fixed fee per patient without regard to the amount of care given.

Preventive Care

- HMOs are known for stressing preventive care.

Funding

- Insurers may sponsor HMOs, or
- HMOs may be self-contained or self-funded.

Primary Care Physicians ("Gatekeepers")

- Subscribers select **primary care physicians (PCPs)**.
- The PCP controls all referrals for specialized care.
- The use of PCP referrals is the **gatekeeper** system.

Local or Regional Networks

- HMO networks are local or regional, not national.

Emergency Care

- Emergency care is available in-network.
- If an emergency is life-threatening, HMO members are covered at the nearest medical facility, even if it's out-of-network.

HMO Structures

- HMOs use different models to deliver subscriber services, which can be described as either a **closed panel** or an **open panel**.
  - If an HMO consists of a physician's group or salaried employees who work out of the HMO's facility, then it's a **closed panel network**.
  - If an HMO provides services through a network of physicians who see subscribers in their own offices, then that organization is defined as an **open-panel** HMO.

Staff Model (Closed Panel)

- Medical care is provided by physicians and hospitals that participate in the HMO (employed by the HMO).

Group (Practice) Model (Closed Panel)

- The group model offers subscribers a variety of services.
- The HMO pays the group a capitation or a predetermined fee.
- The group pays the physicians for their services.

Network Model (Closed Panel)

- The network model is like the group model; however, it involves more than one physician group.
- Provider compensation is based on a capitation fee.

Individual or Independent Practice Association (IPA) (Open-Panel)

- HMOs that are IPAs have a network of physicians who work out of their own facilities.
- Providers participate in the HMO on a part-time basis.
- An IPA is also referred to as an open panel network.

Preferred Provider Organizations (PPOs)

- A PPO offers medical insurance but not care.
- A PPO sponsors a network of health care providers, such as physicians, hospitals, and clinics.
- Network (preferred) providers contract with the PPO to offer discounted services to PPO subscribers in return for referrals.

PPO Characteristics

Financing Healthcare Only versus Financing and Delivery

- PPOs don't assume the role of healthcare provider.
- PPOs assemble networks and administer the financing of care.
- PPO contract price represents a discount of what may be considered "usual and customary."

Fee-for-Service

- PPOs operate on a fee-for-service basis.
- PPOs often require subscribers to pay a percentage of their medical costs, which is referred to as co-insurance.
  - PPO co-insurance is a percentage, whereas an HMO's co-pay is a flat dollar amount.
  - PPO co-insurance is a cost-sharing mechanism in which the subscriber pays a portion of the "fee for service." An HMO co-pay primarily covers administrative costs.
- HMOs have utilization risk because of capitation, whereas PPOs do not.

In-Network versus Out of Network

- PPOs provide coverage out-of-network coverage for non-emergency care.
- PPOs reduce out-of-network coverage.
- PPOs increase co-insurance.
- Also, out-of-network providers don't abide by discounted network guidelines.

Direct Access to Any Provider

- The traditional PPO model doesn't require primary care physician referrals to in-network specialists.

PPO Innovations and Options

- PPOs can include dental care and long-term care in the form of nursing services.

Point-of-Service (POS) Plans

- A POS plan combines indemnity (traditional major medical) plan features with those of an HMO.
- A POS allows subscribers to choose out-of-network as well as in-network providers.

In-Network Coverage

- With in-network coverage, the insured receives care much like an HMO.
- The insured's PCP coordinates all care.
- Subscribers must follow the referral requirements to receive full in-network coverage.

Out-of-Network Coverage

- Insureds who receive out-of-network care pay a higher share of the cost.
- Subscribers pay a substantial co-insurance percentage.
- POS plans don't necessarily base payments on average market prices (usual and customary costs). Instead, they calculate their coverage based on their lower in-network costs.

Exclusive Provider Organizations (EPOs)

- An EPO is a hybrid of an HMO and a PPO.
- Like a PPO, an insured doesn't need a referral to obtain care from an in-network specialist.
- Like an HMO, an insured is responsible for paying out-of-pocket for care from an out-of-network provider.

Group Insurance Plans

- Group health insurance is a class of policy rather than a provider.
- Group health insurance is a distinct source of coverage with shared characteristics. The entire class of policies is treated as a distinct provider.

Basic Group Plan Characteristics

- The nature of the sponsoring group must be acceptable.
- State laws specify the minimum number of persons to be covered under a group policy.
- Employers may differentiate the benefits offered according to the common characteristics that distinguish the employee classes (union versus non-union, full-time versus part-time, etc.).
- Employers cannot discriminate against specific individuals within a particular employee class.

Eligible Groups

- To qualify for group health coverage, the group must be a **natural group**.
- The term "natural group" means that it must have been formed for some reason other than to obtain insurance.
- **Taft-Hartley Trusts** are formed as a result of collective bargaining between a labor union and an employer.
- Employers are prohibited from paying funds directly to a labor union to provide group health insurance to its members.

Policy Ownership

- Insurers issue the policy—referred to as the **master contract**—to the employer or the other sponsoring organization.
- The sponsor is considered the **master policy owner**.
- Covered individuals receive a **certificate of insurance.**
- Participants also receive an outline or booklet that describes their benefits.
- Typically, group benefits are more extensive than those provided by individual health insurance policies.
- Group health plans often offer broader coverage, including ancillary programs, higher benefit maximums, and lower out-of-pocket costs.

Lower Cost

- The cost of insuring an individual under a group health plan is lower than an individual policy's cost because of lower administrative and selling expenses.

Consolidated Administration

- Administrative costs are lower because the carrier insures multiple individuals under one contract.
- Also, the policy owner (employer or another sponsor) helps provide services to the enrolled participants.

Predetermined Benefits

- The sponsor predetermines benefits for individual insureds, which simplifies underwriting and administrative costs.

Increased Persistency

- When a person drops an individual insurance policy, the contract is lost.
- When an individual participant leaves a group, the master contract remains in force.

Underwriting and Risk Management

- Factors such as the group's claim experience and the ages of group members help determine premiums.
- Depending on group size, insurers determine premiums using one of two basic risk rating methods—the group's **experience rating** or their community's **community rating**.

Group Underwriting

- Group insurers establish premiums based on the average level of risk in a prospective group.
- Risk factors include the group's size, composition, and average age of the group members.
- The aggregate rate of losses or claims is referred to as the group's **experience rating**.
- Insurers use the surrounding community to gauge small group risks and assign a **community rating** to the group and the surrounding area.
- Other group underwriting considerations include:
  - The reason for a group's existence
  - Group stability – among members
  - Group persistency – with carriers
  - Method of determining benefits

  - How eligibility is to be determined
  - Whether the group plan is contributory or non-contributory
  - The group's industry or business and the employees' occupations

Individual Eligibility

- Commonly imposed eligibility requirements include:
  - Full-time workers only (30 or more hours per week)
  - A probationary period of at least one to three months of services before a person is eligible for coverage.

Enrollment Period

- Once an employee is eligible for coverage, there's a limited **enrollment period**, during which time the employee can elect coverage.
- Enrollment periods are 31 days unless state law requires a longer period.
- If an employee doesn't elect insurance coverage during the enrollment period, an application for coverage that's submitted outside of enrollment periods will be evaluated on an individual basis, which would require **evidence of insurability.**
- **A change of life event** (e.g., marriage or the birth of a child) allows individual participants a special enrollment period.

Participation Requirements

- Minimum participation requirements from among eligible classes of enrollees help insurers to avoid adverse selection.
- If a group's participation percentage drops, the insurer may terminate the plan.

Contributory Plans

- If employees pay a portion of the group insurance premium, the plan is a **contributory plan**.
- Contributory group health plans often require participation by 75% of eligible members.

Non-Contributory Plans

- If the employer pays the entire premium, the plan is a **non-contributory plan**.
- Most non-contributory group health plans require 100% participation by eligible members.

State Variations

- Standard percentages for participation are benchmarks, not the product of law. Requirements may vary with each state.

Alternative Forms of Group Insurance

Multiple Employer Trusts (METs)

- The **Multiple Employer Trust (MET)** is a method of marketing group benefits to employers that have few employees.
- A MET combines multiple employers (10 or more) into a single pool for the purpose of providing group insurance.
- A MET holds the master contract rather than the participating employers.

- An employer that wants to obtain coverage for employees from a Multiple Employer Trust must first become a member.
- A MET typically funds benefits with an insurance contract that's purchased from an insurance company.
- A MET may be insured and administered by a third-party administrator (TPA).
- These trusts are also referred to as 501(c)(9) trusts after the relevant section of the Internal Revenue Code.
- Partially self-funded trusts limit potential losses by purchasing stop-loss insurance.
- State regulations pertaining to METs vary.

Multiple Employer Welfare Arrangements (MEWA)

- A Multiple Employer Welfare Arrangement is similar to a MET; in fact, the terms are often used interchangeably.
- MEWAs are tax-exempt entities.
- MEWAs consist of two or more employers that have joined to provide affordable health benefits for their employees on a self-funded (or self-insured) basis.
- Employees who are covered by a MEWA are required by law to have an employment-related common bond.
- MEWAs are risk retention instruments. The law treats them as "**employee welfare benefit plans**" and subjects them to the Employee Retirement Income Security Act (ERISA) mandates, which often supersede state insurance department regulations.

Self-Insurance

- "Self-insurance" does NOT mean "no insurance."
- Many self-insuring employers cap their financial risk by buying stop-loss insurance coverage from an insurance company.
- The stop-loss coverage reimburses the employer if the total amount of covered claims exceeds the policy's risk retention limit.

Administration Services Only (ASO)

- With **Administration Services Only (ASO)** contracts, the employer purchases specific administrative services from an insurer or a TPA.
- Self-funded plans commonly use the services of an insurance company to act as a third-party administrator.

Small Employer Group Insurance

- A **small employer** is generally defined as a business with a range of employees from two to 50.
- All full-time employees must have access to coverage.
- The level of coverage must reflect general group insurance requirements.

Franchise Health Plans

- Franchise health plans may be referred to as wholesale plans.
- Franchise health plans provide health insurance coverage to members of an association or professional society.
- They're used to cover a group of persons who don't qualify for true group insurance.
- Each franchise plan participant receives an individual policy.
- Each participant must complete a separate health policy application.
- Rates are typically discounted.
- Employers can use a franchise arrangement when offering coverage for workers who are not eligible for true group insurance.

Regulations That Apply to Group Insurance

- Insurers must take into consideration state regulations when advertising and marketing group insurance.
- When a group policy covers individuals in multiple states, the state in which the group policy (master contract) is delivered becomes the state of jurisdiction. This is based on the Constitutional Doctrine of Interstate Comity.
- Having a single state of jurisdiction means that the group insurance contract must only conform to that one state's laws and regulations.
- The producer will generally deliver a group health insurance policy to the location of the employer.
- Federal regulatory requirements apply regardless of state lines.

The Termination of a Group Plan

- An employer or fiduciary must provide a 45-day notice of termination of the plan to all those covered.
- If a group health plan terminates, employees may convert to an individual health plan without evidence of insurability.

Impact of Termination on Covered Individuals

- Unless the law states otherwise, coverage for an employee and his dependents can terminate on the date employment is terminated.
- Termination may occur in other circumstances, including:
  - An employee ceases to be eligible (regardless of the reason)
  - The master policy is surrendered or canceled
  - An employee fails to make a required contribution
  - The end of a continuation of benefits period for employees and dependents that follows the termination of a person's employment
- Coverage under group plans may be continued for employees and dependents even after employment ends due to COBRA or other applicable laws or policy provisions.

Continuation and Conversion

Extension of Benefits

- An extension of benefits covers open, existing claims when an employee or dependent is sick or disabled at the time the insured's group membership ends.
- This extension doesn't cover new claims.
- Disability benefits will continue until the disability ends.
- Medical insurance offers coverage that continues to pay for active claims at the time of termination, including hospitalization or medical care, but generally not for more than 12 months.

Consolidated Omnibus Budget Reconciliation Act (COBRA)

- COBRA mandates employers to provide employees and their beneficiaries with group health coverage following a qualifying event.
- COBRA eligibility begins as soon as they qualify for coverage under their employer's group medical plan.
- COBRA temporarily continues a person's group insurance; it doesn't convert them to an individual plan.

Covered Employers

- COBRA covers employers with 20 or more employees.
- These companies are referred to as "COBRA Groups."

Qualifying Events

- The law defines the following circumstances as qualifying events for COBRA:
  - The insured employee dies
  - The insured employee divorces a covered spouse
  - An insured dependent becomes too old to be covered on the group plan
  - The insured employee qualifies for Social Security disability benefits
  - The employee leaves his job, either voluntarily (resigns or retires) or because he's terminated for any reason other than gross misconduct

Notification Period

- Employers must notify employees or their dependents if the insured employee becomes eligible for COBRA.
- The law requires employers to provide employees notice of their option to choose COBRA no later than 14 days after the qualifying event (termination, etc.).

Decision Period

- Employees have up to 60 days to decide whether to accept the coverage.
- If the employee or dependent fails to notify the employer in time, the right to elect COBRA coverage is lost.
- This 60-day period begins on the date of the qualifying event or when notice is received, whichever is later.

The Benefit Period – COBRA

18 Months: Loss of Employment

- Benefits for covered employees who separate from their employer for reasons other than gross misconduct, and covered dependents

36 months: Loss of Dependent Benefits

- Benefits for covered dependents are available for the following qualifying events:
  - The employee dies
  - The employee divorces a covered spouse
  - A child's coverage ceases, especially when she reaches the age limit for coverage

29 Months: Loss of Benefits Due to Disability

- COBRA covers insureds that qualify for Social Security disability
- The benefit period encompasses a five-month Social Security Disability waiting period plus the 24 months until the individual is eligible for Medicare.

COBRA Premiums

- Beneficiaries pay the insurer's COBRA claim unit.
- Beneficiaries must pay the entire group premium plus an additional 2% administration fee.
- In total, the terminated employee pays 102% of the group premium versus a standard employee contribution.

Conversion

- Group plans also provide a conversion privilege.
- COBRA beneficiaries can convert their group coverage to an individual policy when benefits end.
- Beneficiaries typically have 31 days to decide.

Health Insurance Portability and Accountability Act (HIPAA)

- The Health Insurance Portability and Accountability Act (HIPAA) prevents insurers from imposing new pre-existing condition exclusions when employees change employers.
- Previous coverage could be used to satisfy any such exclusionary period if there were no gaps in coverage of 63 days or more.
- The previous qualifying insurance is referred to as "creditable coverage."
- HIPAA requires health insurance plans to provide new subscribers with a Notice of Privacy Practices at the time of enrollment and every three years thereafter. The Notice details the health plan's compliance with the HIPAA Privacy Rule and the rights of the consumer.

Pregnancy Discrimination Act

- This act requires pregnancy, childbirth, or related conditions to be treated like other health-related conditions.
- Plans must cover abortions if the mother's life is in danger.
- Insurers must treat pregnancy as a disability to the degree it impairs the insured's ability to perform her duties. Employer benefit plans must do the same.

Special Regulations for Small Group Health Insurance

- Small groups have up to 50 employees (only 25 in some states).
- Small group benefit plans must:
  - Offer coverage to all eligible employees and dependents
  - Not discriminate against an employer due to the nature or category of the business
- Insurers must renew coverages unless the employer fails to pay the premium, engages in fraud, fails to meet participation or contribution requirements, or closes the business. Insurers may also withdraw from the small group market.
- Plans must also offer standard and essential types of benefits.
- Insurers can change rates annually to reflect changes in the group's composition and claims experience.
- Carriers marketing small employer health plans must offer at least two health plans to the employer (basic and standard).
- Insurers cannot refuse to cover a group because of an individual group member's health history.

REVIEW NOTES: MEDICAL EXPENSE INSURANCE

Basic Health Insurance Policies (Medical Expense)

- Basic health insurance is often referred to as "first dollar insurance."
- It provides benefits upfront without needing to satisfy a deductible.
- Basic policies define their coverage by the following three general medical categories—*hospital expense, surgical expense,* and *physicians' expense*.
- Basic policies have lower benefit limits than major medical plans.
- Basic policy benefits are lower than the actual expenses incurred.

Hospital Expense Policy

- Covers hospital room and board, plus miscellaneous expenses.
- Covers expenses while the insured is confined in a hospital.
- There's no deductible.
- This policy provides coverage up to a stated maximum number of days.
- The contract sets the maximum benefit limit for hospital room and board at a specified dollar amount per day.
  - Indemnity policies pay the stated benefit amount per day regardless of charges.
  - Reimbursement policies pay actual charges up to the stated daily maximum.
  - Policy limits may not cover the full cost of room and board.

Basic Surgical Expense Coverage

- These policies pay for the cost of surgeon services.
- This contract pays for the services of the anesthesiologist as well as the surgeon's fee.
- Policies use one of three methods to determine coverage for various covered procedures:
  - **Surgical Schedule**: The insurer assigns every surgical procedure a dollar amount, which equals the policy benefit.
  - **Relative Value Scale**: The insurance carrier establishes the dollar value of a single unit on its scale.
    - The insurer assigns each procedure a benefit value defined as a specific number of units.
    - When the insurer needs to change the benefit limits for all surgeries—while still maintaining the existing relationship of their relative values—the insurer can change a single unit's dollar value.
    - The insurer can change the benefit for one procedure by changing the number of units assigned to the procedure.
    - The stated unit valuation (dollars-per-unit) used to determine each procedure's benefit is referred to as the **conversion factor**.
  - **Usual, customary, and reasonable (UCR)**: Under the usual, customary, and reasonable approach, the policy pays amounts for fees that are equal to or less than the fees most commonly charged within an identified market region. If the charge is greater than the UCR limit, the insured must pay the excess.

Basic Physician Expense Coverage

- This policy covers the non-surgical services that are provided by physicians.
- In some cases, this policy is referred to as basic medical insurance.
- Regardless of what type of plan or coverage is purchased, these policies typically offer only limited benefits that are subject to time limitations.
- No agency, institution, or physician that provides a covered service may be denied payment or reimbursement because the covered services were rendered through a physician assistant.
- Policies generally define benefits based on a schedule or by using the usual, customary, and reasonable approach.

Major Medical Expense Plans

- Major medical expense insurance offers high maximum benefits and broad coverage under one policy.
- A key element provided by major medical insurance policies is catastrophic medical expense protection.
- Policies provide both inpatient and outpatient hospital and other necessary medical expenses.
- Since the policies offer coverage on an "open-peril" basis, they have fewer exclusions and cover the gaps that can exist when a consumer relies on basic insurance plans.
- The Affordable Care Act further defined compliant major medical policies as those that provide a variety of benefits defined as minimum essential coverage (MEC).
- Major medical insurance coverage is available through employer plans, commercial agents, and government-sponsored online marketplaces that are established under the provisions of the Affordable Care Act.
- Policies must offer minimum essential coverage to qualify as major medical plans which are able to be sold on the online government exchange.
- Major medical plans that offer MEC satisfy the requirements of the ACA mandate on group plans. Such plans will cover at least 60% of projected costs based on an estimate of average utilization. Without limit, they also provide limit the 10 essential health benefits (EHBs) as defined in the ACA.
- Grandfathered group major medical plans are exempt from certain ACA requirements.
- Benefits designated as being non-essential benefits
- One of the mandatory major medical benefits defined in the Affordable Care Act is coverage for prescription medications. The list of prescription drugs that are covered by a pharmacy benefit is referred to as a drug formulary.
- Major medical insurance policies also offer hospice benefits.
- Major medical expense insurance typically begins where basic medical expense insurance leaves off in one of two ways— (1) as a supplement to a basic plan or (2) as a comprehensive stand-alone plan.

Supplemental Major Medical

- These policies are purchased separately to supplement coverage that's payable under an insured's basic health insurance policy.
- A supplemental major medical policy will provide coverage for expenses that are not covered by the insured's basic policy. It will also pay claims for those categories of care that are covered by the insured's basic policy to the extent that they exceed the basic policy's maximum benefit limit.
- The contract imposes a deductible between the end of the basic health plan benefits and before the major medical coverage begins. This deductible is referred to as a *corridor deductible*.

Comprehensive Major Medical

- Combines the features of basic expense coverage and major medical insurance by combining both types of coverage into one policy.
- Comprehensive major medical policies cover a larger percentage of the insured's medical expenses, including hospital expenses, the cost of surgery, nursing services, drugs, the fees charged by physicians, as well as the fees of allied health service providers, and laboratory tests, etc.
- Comprehensive major medical policies include an integrated deductible before the major medical coverage pays for claims, but amounts that are paid by the basic health benefits are credited toward meeting this deductible.

Major Medical Policy Features

Major medical policies have several cost-sharing tools that they use to help control costs.

Deductible A deductible is a stated initial dollar amount that an individual insured must pay before the insurance carrier begins to pay its share of covered claims. Deductibles are used primarily to help control the cost of premiums and are used with major medical policies. A policy can have multiple types of deductibles.

Flat (Initial) Deductible

- A flat (initial) deductible is a stated dollar amount that applies to a covered loss (e.g., $500). This type of deductible is also referred to as an "initial deductible."
- Most major medical policies have an annual deductible.
- Health insurance deductibles generally apply to each individual who's insured by the policy.

Corridor Deductible

- Corridor deductibles are used with supplemental major medical insurance policies.
- Corridor deductibles occupy the gaps between basic coverage and major medical insurance. They typically represent the insured's first cost-sharing element.
- When a major medical policy supplements basic health insurance coverage (containing no deductible), the insurer doesn't apply the corridor deductible until the basic coverage has been exhausted.

Integrated Deductible

- An integrated deductible is used when major medical insurance is sold in combination with basic health coverages.
- An integrated deductible credits all payments made to medical providers for covered services toward meeting the major medical deductible. Such payments include basic medical expense benefits.
  - For example, let's assume that John has a $7,000 medical bill. He also has a comprehensive policy with an integrated deductible of $5,000 and a built-in basic benefit of $2,000. Given this information, the following sequence of payments occur:
    - The basic coverage pays the first $2,000 and helps satisfy the $5,000 deductible, which leaves $3,000 to the insured.
    - The insured must pay the next $3,000 out-of-pocket.
    - The major medical insurance covers the last $2,000 of the claim.
- If (all else being equal) the insured had a policy with a $5,000 corridor deductible, rather than an integrated deductible, the cost-sharing amounts would be altered. The basic policy would cover the first $2,000, and the insured would pay the next $5,000 to satisfy the deductible.

Family Deductible

- The family deductible caps the total deductible amount due from a family that's covered on a single policy. In most cases, the family deductible equals two or three times the individual deductible.

Per-Cause (or Occurrence) Deductible

- If a policy has a per-cause deductible, the insured must satisfy a deductible for each accident or illness.

Common Accident or Sickness Deductible

- Some major medical policies have a **common accident or sickness deductible**, which means that only one deductible needs to be satisfied when two or more insureds from the same family are injured in the same accident or suffer concurrently from the same illness.

Co-Insurance

- Co-insurance, which is characteristic of major medical insurance policies, describes how the insured shares the cost of covered claims with the insurance company after the deductible is paid.
- Co-insurance clauses assign a percentage of all covered claims to each party, with the insurance carrier paying the majority of the costs.
- The policy may limit the amount of co-insurance that must be paid by the policyholder. This limit is referred to as a stop-loss or out-of-pocket maximum.

Stop-Loss / Out-of-Pocket Maximum

- A stop-loss is a feature that's designed to limit the out-of-pocket expenses an insured must pay during one policy year.
- Originally, the term "Stop-Loss" referred to the maximum amount of co-insurance that an insured was required to pay. Today, the term "stop-loss" is equivalent to the "out-of-pocket maximum" as defined in the policy, which includes the deductible.
- Policies define the "out-of-pocket maximum" as the total amount of covered costs that the insured is required to pay annually. It consists of the deductible, co-insurance, and other co-pays if applicable.
- Some of the potential costs that are not included in the definition of "out-of-pocket maximum" include the following:
  - Policy premiums
  - Charges that are in excess of what the contract defines as being usual, customary, and reasonable," and
  - Out-of-network services that are not covered by the plan
    - Let's return to the earlier scenario regarding John's $30,000 hospital stay and apply the impact of co-insurance and a maximum out-of-pocket limit.
- Policies that comply with the Affordable Care Act requirements must also conform to the law's limits on annual out-of-pocket expenses for insureds. For 2021, the maximum stop-loss limit for qualified major medical policies is $8,550.

Other Major Medical Features and Concepts

Internal Limits Internal limits, also referred to as inside limits, restrict coverage for specific services.

- With the passage of the Affordable Care Act, insurers can no longer apply annual internal limits to essential health benefits.
- The practice of internal limits can still exist in what are referred to as limited "skinny plans."

Benefit Period Benefit periods either begin immediately when the accident or illness occurs or when the insured meets the deductible.

- Major medical insurance plans have an annual benefit period.

Pre-Existing Conditions Although the Affordable Care Act prohibits pre-existing condition exclusions in compliant major medical plans, they still exist in short-term policies and skinny plans.

- Traditionally, insurers rated applicants with existing conditions that were revealed on applications or excluded such conditions permanently with an impairment rider.
- When policies were not individually underwritten, insurers used a blanket pre-existing condition exclusion, which excluded coverage for any condition requiring coverage immediately before the policy is scheduled to go into effect.

Statutes Governing Medical Insurance

The Affordable Care Act

- The **Affordable Care Act** restructured the market for medical expense insurance.
  - No consumer can be denied coverage or dropped due to a pre-existing condition.
  - Plans can no longer enforce a lifetime cap or dollar limit on benefits for most treatments and follow-up care.
  - Women can now choose any OBGYN or provider in their network; however, they previously needed a referral.
  - Insurance providers can no longer charge women more than men for the same coverage.

Health Insurance Exchange (Marketplace)

- The health insurance exchange is a federal website that allows consumers to:
  - Check their eligibility for government assistance
  - Compare individual and small group insurance plans, and
  - Link to insurers so that they can buy health insurance

The Structure of Coverage

- The ACA requires health insurers to offer plans within health insurance exchanges that conform to four "metal tiers."
- Each of the four metal tiers has a specific "actuarial value," which is the anticipated percentage of healthcare costs that will be covered by a typical plan that's classified as being on that metal tier, including the following:
  - The percentage (or actuarial value) of expected "essential health benefits" that will be paid by the insurer, and

  - The percentage of benefits expected to be paid by the insured through their deductibles, co-payments, and out-of-pocket limits
- The four metal tiers and their level of coverage are as follows:
  - Bronze plans must have an actuarial value of 60%.
  - Silver plans must have an actuarial value of 70%.
  - Gold plans must have an actuarial value of 80%.
  - Platinum plans must have an actuarial value of 90%.
- All marketplace health insurance policies are subject to the same annual, out-of-pocket maximum for covered costs, consisting of deductibles, co-payments, and co-insurance.
  - For 2021, the individual out-of-pocket limit is $8,550 (for 2022, it's $8,700)
  - For 2021, the out-of-pocket limit for families is $17,100 (for 2022, it's $17,400)
- The following are considered eligible dependents:
  - A spouse who's not legally separated, and
  - Dependent offspring up to age 26

Essential Health Benefits

- The ACA defines the following 10 **essential health benefits** that major medical plans must offer without a lifetime or annual cap.

1. Ambulatory Patient Services
2. Emergency Services
3. Hospitalization Coverage
4. Maternity and Newborn Care
5. Mental Health and Substance Use Disorder Services
6. Prescription Drugs
7. Rehabilitative and Habilitative Services and Devices
8. Laboratory Services
9. Preventive and Wellness Services and Chronic Disease Management
10. Pediatric Services

Preventative Services

- Plans cover 100% of the cost for most preventative services, which include:
  - Annual screenings for breast and cervical cancer
  - Annual or biennial mammograms over the age of 40
  - HPV screenings every three years over the age of 30, and
  - Pap smears every three to five years over the age of 21
- Other preventive services covered include, but are not limited to:
  - Pre-and post-natal services
  - FDA approved methods of contraception
  - Domestic violence screening and counseling
  - HIV screenings

Grandfathered Plans

- A grandfathered plan is one that existed as is, without significant increases in participant costs, since before the ACA became law.
- Grandfathered plans avoid certain ACA requirements:
  - Coverage of preventive care for free
  - Coverage of essential health benefits, and
  - Coverage of pre-existing conditions in the individual market

The Health Insurance Portability and Accountability Act (HIPAA)

- The **Health Insurance Portability and Accountability Act of 1997** (**HIPAA**) expanded the federal regulation of health insurance. The Affordable Care Act extended some of these protections and removed the insurance company's ability to impose some of the stated limitations.
- HIPAA helped make coverage portable by ensuring individuals would not lose access to major medical insurance (including new pre-existing condition exclusions) when they changed jobs and group plans.
- HIPAA assumes a person maintains creditable coverage with no gap in coverage of 63 days or more.
- A worker who switches employers and health plans would be eligible to receive a **certificate of creditable coverage**, which a worker could use when applying for coverage under a new plan.
- HIPAA also put limitations on pre-existing conditions in major medical plans by:
  - Limiting exclusion periods to one year, except for late enrollees (outside enrollment periods), who may be subject to an 18-month exclusion.
  - Limiting the definition of a pre-existing condition to a condition for which treatment, advice, care, or a diagnosis was received within six months immediately preceding the start of an employee's new group coverage.
  - Covering undiagnosed conditions that are later uncovered without any pre-existing condition limitation.
  - Excluding maternity, births, and adoptions from pre-existing condition language.
- HIPAA requires policies to cover newborns with congenital conditions if the child is added to the policy in the first 30 days.
- This same coverage also applies to newly adopted children with existing conditions.
- HIPAA also expanded the eligibility for COBRA benefits.

Innovations and Taxation

Cafeteria Plans (Section 125 Plans)

- A **cafeteria plan** is a financial vehicle that was developed for U.S. businesses and allows them to offer a variety of employee benefits on a pre-tax basis.
- Cafeteria plans also allow employees to choose from a variety of standardized options to customize some key benefits to address differing individual needs.

Consumer Driven Health Plans (CDHPs)

- Consumer-driven health plans incentivize individuals to consider the cost of utilizing medical services and factor it into their decision-making.
- A consumer driven health plan has the following three elements:
  - A tax-advantaged (pre-tax) savings vehicle that allows participants to pay for services using pre-tax dollars
  - A corridor or integrated deductible, which represents an insured's out-of-pocket expense, and
  - A qualifying high deductible insurance policy that will cap the individual participant's exposure

Tax-Advantaged Accounts

- There are several types of accounts available. Some of these instruments are limited to employer-sponsored plans, while others are available to individuals. In fact, one is available to both groups and individuals.

Health Savings Accounts (HSAs) Health savings accounts (HSAs) are tax-favored vehicles for accumulating funds to cover medical expenses.

- Contributions are not subject to federal income tax at the time of deposit (i.e., they're either tax-exempt (pre-tax) by the employer or deductible by the employee.
- Balances roll over and accumulate year-to-year.
- HSAs are owned by the individual and are portable.
- The owner can also make tax-free withdrawals to cover current and future qualified health care costs.
- Distributions (other than those used for qualified medical expenses) are subject to income tax and a penalty of 20%.
- If an individual loses access to a qualified HDHP:
  - The covered individual can still use the funds.
  - The insured CANNOT make additional contributions until the insured once again has coverage through an HDHP.
- Annual HSA contributions are allowed up to the lesser of the IRS maximum or 100% of the individual's deductible.
  - For 2021, maximum allowed contribution limits are:
    - $3,600 ($3,650 for 2022) for an individual, and
    - $7,200 ($7,300 for 2022) for a family
- Individuals who are between 55 to 65 years of age can make an additional catch-up contribution of $1,000.
- To be eligible for an HSA, an individual must be:
  - Covered by an HDHP
  - Not eligible for Medicare (under age 65) and
  - Not claimed as a dependent by another person

Health Reimbursement Accounts (HRAs) Health reimbursement accounts (HRAs) resemble HSAs in that they:

- Serve the same purpose as HSAs
- Are both established and funded by an employer

- Allow unused amounts to roll over for future use
- Use pre-tax dollars to pay for qualified medical expenses
- Allow for tax-exempt employer contributions

- Health Reimbursement Accounts (HRAs) differ from HSAs in that:
  - Individuals cannot set up an HRA
  - Individuals cannot contribute to an HRA
  - There's no limit on HRA annual contribution amounts
  - Employers don't transfer HRA funds to employees; they provide an available credit that can only be used for expenses that are approved by the program
  - HRA funds are NOT portable.

Medical Savings Accounts Archer Medical Savings Accounts (Archer MSAs) were created to help the self-employed and employees of small employers pay for their medical expenses.

- The MSA program served as a pilot program for the establishment of today's HSAs.
- Since January 1, 2008, only individuals who participate in grandfathered MSAs may continue to make or receive contributions.

Flexible Spending Accounts (FSAs) Flexible spending accounts (FSAs) are tax-advantaged accounts that can only be set up through an employer's cafeteria plan.

- FSAs allow an employee to set aside a portion of earnings to pay for qualified medical expenses with some limitations:
  - Participants cannot have an MSA or HSA (HRAs are acceptable).
  - FSA balances do NOT roll over; employees must "use or lose" their account balances, except for $500 that participants may carry forward.
  - Employers cannot reimburse employees for unused funds.
- For 2021, employee contribution limits are $2,750.
- No HDHP is required

High Deductible Health Plan (HDHP)

- A qualifying **high deductible health plan** (HDHP) is a major medical insurance contract that:
  - Doesn't cover basic expenses (other than preventative care that's mandated by the ACA), and
  - Establishes an annual cap on out-of-pocket costs
    - The IRS sets the minimum annual deductible and the maximum out-of-pocket cost for qualified HDHPs.
    - For 2021, the deductible minimum and out-of-pocket maximums are as follows:
      - The minimum deductible allowed for individual coverage is $1,400 and $2,800 for a family.
      - The maximum out-of-pocket cost allowed is $7,000 for an individual plan and $14,000 for plans that cover families.

Taxation of Medical Expense Insurance

- Benefits that are received through a medical expense policy are not taxable because they offset expenses.
- The deductibility of premiums and other costs is dependent on the tax status of the individual.

Employees For most individuals, medical and dental expenses are tax-deductible only to the extent that they exceed 7.5% of the taxpayer's Adjusted Gross Income (AGI), and:

- The taxpayer itemizes, and
- The individual pays the premiums with after-tax dollars, and
- The expenses are cost-sharing amounts and certain other expenses that are not covered by an insurance policy

Sole Proprietors For those who are either self-employed or sole proprietors, the IRS allows them to deduct 100% of their health insurance premiums because they're considered a deductible cost of doing business.

- Other medical costs are subject to the same restrictions faced by employees (i.e., they're deductible to the extent they exceed 7.5% of the insured's AGI.)

Partnerships and Limited Liability Companies (LLCs) For partnerships and LLCs, the premiums are tax-deductible to partnerships (paid by the partnership) and the LLC.

Affordable Care Act (ACA) – Subsidies and Tax Credits

- An employer with fewer than 25 employees and provides employees health insurance may be eligible for a tax credit of up to 50% of premiums.
- Individuals and families with incomes that range from 100% to 400% of the federal poverty level qualify for subsidies on state or federal exchanges.

BASIC CONCEPTS OF DISABILITY INSURANCE

The Purpose of Disability Insurance

- Disability income insurance protects an insured's earned income if he cannot work due to total disability.
- Disability income policies are available as individual plans and group plans.
- Disability insurance also serves the needs of businesses and business owners by:
  - Helping assure the continuation of a business if a principal owner becomes disabled
  - Being a vital employee benefit in the form of group disability insurance
  - Indemnifying businesses against the loss of key employees

Causes of Disability

- Disability policies provide benefits when an insured experiences a disabling condition that's caused by an accident or an illness.
  - An accident (**accidental bodily injury**) is an incidental event.
  - Illness is covered unless coverage is restricted because it's defined as a pre-existing condition or otherwise excluded.
- If a combination of an accident and illness causes a disability, the insured will only collect one loss of income benefit. Remember, collecting two or more benefits is a prohibited act.

Short-Term and Long-Term Disability Programs

- The purpose of a short-term disability (STD) policy is to quickly replace a percentage of the insured's income while she recovers from a temporary injury or illness that prevents her from working but is less serious in nature.
  - Common uses included surgery and childbirth.
- Long-term disability (LTD) plans provide longer benefit periods and are typically reserved for an injury or illness that's more serious in nature.

QUALIFYING FOR BENEFITS

- ~~Disability income policies primarily define "disability" as the inability to perform tasks or earn an~~ income.
- Disability income policies also include "medical definitions" of disability based on a direct physical injury rather than any consequential income loss.
- Some contracts cover losses at work, while others do NOT.

Disability Defined

- Being under the care of a physician is required regardless of whether the contract defines disability based on a person's:
  - Loss of income, or
  - Inability to perform the duties of his employment

Total Disability

- Disability insurance policies define the term "disability" as either a loss of income, a loss of a person's ability to work at a job, or both.

Inability to Perform Duties

- Disability income policies generally define disability as a person's "inability to perform the material and substantial duties" of one or more occupations.
- The phrase "material duties" refers to the actual tasks or activities that a person performs while doing her job.
- The term "substantial duties" can also be referred to as "key duties" or "essential capabilities."

Any Occupation

- The "**any occupation"** definition of disability requires an insured to be unable to perform "the material and substantial duties" of:
  - Her own occupation, or
  - Any occupation for which she's reasonably suited by education, training, or experience.

Own Occupation

- The **own occupation** definition of disability requires the insured to be unable to perform "the material and substantial duties of her own occupation."
- This definition is less restrictive than the "any occupation" definition.
- Such policies are more expensive and often reserved for certain professions.

Combination Definition

- The "own occupation" definition of disability applies during the first two years of the claim.
- If a claim continues beyond two years, the "any occupation" definition applies.

Loss of Earnings

- The **loss of earnings test** is used to determine whether an income loss has actually occurred.
- Earned income doesn't include passive income.

Pure Loss of Income (Income Replacement Contracts)

- A person must generally lose at least 20% of his income to qualify for a disability benefit.
- Policies that define disability purely as a loss of income are referred to as "**income replacement contracts**."

At-Work Benefits

- Insurers first offered at-work benefits to encourage beneficiaries to return to work.

Partial Disability

- **Partial disability** is defined as a person's inability to perform some of the key duties of his own occupation or the inability to work at his own job full-time.
- This benefit encourages disabled insureds to return to work without fear of losing all their benefits.
- The traditional partial disability benefit was 50% of the total disability benefit for a maximum of six months.

[EXAM TIP: Assume this is true for the licensing exam.]

Residual Disability

- **Residual disability** is a proportional disability benefit that's based on loss of income. The amount of income lost defines the degree of disability. The insured receives a percentage of the total disability benefit.

  For example: If Frances suffers a disability that results in a 40% loss of income, she will have a residual disability rating of 40%. Frances's policy will pay her 40% of her policy's total disability benefit.

Recurrent Disability

- The **recurrent disability** clause applies when the insured returns to work after a disability but suffers a relapse.
- Under the terms of the recurrent disability provision, the relapse is considered part of the original disability if it occurs within six months after the insured returns to work. As such, the following conditions apply:
  - No new elimination period (benefits begin immediately)
  - No new benefit period (If the insured has a five-year benefit period and has already received six months of benefits before returning to work, he now has 4.5 years remaining.)

Presumptive Disability

- **Presumptive disability** identifies certain conditions that automatically qualify an insured for the total benefit.
- Losses that qualify as presumptive disabilities include the following:
  - Double dismemberments
  - Total and permanent loss of sight
  - Total and permanent loss of hearing
  - Total and permanent loss of speech

Other Definitions of Disability

Concurrent Disability

- When disabling events occur in tandem and result in a single period of disability, the condition is referred to as a **concurrent disability**.

Delayed Disability

- In some cases, total disability doesn't occur immediately after an accident.

- Most policies cover total disability claims that manifest some time (e.g., 20, 30, 60, or 90 days) after the occurrence that caused them.
- The amount of time allowed for a delay between the cause and resulting disability is referred to as **delayed disability**.

Confining versus Non-Confining Disability

- **Confined disability** requires the insured to remain indoors (at home or in the hospital).
- **Non-confined disability** means that an insured is not required to remain indoors.

Occupational versus Non-Occupational Coverage

- Some disability income policies don't cover losses arising out of the occupation of the insured.
- This type of disability income contract is referred to as **non-occupational coverage**.
- If the policy pays a monthly income in addition to any benefits received by Workers' Compensation or other social insurance plans, it provides **occupational coverage**.

Credit Disability

- **Credit disability** guarantees the payment of loan installments if the insured debtor becomes disabled.
- Credit disability contracts may also be referred to as "**decreasing term disability policies**."
- The policy pays the creditor, not the debtor.
- Once the debt is paid off, the policy terminates.

Disability Benefits in Life Insurance

- There are two types of disability benefits found in life insurance:
  - The **waiver of premium rider**, which waives the cost of coverage while the insured is disabled.
  - The **disability income rider** converts 1% of the policy's face amount into a disability benefit.

GOVERNMENT (SOCIAL) DISABILITY INSURANCE

Social Security Disability Income

- Social Security provides disability benefits that are funded by payroll taxes.
- Only fully insured individuals are eligible for **Social Security Disability**.
  - Workers who have paid **Federal Insurance Contributions Act** (**FICA**) taxes for 10 years (40 quarters) earn permanent, fully insured status.
- Social Security imposed a **five-month waiting period** before an individual will qualify for benefits.
- The **Social Security Disability Income** (**SSDI**) benefit equals 100% of the worker's **primary insurance amount (PIA)**.
- Social Security defines "disability" as a person's inability to perform any **substantial gainful work,** which means:
  - She's not able to do work because of her medical condition, and
  - Her disability is expected to last for at least one year or to result in her death.

Workers' Compensation

- **Workers' Compensation** is a form of liability insurance that guarantees benefits for workers who are harmed by work-related accidents or occupational diseases.
- Workers' Compensation pays both total and partial disability benefits. It also classifies disabilities as either a "**temporary disability**" or a "**permanent disability**."
- Workers' Compensation is the primary coverage when it's paid.

INDIVIDUAL DISABILITY INCOME INSURANCE

- Individual disability income insurance is an occupational contract.
- Insurers underwrite the risk based on the applicant's occupation as well as personal characteristics.
- The issued policy provides 24/7 coverage for losses due to injuries and illnesses.

Basic Structure

Benefit Period

- The **benefit period** is the maximum length of time that disability income benefits will be paid to the disabled insured.
- Individual short-term disability policies provide benefits for six months to two years.
- Individual long-term disability policies are characterized by benefit periods of two years or more per disability.

Elimination Period (Waiting Period)

- The **elimination period** is also referred to as the **waiting period.**
- This is the time immediately following the start of a disability when benefits are not payable.
- The elimination period serves as a time-based deductible in a disability income policy.
- The longer the waiting period selected, the lower the policy premium.

Probationary Period

- A probationary period occurs only once, and it's at the policy's inception.
- In a disability insurance policy, the probationary period defines the period that must elapse before claims due to illness are covered.
- The probationary period's purpose is to exclude pre-existing sicknesses from coverage, which may not manifest themselves until after the policy is in force.
- The probationary period helps protect the insurer against adverse selection.
- Probationary periods don't apply to accidents.

Disability Benefit Amounts

Monthly Benefit Limit

- Disability income insurers that issue individual policies limit coverage to a percentage of the insured's income.

  For example, if an applicant's gross earned income is $3,000 per month, an insurer will allow him to buy a policy with a monthly benefit of up to $1,800.

Disability Benefit Methods

- **Percent-of-Earnings Approach** This approach defines the benefit as a fixed percentage of the insured's pre-disability earnings.
- This approach is primarily used in group insurance.
- If the insured's income increases, the benefit also increases to maintain the percentage.
- **Flat Amount Approach** Individual disability policies use the **flat amount method,** which defines benefits as a specific dollar amount.
- It remains fixed despite changes in income unless the insured has purchased riders allowing him to increase his coverage.

Loss Settlement

- When calculating a disability claim, we must account for the elimination period.

  For example, let's assume that Ellen owns a policy with a $1,000 per month total disability benefit and a 60-day elimination period. If Ellen is totally disabled for 90 days, she's subject to the elimination and will only collect a single month of benefits (90 days – 60 days), or $1,000.

Premiums

- **Premium** rates are based on the monthly benefit as well as:
  - The length of the waiting period and the benefit period
  - The age, sex, income, and health of the insured
  - The occupation of the insured

Payment Options

- Most individual disability policies are sold with a level premium.
- Groups or association-sponsored plans often have five-year premium age bands, and the premium increases as the insured ages.

Underwriting Considerations

- Personal underwriting criteria includes the insured's:
  - Age
  - Sex (gender)
  - Occupation
    - An insured's occupation is an essential element of her morbidity risk. **Morbidity** is considered the likelihood of a person becoming disabled.
    - Individuals in certain professions (e.g., physicians and attorneys) engage in less hazardous work. Also, their income potential is much higher than their potential benefits.
    - Other white-collar and gray-collar occupations are considered riskier, especially since the incentive to return to work is not as great.
    - Many blue-collar occupations have a higher incidence of physical injury and the highest morbidity rates. In such cases, the insurer will restrict policy terms and limit the benefit period's length to either two or five years.

Standard Provisions and Benefits

Change of Occupation Provision

- This provision allows the insurance carrier to automatically change the premium or benefit if the insured has not informed the insurer of a change in risk.
- If the insured's new occupation is riskier, the benefit decreases.
- If the insured's new occupation is less risky, the premium decreases.

Other Insurance – Relation of Earnings to Insurance

- The **relation of earnings to insurance** limits the total amount of benefits paid to the amount of pre-disability income, even if the available insurance from multiple policies is greater than the income lost.
- If the available insurance that covers a loss is greater than the loss itself, each policy's benefit is reduced on a **pro-rata** basis.

Impairment Rider

- This type of rider is also referred to as an exclusion rider or **waiver for impairments**.
- Insurers use this rider to permanently exclude certain losses if the risk is too high or too uncertain.
- It allows insurers to cover most risks for an applicant while still charging a standard premium.

Rehabilitation Benefit

- The **rehabilitation benefit** encourages individuals to actively participate in their recovery.
- The rehabilitation benefit facilitates vocational training to prepare insureds for a new occupation.
- The rehabilitation benefit provision requires the insurer to pay the approved cost of a rehabilitation program as long as the insured remains disabled and active in the program.

Medical Reimbursement (Non-Disabling Injury) Benefit

- The **non-disabling injury benefit** pays up to a specified amount if the insured suffers an injury and no other claim is filed.

Renewal Provision

- Disability insurance policies are either **non-cancelable and guaranteed renewable** or **guaranteed renewable**.
- Neither type of policy can be canceled or non-renewed by an insurer unless the insured fails to pay his premium.

Non-Cancelable and Guaranteed Renewable (Non-Cancelable)

- If a policy is **non-cancelable,** the insurer guarantees the premium rate for the contract's life as it existed when the insurer issued the policy.

Guaranteed Renewable

- If the policy is guaranteed renewable, the insurance carrier has the right to raise rates if the cost of disability claims exceeds expectations.
- The law prohibits an insurance company from raising policy premiums on a particular individual.
- A company may raise rates on an entire class of policies. This is referred to as raising rates on a "class" basis because it's based on the entire pool of affected contracts.
- Guaranteed renewable policies are more common, especially for classes of employment with higher levels of morbidity risk.

Coverage After Age 65 Provision

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

Exclusions

- The more common exclusions in a disability income policy include:
  - War (declared or undeclared)
  - Intentionally self-inflicted injuries

- Non-commercial aviation
- Military service
- All illegal occupations

Individual Disability Income Policy Riders

Accidental Death and Dismemberment (AD&D)

- This benefit applies when an accident results in a catastrophic loss, defined as death, the permanent loss of limbs, or a permanent loss of one or more of the senses (sight, hearing, or speech).
- The death benefit paid under accidental death coverage is referred to as the **principal sum**.
- The dismemberment benefit is referred to as the **capital sum**.
- The principal sum is the rider's face amount, while the capital sum is typically 50% of the principal sum.

Elective Indemnity Option

- Some disability policies allow the insured to take an optional lump-sum payment rather than periodic income. This is referred to as an **elective indemnity option.**
- The elective indemnity option is also used in policies that facilitate transfers of ownership related to disabilities, such as **disability buyout** policies.

Hospital Confinement Rider

- This is an indemnity rider that pays an additional sum on top of the regular monthly disability benefit based on the number of days that the insured is confined to a hospital.
- The hospital confinement rider also waives the elimination period while the insured is hospitalized.

Return of Premium Rider

- The **return of premium rider** refunds premiums if the insured doesn't have a claim.

Cash Surrender Value Rider

- This rider returns all premiums to the policy owner at the age of 65 if no claims have been made over the contract's life.

Lifetime Extension Rider

- The **lifetime extension rider** extends the benefit period beyond the age of 65 if the insured is totally disabled as a result of an injury or illness that occurs before the age of 65.

Social Security Rider (Social Insurance Supplement or Social Insurance Substitute)

- The Social Security rider coordinates individual disability policy benefits with **Social Security Disability Insurance** (**SSDI**) and other forms of social insurance, such as **Workers' Compensation**.
- An individual disability policy is relatively expensive, and it pays regardless of whether SSDI or other social benefits apply.
- By shifting some coverage from a policy's basic, individual disability benefit to a Social Insurance Supplement, a consumer accepts coordination of benefits on some of the policy's benefits in exchange for a lower premium.
- The insured will ultimately receive sufficient insurance, either from the insurance company or the government benefit.

Additional Monthly Benefit (AMB) Rider

- This rider is a short-term benefit that addresses the insured's needs during the initial six to 12 months of disability.
- The additional monthly benefit rider can also fill a coverage gap during the five-month SSDI waiting period.

Guaranteed Insurability Rider (Additional Purchase/Future Increase Option)

- This rider helps guarantee that a person's coverage will keep pace with his income.
- The future increase option (FIO) "guarantees" that the insured can purchase additional amounts of disability income insurance at various specified future dates without evidence of insurability.
- The insured can exercise this option **as long as his income has increased.**
- Also, the insured must exercise the **guaranteed insurability** rider if it's available or lose the option.

Cost-of-Living Adjustment (COLA) Rider

- This rider offsets the impact of inflation that can erode a fixed income's purchasing power.
- The COLA rider indexes the disability benefits that are paid for an active claim to changes in the Consumer Price Index (CPI).
- This rider doesn't increase coverage like an FIO; instead, the COLA rider increases the benefits that are paid once a claim has been made.
- This rider is also only found on long-term disability policies.

  For example, a $1,000 per month benefit with a COLA rider may be increased each year by the lesser of the inflation rate as determined by the Consumer Price Index (CPI) or a specified percentage stated in the policy (generally 5%).

GROUP DISABILITY INCOME INSURANCE PLANS

- The group must be a natural group.
- Insurers base premiums on the group's aggregate.
- Employers may sponsor multiple plans and restrict participation per plan according to the class of the employees.
- Insurance carriers require a minimum level of participation to avoid adverse selection.

Group versus Individual Disability Insurance

Probationary Period

- Group policies often don't have probationary period provisions. Instead, most group disability plans require new participants to fulfill a minimum required length of service before becoming eligible for coverage.

Elimination Period

- Group insurance policies have an elimination period.
- For example, let's assume that an employer allows employees two weeks of sick leave per year, a six-month short-term disability plan, and long-term disability insurance. The benefit design may include the following:
  - A five-day or 10-day elimination period for the short-term disability benefit, and
  - A 180-day elimination period for the long-term disability benefits
- Ideally, the package design allows participants to move seamlessly between the different disability benefits.

Benefit Periods

- The benefit periods for group insurance mirror those for individual insurance policies.

Benefit Amount

- Group insurance policies define disability benefits as a percentage of an insured's wages.
- The benefit amount changes as the employee's compensation changes.

Coordination of Benefits

- Group disability plans **coordinate benefits** with other groups and social insurance programs, such as Social Security.
- Group plans are secondary to Workers' Compensation for work-related claims.
- Some group disability plans limit coverage to non-occupational disabilities.

[EXAM TIP: In a real-world group, disability insurance can be "occupational" or "non-occupational" insurance. For purposes of the licensing exam, we suggest for students to consider it to be "non-occupational."]

Qualifying for Benefits and Benefit Periods

- Group insurance plans often provide both total disability and partial disability benefits.
- As with individual plans, group disability can include short-term plans or long-term plans.
- The labels "short-term" disability and "long-term" disability are used a little differently in group plans.

Group Short-Term Disability Income Plans

- Group short-term disability plans have short maximum benefit periods of 13 weeks (where allowed by law) or 26 weeks.
- Benefits are typically paid weekly and range from 50% to 100% of the individual's income.
- The definition of disability is the insured's own occupation.

Group Long-Term Disability Income Plans

- Group long-term disability plans provide maximum benefit periods of two years or more, often extending to the insured's retirement age.
- Benefit amounts are generally limited to between 50% and 70% of the participant's income.
- In some cases, the employer will pay for a benefit that's equal to 50% of their employees' wages and allow employees to enhance their coverage level up to 20% at their own expense.
- Long-term plans often use an "own occupation" definition of total disability for the first two years of disability and then switch to an "any occupation" definition.

BUSINESS USES FOR DISABILITY INSURANCE

- Insurers use disability insurance to facilitate business continuation in the event of a disabling sickness or injury.
- Policies used for business continuation are individually underwritten.
- While group insurance is designed for the average worker, these policies benefit owners, key employees, and the organization.

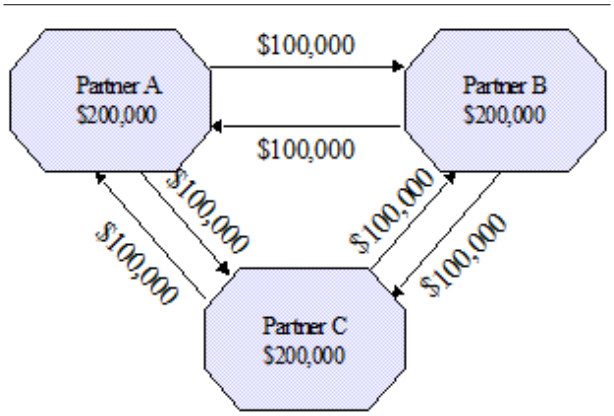
Business Overhead Expense Insurance

- **Business overhead expense** (**BOE**) insurance covers business expenses and payroll costs if the owner becomes disabled.
- **BOE** policies don't insure the disabled owner's income.
- **BOE** contracts cover the costs of the day-to-day business operations to help the enterprise continue functioning.
- Insurers sell BOE to professionals in private practice, self-employed business owners, partners, and close corporations in which a business owner:
  - Directly generates a significant portion of company income, or
  - Directly oversees day-to-day operations

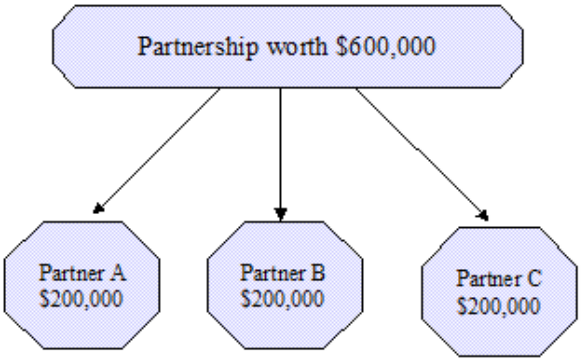
- Rather than a fixed indemnity, business overhead expense policies pay a maximum monthly amount for covered expenses such as:
  - Rent or mortgage payments
  - Utilities
  - Telephone and internet service
  - Leased equipment
  - Employee wages
  - The cost to hire a temporary replacement

Disability Buy-out Policies (Buy-Sell Plans)

- Disability buy-out policies fund disability buy-sell agreements much the same way life insurance policies do.
- The buy-out plan sets forth the terms for transferring the ownership share of a business; the insurance provides the funds.
- In the **cross-purchase plan**, each partner buys a policy that covers each of the other owners. The value of each disability policy benefit equals 50% of each partner's $200,000 share.



- In an **entity buy-sell plan**, the company purchases a policy on each partner or shareholder. The company is the beneficiary of each policy and uses the funds to buy out the disabled partner or shareholder.



- Unlike typical disability income insurance contracts, disability buy-out policies contain a provision that allows the insurer to pay a lump-sum benefit.
- Disability buy-sell policies also have lengthy elimination periods, often as long as two years.

Key Person (Employee) Disability Insurance

- **Key-person disability insurance** indemnifies the business for a key person's lost services.
- This type of coverage pays a monthly benefit or lump sum if an essential person is disabled.
- A key person could be a partner, stockholder, or key employee.
- The key person's economic value to the business is the potential loss of business income plus the expense of hiring and training a replacement.
- Generally, the policy's elimination period will be from 30 to 90 days, and the benefit period will be from one or two years.
- The business is the owner and premium payor of the policy.

TAXATION OF DISABILITY INSURANCE POLICIES

- When it comes to disability insurance, the IRS generally taxes the money only once—either when the premiums are paid in or when the benefits are taken out.

Government (Social) Disability Insurance

- The taxation of social insurance disability benefits depends on the program and the income of the recipient.

Social Security Disability Insurance

- Social Security Insurance benefits are partially taxed after one's total income reaches $25,000 for individuals and $32,000 for married couples filing jointly.

Workers' Compensation

- In general, workers' compensation benefits are not subject to state or federal income tax.

Individual Disability Income Insurance

- **Premiums are not deductible. T**he IRS counts premiums as part of taxable income and captures a percentage as income tax.
- Benefits are not taxable. Because the IRS collects income tax on money going into the policy, the insured receives benefits from the policy, free of income tax.

Group Disability Income Insurance

Employers

- The premiums paid by employers are tax-deductible as legitimate business expenses.
- The group policy benefits the employees, not the employer or the business.

Employees

- The taxation of employee premium dollars and benefits depends on several sets of circumstances (described below).

Employer-Paid Premiums

- If the employer pays a participating worker's disability insurance premium, the benefits are taxable.
- The employer deducts the premium from taxable income; therefore, the IRS will tax the money coming out of the policy in the form of benefits.

Employee-Paid Premiums – Pre-Tax Premiums

- If an employee pays group premiums on a pre-tax basis through a cafeteria plan, the IRS will tax any benefits as income.
- The pre-tax contribution avoids taxation when money is paid to the insurer; therefore, the IRS will tax funds when benefits are paid, often when they're needed the most.

Employee-Paid Premiums – After-Tax Premiums

- In some companies, employees pay their disability premiums with after-tax dollars.
- In such cases, the premiums are not deductible (i.e., they're after-tax), so the benefits are not taxable.

Premiums Shared by Employer and Employees

- If the employee-paid portion of the premium is paid pre-tax, then the entire benefit is taxable.
- If employees pay their portion of the premium with after-tax dollars, the benefit will be partially taxable and partially tax-free. The degree to which the benefit is income tax-free reflects the percentage of the premium that's taxable.

Business Uses For Disability Insurance

- The IRS will only tax the funds once—either on the way in or on the way out.

Business Overhead Expense (BOE) Insurance

- For a business overhead expense policy, the premium is a tax-deductible business expense.
- The benefit is considered a part of taxable revenue.
- The benefits offset other deductible business expenses.

[EXAM TIP: When trying to figure out what a BOE policy does NOT cover, the answer is "employer income" or "the insured's lost income" or some other similar answer.]

Disability Buy-Out Policies

- The company buys disability insurance on each partner or each shareholder in a closed corporation.
- If the partner or the shareholder is disabled, the company receives the benefit.
- The taxation works like a standard individual policy. Since the policy holder (the company) pays a premium with after-tax dollars, the policy benefit is income tax-free.
- The insurance carrier pays the policy holder (the insured company) a lump-sum or periodic benefit, either of which is income-tax-free.
- Once the company receives the benefit, any further payments or taxation are no longer part of the insurance transaction.

Key Person (Employee) Disability Insurance

- The taxation of the key-employee policy mirrors the taxation of the individual disability policy.
- The insured company is protecting itself from the economic impact of a loss.

MEDICARE

- The federal government administers Medicare through the **Center for Medicare and Medicaid Services** (**CMS**).
- Medicare is considered part of **OASDHI** and is funded primarily through payroll taxes.
- Medicare provides hospital and medical expense insurance primarily to those who are the age of 65 and older.
- Any person who's eligible for Social Security retirement benefits is automatically eligible for Medicare.
- Medicare is also available for disabled individuals who are younger than the age of 65 and who have received Social Security Disability benefits 24 months following their five-month waiting period.

Original Medicare versus Medicare Advantage

- There are two ways to access Medicare—**Original Medicare** and **Medicare Advantage**.
- Original Medicare is administered by the federal government and includes **Medicare Part A** (hospital insurance) and **Medicare Part B** (medical insurance).
- Original Medicare is a fee-for-service program and includes cost-sharing.
- Individuals who choose Original Medicare also must purchase a **Medicare Part D Prescription Plan** to cover their outpatient prescriptions.
- Individuals who choose Original Medicare generally need to buy a **Medicare Supplement** (**Medigap**) policy to help pay their remaining health care costs, such as co-pays, co-insurance, and deductibles.
- **Medicare Advantage** is an "all in one" alternative to Original Medicare.
- These "bundled" plans include Part A, Part B, and the coverages that are found in a Medicare Supplement policy.
- These plans often resemble other HMOs and PPOs in their structure and mode of operation.
- Individuals may get prescription drug coverage through a separate Medicare Part D plan or as part of their Medicare Advantage policy.

Original Medicare

- Enrollment in Medicare Part A and Part B is automatic for any person who's receiving Social Security benefits at the age of 65; however, a person can decline Part B.
- Any person who's still working and not receiving Social Security must enroll on his own.
- Eligible individuals can enroll in Part A at any time after they become eligible.

Enrollment

- The initial enrollment period for Medicare begins three months before the beginning of the month an individual turns the age of 65.
- Enrollment ends after the end of the three months that follow the month an individual turns the age of 65.

  For example, if John's birth month is July, his initial enrollment period begins on April 1 of the year in which he turns the age of 65. It ends on the last day of October later that year.

- If an individual fails to enroll in Part B during the initial enrollment period, she may use the annual open enrollment period, which is January 1 through March 31.
- However, coverage doesn't begin until the following July 1.
- Late enrollees may pay a higher premium.

Premiums

- There's no Medicare Part A premium for any individual who's covered by Social Security and is "fully insured." Other Medicare-eligible persons must pay a monthly premium.
- Every person who elects Medicare Part B pays a monthly premium that's automatically deducted from his Social Security check.
- In 2021, the standard monthly premium is $148.50.
- Individuals and joint filers with incomes of $88,000 and $176,000, respectively, will pay more.

Participating Providers and Medicare Assignment

- **Participating providers** accept assignment and agree to accept the approved Medicare fee for their services.
- **Non-participating providers** don't accept assignment. They collect their fees directly from the insured and may charge up to 15% more than the Medicare-approved amount.

Medicare and Group Insurance

- Eligible beneficiaries may delay enrolling in Medicare Part B depending on their employers' group major medical plan.

Employer Group Medical – COBRA Groups

- If an employer's group health plan covers a person who's the age of 65 or older, and the employer is a qualified COBRA group, then the employee can delay enrolling in Part B because:
  - The group insurance is **primary,** and Medicare is **secondary**.
  - The employee will be eligible for a "special enrollment period" when he retires.

[TEST TIP: If the exam refers to "group insurance," assume it's a "COBRA group."]

Individual and Retiree Insurance and Medicare

- If a Medicare-qualified person owns individual health insurance, he should enroll in Medicare because Medicare is his primary insurer. The same is true for non-COBRA groups.
- Retiree health insurance programs are also secondary payors after Medicare.

Medicare Part A – Hospital Insurance

- Medicare Part A provides inpatient hospital care, skilled nursing care, home health care, and hospice care.
- The primary source of financing for Part A is federal payroll and self-employment taxes.
- Part A defines a new benefit period as the start of a new claim rather than a new calendar year.

Inpatient Hospital Care

- Inpatient hospital benefits cover the expense of a semi-private room, meals, nursing services, drugs, tests, operating room, and other medical services and supplies.

The Benefit Period

- A new benefit period begins when an individual is admitted to a hospital.
- Each benefit period ends 60 days after the individual is discharged from care.
- If an insured re-enters the hospital less than 60 days after being previously released, Medicare treats it as a continuation of the same benefit period.

Hospital Benefits

- Each year, the CMS adjusts the benefits and cost-sharing percentages for Medicare Part A and Part B.
- **Medicare Part A: Basic inpatient benefits**
  - Medicare covers up to 90 days of inpatient hospital care per benefit period.
  - These benefits are restored with each benefit period.
- **Medicare Part A: Reserve inpatient benefits**
  - Part A provides an additional **60 Lifetime Reserve Days.**
  - Reserve days are not restored (i.e., once they're used, they're gone).

Cost-Sharing

- Beneficiaries must pay a Part A deductible for each new benefit period.
- Once the deductible is paid, there's no co-insurance for the first 60 days.
- There's a daily co-insurance amount for the last 30 days (in 2021, it's $371).
- The Lifetime Reserve Days have a daily co-insurance amount that's twice the basic amount, which in 2021 is $742 per day.

Skilled Nursing Care Benefits

- Medicare provides a short-term recovery benefit in a **skilled nursing facility**.
- Beneficiaries qualify for this benefit following a recent hospital stay of at least three inpatient days.
- Medicare only covers up to a maximum of 100 days.
- Coverage ends sooner if the maximum level of recovery is achieved.
- Skilled care is defined as nursing care and therapeutic services that can only be safely and effectively delivered by licensed professionals or technicians or done under their supervision.
- Medicare doesn't cover **custodial care** or assistance with the **activities of daily living**.

Cost Sharing

- There's no cost-sharing for the first 20 days of residential care.
- Starting on day 21, there's a daily co-insurance amount (in 2021, it's $185.50).
- All coverage ends after a maximum of 100 days.

Other Part A Benefits

Inpatient Psychiatric Care

- Medicare Part A covers up to 190 days (lifetime) of inpatient care at a psychiatric facility.

Home Health Care Benefits

- Medicare Part A covers **home health care** costs, such as nursing and physical therapy.

Hospice Care

- **Hospice care** is comfort care.
- Medicare offers hospice benefits to individuals who have a life expectancy of six months or less.
- Medicare provides two 90-day benefit periods.
- A person may receive additional care in 60-day increments.

Exclusions (Medicare Part A)

- A private duty nurse or attendant in private rooms
- The first three pints of blood
- Personal conveniences (telephones, TV rentals, etc.)
- The cost of surgeons and anesthesiologists who are not hospital employees

Medicare Part B – Supplemental Medical Insurance

- Medicare Part B is medical insurance.
- Part B covers doctors' services, outpatient medical services, medical supplies, durable medical equipment, and many services that are not covered by Part A.
- Part B also pays for the cost of non-employee surgeons and anesthesiologists who perform inpatient surgery.
- Unlike Part A, this coverage is optional.

Covered Services

- Medicare Part B covers doctor's services and exams that are performed anywhere in the United States.
- Other covered services covered include:
  - X-rays
  - Diagnostic tests
  - Medical supplies
  - Home health care services
  - Various types of therapy
  - Prosthetics, and
  - Durable medical equipment

Medicare Part B – Exclusions

- The services of a private duty nurse or attendant
- Intermediate or custodial care
- The cost of skilled nursing care over 100 days
- Vision and hearing care
- Dental care
- Outpatient prescription drugs and immunizations
- Cosmetic surgery
- Routine physical examinations and foot care
- Physician costs exceeding Medicare's approved amount

Medicare Part B – Cost-sharing

- Medicare Part B requires all beneficiaries to pay an annual deductible (in 2021, it's $203).
- After meeting the deductible, Medicare Part B and the insured split covered charges 80%/20%.

Medicare Part C – Medicare Advantage (Formerly Medicare + Choice)

- **Medicare Part C** (Medicare Advantage) is a private alternative to the Original Medicare program and is administered by the federal government.
- The government pays private companies a fixed amount for each insured who chooses an Advantage plan, typically 95% of the government's average cost.
- The private insurer provides major medical insurance that replaces Original Medicare and eliminates the need to purchase a Medicare Supplement policy.

Qualifying for Medicare Part C

- To be eligible for **Medicare Advantage**, a person must be enrolled in Medicare Parts A and B.
- Part C enrollees must continue to pay the Part B premium.
- Part C enrollees also pay a premium to their chosen insurer.
- Medicare-qualified individuals may choose **Medicare Advantage** (Part C) by enrolling in one of the private plans in their area.
- Evidence of insurability is not required for enrollments during the six months following their 65th birthday.
- An individual may only participate in one Medicare Advantage plan at a time.
- Part C Participants may use HSAs to pay medical expenses.

Plan Types

Health Maintenance Organizations (HMOs)

- Medicare Advantage HMOs follow the same general approach as other HMOs.
- They provide coverage through a defined network.
- Participants select a primary care physician who manages care and refers patients to network specialists.
- HMOs, restrict out-of-network care to emergency services only.

Preferred Provider Organizations (PPO)

- Medicare Advantage PPOs follow the same general approach as other PPOs.
- They provide coverage through a defined network that discounts its fees.
- They also provide some coverage for out-of-network services.

Private Fee for Service (PFFS) Plan

- In a **Private Fee for Service (PFFS) Plan**, an individual may go to any participating Medicare provider.
- The insurance plan, rather than Medicare, decides how much the insurer and insurer will pay, respectively.
- PFFS plans may include extra benefits that are not covered under Original Medicare.

Medicare Part D – Prescription Drug Plans

- **Part D prescription drug plans (PDPs)** cover outpatient medication costs.
- Private companies offer and administer these PDPs, which offer conventional prescription drug coverage, including monthly premiums and co-payments.
- The initial enrollment period mirrors the initial enrollment period for Part B.
- In subsequent years, the annual open enrollment period is October 15 through December 7.
- Any individual who fails to enroll during her first opportunity to do so is subject to a premium penalty.
- Each plan covers the cost of those prescription medications that are listed in its formulary. The degree of coverage also depends on whether the medication is a generic, brand-name, or specialty drug.
- Part D PDPs typically have a gap in coverage between the two layers of coverage—basic and catastrophic. This is referred to as the **donut hole.**
- Medicare Advantage policies may include prescription drug coverage as an integral part of their plan.

MEDICARE SUPPLEMENTS (MEDIGAP)

- **Medigap** or Medicare Supplement policies are sold by private insurers and other health care providers.
- Medigap policies help fill in any gaps in coverage under Original Medicare. They help pay a person's Medicare cost-sharing amounts, which include deductibles and co-insurance.
- The National Association of Insurance Commissioners (NAIC) established regulated coverage forms labeled **Plans A through L**.
- Currently, there are 10 plans available for purchase.
- Only contracts that conform to one of these forms can be referred to as a **Medicare Supplement** policy.
- Original Medicare (Parts A and B) limit the types of coverage that Medigap policies can offer.
- A Medicare Supplement policy CANNOT contain benefits that duplicate Medicare benefits.
- Medigap plans cannot add additional benefits, such as dental.
- Benefit restrictions and qualifications cannot be more restrictive than those for Medicare itself.
- Medicare Supplements are always individual contracts, and a person may only have one policy.
- Medigap benefits change annually, reflecting changes in Medicare.
- Insurers must give insureds at least 30 days' notice.

Medigap Enrollment

- The best time for a person to buy a Medigap policy is during the open enrollment period, which is the six months following the date she first enrolls in Medicare Part B.
- Medicare Supplements are guaranteed issue contracts during open enrollment.

Standardized Plans

- The National Association of Insurance Commissioners (NAIC) standardized these policies to help consumers understand them, compare them, and make informed buying decisions.

Core Benefits

- All Medicare Supplement policies must include the core benefits, even if insurers offer the additional authorized benefits.
- The core benefits must always be present in any policy sold as a Medicare Supplement insurance contract.
- Plan A is the most basic Medigap policy, which only offers the **core benefits.**

Part A Hospital Benefits

- 100% of the daily hospital co-insurance for days 61 through 90 of inpatient care during a standard benefit period
- 100% of the daily hospital co-insurance for the insured's lifetime reserve days
- 365 additional lifetime reserve days

Part A Hospice Benefits

- 100% of hospice care co-insurance or co-payments

Part B Medical Benefits

- Medigap policies cover the 20% co-insurance for approved charges in excess of the annual deductible.

Part A and B Benefits

- Medigap plans pay for the first three pints of blood, which neither Medicare Part A nor Part B cover.

Additional Benefits

- Plans B through L provides additional benefits such as:
  - Medicare Part A deductible
  - Medicare Part B deductible
  - Medicare Part B excess charges
  - Skilled nursing facility (daily co-pay for days 21 to 100)
  - Foreign travel emergency (80% up to plan limits)

Plans K and L

- Initially, the only expenses they fully cover are the Part A daily co-insurance amounts.
- They cover most other cost-sharing amounts until an annual out-of-pocket limit is reached; thereafter, they cover 100%.

Plans F and G

- In some states, Plans F and G also offer a high-deductible option.
- In 2021, the deductible amount is $2,370.

Contract Requirements

- The NAIC Model Act governs Medigap policies and establishes several requirements that they must meet, including:
  - Medigap policies must have a 30-day free-look period.
  - Medicare Supplements must be guaranteed renewable for life, as long as premiums are paid.
  - Medigap policies cannot contain exclusions, limitations, or reductions that are inconsistent with or more restrictive than Medicare.
  - Pre-existing conditions cannot be excluded.
  - Any waiting period connected with pre-existing conditions cannot exceed six months.
  - Benefits must automatically increase to cover deductibles and co-insurance that are not covered by Medicare, as well as statutory changes.
  - Soliciting duplicate coverage is prohibited by law.
  - During the initial six months after qualifying for Part B of Medicare, insurers may not charge higher rates based on adverse health, the number of claims submitted, or other medical conditions.
  - These policies must include a six-month open enrollment when an insured initially enrolls in Medicare Part B.
  - A new probationary period may not apply to a replacement Medicare Supplement policy.
  - Insurers must achieve specific loss ratios.
    - The minimum loss ratio requirement for individual Medigap policies is 65%, while the loss ratio for group Medigap policies is 75%.
- Insurers use one of three methods to calculate Medigap premium rates—*issue age, attained age,* or *community rating*.

Advertising and Marketing Standards

- Insurers must submit Medigap policies to the state insurance department before they're marketed in most states.

- Insurers must submit Medigap policy advertisements to the state insurance department at least 30 days before being used.
- Insurers must provide applicants with a copy of the Medigap Buyer's Guide at the time of application.
- When an agent replaces an existing Medigap plan, the agent must provide a "Notice of Replacement" to the applicant, which must be signed by both the agent and applicant.

Prohibited Practices

- **Duplication of coverage –** This is the illegal sale of multiple Medigap policies to one person. The producer must attempt to determine whether other coverage exists.
- **High-pressure tactics** – This refers to any sales approach that uses explicit or implicit threats, excessive pressure, or creates a climate of fear.
- **Cold lead advertising** – This is an advertising or marketing practice that fails to disclose that an agent may call to solicit the sale of a Medicare supplement.
- **Twisting** – This is the illegal use of misrepresentation or deception to induce an individual to replace an existing policy with another contract.

Producer Compensation

- First-year commissions cannot exceed 200% of the second-year commissions paid for the same sale.
- Furthermore, the commission amount paid in year two of the contract must continue for five years.

Medicare Select

- **Medicare Select** is a type of Medicare Supplement that's available in most states and works like a closed-end HMO.
- Medicare Select plans mirror the benefits in standard Medigap policies, but the individual agrees to use certain, insurer-designated providers in return for a lower premium.

Long-Term Care Insurance (LTCI)

- **Long-term care insurance (LTCI)** pays for a broad range of medical and personal services for individuals who need assistance with the **activities of daily living (ADLs)** for an extended period.
- Individuals may need such assistance due to either cognitive impairment or a physical loss of function.
- Long-term care recipients receive differing levels of nursing care depending on their level of disability.
- There are three distinct levels of nursing care—**skilled nursing care**, **intermittent care**, and **custodial care**.
- Individuals receive care in various venues such as nursing homes, assisted living facilities, adult daycare centers, and home care in the individual's own home.
- Medicare and Medigap provide minimal protection for this risk because they focus on a person's recovery from illness rather than the maintenance of his quality of life.
- Long-term care insurance is designed to cover at least 12 consecutive months of care in a setting other than a hospital.

The Levels of Long-Term Care

- The three long-term care levels are *skilled nursing care, intermediate nursing care,* and *custodial care*.
- **Skilled Nursing Care**
  - Skilled nursing care consists of daily nursing and rehabilitative care.
  - Care may be performed by (or under the supervision of) skilled medical personnel and based on an attending physician's orders.
  - Skilled nursing care involves 24-hour care.
- **Intermediate Nursing Care**
  - Intermediate nursing care is intermittent or occasional nursing and rehabilitative care.
  - It's based on a physician's orders and provided by skilled medical personnel.
- **Custodial Care**
  - Custodial care is **non-medical care**.
  - It involves assistance with personal needs such as bathing, walking, eating, dressing, or taking medication (the ADLs).
  - Medically unskilled persons can provide this care; however, it must still be approved and ordered by a physician.

The Delivery of Long-Term Care Services

- Formal care is paid care.
  - Individuals receive formal care from paid caregivers, whether in a nursing home, assisted living facility, or at their own home.
- Informal is unpaid care.
  - Caregivers in one's family, such as a spouse or offspring, traditionally provide informal care.
- Insurance policies only pay for formal care; however, policies may provide informal caregivers with a training allowance.
- **Nursing Homes**
  - Nursing homes are primarily designed to provide skilled nursing care for persons with medical issues and a significant loss of functions.
  - Nursing home residents often need end-of-life care related to significant chronic conditions or recovery from an acute illness.
- **Assisted Living Facilities**
  - An **assisted living facility** is a residential community that provides more limited services than a nursing home.
  - Assisted living facilities offer intermittent nursing services such as help with managing medications.
  - They also provide personal services such as housekeeping, onsite meal facilities, and social activities.
- **Home Health Care**
  - **Home health care** is care provided in the insured's home.
  - It primarily includes skilled care, such as care delivered by visiting nurses, including assistance with medication, wound care, and the monitoring of chronic conditions.
  - Home health care also includes rehabilitative or physical therapy ordered by a doctor.
- **Home Care**
  - **Home care** is personal care.
  - Home health aides help clients perform the activities of daily living and activities such as transportation, meal preparation, and housework.

  - Such care may include **hands-on help** and **stand-by assistance**, both of which fall in the category of **substantial assistance**.
- **Adult Daycare**
  - **Adult daycare** is designed for seniors who live at home but whose family members cannot stay at home with them during the day.
  - Since the primary caregiver is absent or at work, families must make other provisions for the senior adult's care.
  - The level of care provided at adult daycare centers is similar to home health care.
- **Continuing Care Communities**
  - **Continuing care communities** allow elderly individuals to access progressively more intensive levels of care without leaving the community that has become their home.
  - Services range from independent living apartments to skilled care in a facility nursing home.
- **Respite Care**
  - **Respite care** provides the primary, informal caregivers with relief or time off (i.e., it gives the caregiver a break).
  - It may include an overnight stay by a respite caregiver in the disabled individual's home or a short-term admission to a facility.

Long-Term Care Insurance Contracts for Individuals

- **Long-term care insurance** was developed out of various policies designed to cover specific types of care.
- Today there are three types of contracts that provide LTCI—*life insurance riders, hybrid contracts,* and *stand-alone LTCI policies*.

Long-Term Care Insurance – NAIC Model Minimum Standards

- The NAIC authored the Long-Term Care Insurance (LTCI) Model Act, which specifies the minimum standards for LTCI.
- All 50 states have adopted the NAIC model entirely or in part.
- The NAIC model proposes the following standards:
  - Long-term care insurance provides benefits that pay for at least 12 months of ongoing care.
  - Long-term care insurance includes stand-alone policies, hybrid plans, and riders that pay benefits based on the loss of function or cognitive impairment.
  - The maximum pre-existing condition exclusion is six months, with a look-back period of six months.
- The NAIC model includes the following prohibitions:
  - Policies cannot require prior hospitalization.
  - Policies cannot supplement Medicare.
  - Policies cannot require the insured to qualify for coverage by having a particular medical condition or terminal diagnosis.
  - The policy owner must be provided with a free-look period.
  - Policies must be guaranteed renewable or better.
  - Policies cannot require a stay in a residential facility before receiving home care benefits.
  - A policy cannot pay more significant benefits for skilled care than it does for intermediate or custodial care (assumes all three in a facility).
  - Insurers cannot include an impairment rider for specific conditions.
  - Insurers must provide an outline of coverage to the consumer.
- Producers are principally responsible for determining suitability.
- The NAIC definition doesn't include life insurance contracts that pay accelerated death benefits as a lump sum.

Long-Term Care Riders in Life Insurance Contracts

- A person may add LTCI to life insurance as a living benefits rider.

Accelerated Death Benefit Riders

- An **accelerated death benefit rider** pays out a portion of the life insurance policy's death benefit upon the diagnosis of a terminal illness or other condition.
- Some riders pay a monthly benefit if the insured is confined to a nursing home with the expectation that the insured's condition will not improve.
- Insurers subtract any amounts paid as living benefits from the death proceeds paid to the beneficiary.
- The NAIC does NOT include these riders in its model definition of long-term care insurance.

Long-Term Care Riders

- Long-term care riders use part of a life insurance policy's face amount to pay a monthly benefit to pay the cost of long-term care services.
- Insureds qualify for benefits on the same basis as those covered by stand-alone long-term care insurance policies.

LTC Hybrid (Linked) Plans

- **Hybrid long-term care plans** combine annuity (or life insurance) benefits with a traditional long-term care policy.
- The insureds have long-term care benefits guaranteed, or if no care is needed, the other guaranteed contract benefits for themselves or their beneficiaries.
- Hybrid products are written using whole life insurance or annuities.
- Unlike simple life insurance riders, the potential long-term care benefit is greater than the underlying contract and must be underwritten.

Long-Term Care (Stand-Alone) Insurance Policy

- The accident and health insurance licensing exam focuses on the individual long-term care insurance policy.

Qualifying for Long-Term Care

- LTCI contracts have two distinct **benefit triggers**:
  - The loss of the physical ability to perform two or more of the six ADLs, or
  - The existence of cognitive impairment.

Loss of the Ability to Perform Two ADLs

- The six recognized ADLS are as follows:
  - Bathing
  - Dressing
  - Toileting
  - Transferring
  - Continence
  - Eating
- Policies will pay benefits when the insured cannot perform two or more of these tasks without substantial assistance, which the NAIC defines as either:
  - "Hands-on" (physical) assistance, or
  - "Stand-by assistance"

Cognitive Impairment

- The NAIC Model LTCI regulation defines a "**cognitive impairment**" as a deficiency in a person's:
  - Short or long-term memory
  - Orientation as to person, place, and time

  - Deductive or abstract reasoning, or
  - Judgment as it relates to safety awareness
- LTCI specifically covers conditions related to organic neurological disorders related to diseases of aging, strokes, and brain injuries.

Long-Term Care Insurance – Benefit Periods

- The LTCI benefit period is the length of time during which claims will be paid.
- Policies often require a diagnosis that a person's impairment is expected to last 90 days or more.
- LTCI policies define benefits as a maximum daily amount that's payable during the benefit period as stated in the contract.

"Pool of Money" Concept

- The "**pool of money**" **concept** indicates that the policy's total benefits are limited by the number of available dollars, not a limited number of days.

  For example, let's assume that an LTCI contract with a three-year benefit period pays a maximum of $100 per day for institutional care and $50 per day for home care.

  - The maximum daily benefit (for institutional care) is $100 per day.
  - 1,095 days x $100 per day = a $109,500 pool of money.
  - This calculation means that the policy will pay the maximum daily benefit for three years. If the insured only uses the policy to pay for home care, the policy will pay only $50 per day for six years ($109,500 = $50 x 2,190 days).

Daily Benefit Amounts

- LTCI includes a daily limit to benefits.
- A higher daily limit means a higher annual premium.
- Policies often set home care limits between 50% and 80% of the maximum benefit for nursing home care.
- LTCI contracts pay daily benefits in one of two ways—as a fixed daily indemnity or based on the actual costs incurred (reimbursement).

  For example, let's assume that an insured has a long-term care insurance policy with a stated daily benefit of $200 per day. The insured incurs covered costs of $150 during a single 24-hour period.

  - If the insured has a policy that pays a daily indemnity, the insured will receive $200.
  - If the insured has a policy that reimburses actual costs up to $200, the insured will receive $150.

Elimination Period

- LTCI policies generally include an **elimination period**.
- This period helps to restrain the cost of coverage for prospective policyholders.

Waiver of Premium

- The **waiver of premium** provision suspends premium payments while the insured is receiving benefits.
- Some LTC policies offer a lower premium by not including this feature and offering it as an optional rider instead.

Long-Term Care Insurance – Optional Provisions

Return of Premium Option

- The return of premium rider refunds the premiums paid by the policy owner under certain circumstances, such as when a policy lapses or the insured dies without using the policy's benefits.

Guarantee of Insurability Option (Rider)

- The **guaranteed insurability rider** is a form of inflation protection.
- This rider allows the insured to purchase additional coverage at future intervals based on an assumed rate of inflation.

Renewability Provisions

- All long-term care policies must be issued as at least guaranteed renewable.
- An insurance company may only cancel an LTCI policy because the policyholder fails to pay the premium.

Non-Forfeiture Options

- Non-forfeiture benefits allow the insured to receive some value from the plan if the policy lapses due to the non-payment of premium.
- This option is typically available in one of the following three different forms:
  - A reduced paid-up policy
  - Access to the same daily benefit for a shortened period
  - A specified dollar amount that's refunded to the insured

Automatic Inflation Rider (AIR)

- The **automatic inflation rider** annually increases the initial daily benefit of a long-term care insurance policy, typically at a rate of 5% compounded per year.

Policy Exclusions

- Exclusions that are found in a long-term care policy include war, treatment for drug or alcohol abuse, intentionally self-inflicted injury, attempted suicide, nervous disorders, mental illnesses, institutional care received outside the U.S., or losses covered by Workers' Compensation.

Application and Underwriting

Marketing Long-Term Care Coverage

- Insurers that market LTC insurance must establish marketing procedures to:
  - Ensure its agents make fair and adequate policy comparisons
  - Avoid selling excessive insurance; and
  - Advise buyers that the policy may not cover all long-term care costs.
- Insurers must waive any pre-existing condition limitations on replacement LTCI policies.

Disclosures

- Disclosures that are typically required at the time of sale include:
  - Outline of Coverage
  - LTCI Shopper's Guide
  - Personal Worksheet
  - Rating Practices
- To prevent an unintentional lapse, an applicant may designate a third party to receive any notice of a policy lapse or termination due to non-payment of premium.

Underwriting

- Generally, a person's eligibility to purchase LTCI coverage is similar to her ability to buy other types of health insurance plans, such as individual or group disability coverage.
- **Post-claims underwriting** is the act of approving all applicants and only underwriting a risk exposure when a claim is filed.
- The process results in an insurer denying claims based on the insured's health or for other reasons.
- This underwriting approach is a prohibited and unfair trade practice.

Pre-Existing Conditions

- Most long-term care policies define a pre-existing condition as one for which medical advice or treatment was recommended or received within the six months preceding the effective date.
- Long-term care policies may exclude losses due to a pre-existing condition for up to 6 months following the effective date of coverage.

Premium

- Long-term care policy premiums depend on several factors, such as age, health conditions, benefit periods, and level of care.

Association and Group Long-Term Care Insurance

Association (Affinity Group) LTCI

- A sponsoring association provides a marketing channel and addresses member questions.
- Associations must provide objective information regarding endorsed long-term care insurance policies or certificates.
- The association must disclose all of the compensation it receives from the endorsement or sale of insurance to its members.
- It must also disclose the process for selecting the insurance program.

Employer Group Insurance

- Employers often offer LTCI as a voluntary, employee-paid benefit.
- Policies often feature simplified underwriting and discounted premiums.
- Plans allow access to a more extended family group, including parents and siblings.
- Large employers may also offer LTCI as a true group benefit with a limited amount of guaranteed issue coverage for employees.

Tax Considerations

- Premiums that are paid on an individual long-term care policy are not tax-deductible.
- LTCI benefits are not taxable to the extent that they reimburse the insured for his expenses.
- When LTC insurance plans that pay benefits on an indemnity basis and pay the insured more than the insured spent, the insured could be taxed unless the insured's long-term care policy is a **tax-qualified long-term care contract**.
- Tax qualified plans must satisfy specific criteria, and they may be individual or group insurance contracts.
- Expenses that are paid for long-term care services, including premiums paid for qualified plans, are treated as any other medical expense. They're deductible in combination with other medical expenses to the extent that they exceed 7.5% of an individual's adjusted gross income.
- In addition, HIPAA exempts qualified policy benefits in excess of actual expenses from income tax up to a daily limit.

Qualified Long-Term Care Policies

- To be designated as tax-qualified, a long-term care insurance policy must meet the following criteria:
  - The policy cannot pay expenses that are reimbursable under Medicare.
  - The benefit trigger must be either the loss of a person's ability to perform two of the six ADLs or the existence of a severe cognitive impairment.
  - The policy is at least guaranteed renewable.
  - The policy doesn't include a cash surrender value.
  - The policy only provides long-term care services.
  - The policy has a 30-day fee-look period.
  - The policy requires all claims to be based on a medical diagnosis of disability lasting at least 90 days.
  - When an insured files a claim, the policy requires that a medical professional devise a written plan of care.

Medicare, Medicaid, and LTCI

- Medicare, Medicaid, and long-term care insurance address senior citizens' needs, but the role of each policy is distinct and not interchangeable. The following section offers a quick comparison of these three mechanisms.

Medicare

- Medicare is medical insurance in the traditional sense for individuals who are the age of 65 and older, along with certain individuals who suffer from a severe disability. It provides treatment to acute and chronic illnesses to cure acute conditions or treat chronic diseases so as to mitigate them.

Medicaid

- Medicaid is a means-tested, public program that was established to provide medical and supportive services to individuals who are at or below the poverty line. The funding comes from both the federal government and state budgets. Each state administers its own program.
- Medicaid services overlap with both Medicare and long-term insurance. Low-income individuals who are the age of 65 and older can qualify for both Medicare and Medicaid to cover their medical costs more fully. Senior citizens who lack assets can be eligible for **long-term services and supports (LTSS)** paid by Medicaid.
- Originally, Medicaid paid for LTSS delivered in nursing homes. However, given the increasing costs of such care, the federal government granted states the authority to devise alternative programs that deliver such services using alternative avenues, such as in-home care. Individuals can qualify for Medicaid funding for LTSS only when their countable assets (other than their residence and some other such property) are depleted. At times, more affluent individuals may attempt to qualify for Medicaid while sheltering assets from liquidation by transferring property to relatives. The states consider all asset transfers over the five years before any application for Medicaid benefits. If an insured transfers assets to family members, the medical assistance administrators will delay the insured's access to public funding for long-term services and support.

Long-Term Care Insurance

- Long-term care insurance (LTCI) policies are the private alternative to the public funding of long-term services and supports (LTSS). The government has recognized its value as the cost of LTSS continues to burden the government's capacity to fund it. To encourage individuals to purchase private policies, the government established the ability of each state to create a **long-term care partnership** program.

Long-Term Care Partnership Programs

- The Long-Term Care Partnership Program is a federally supported, state-operated initiative that allows individuals who purchase a qualified long-term care coverage to protect a portion of those assets they would otherwise need to spend before qualifying for Medicaid.
- Partnership policy requirements vary by state, but all must be tax-qualified and provide inflation protection. All policies must also meet consumer disclosure requirements.

NAIC MODEL UNIFORM HEALTH INSURANCE POLICY PROVISIONS

- The National Association of Insurance Commissioners (NAIC) developed a Uniform Individual Accident and Sickness Policy Provisions Law Model. In accordance with the NAIC Model, there are 23 uniform provisions for use in insurance contracts—**12 uniform mandatory provisions** and **11 uniform optional provisions.**
- Insurance companies may substitute their own language with approval from their various state regulators.
- Substitute language can be no less favorable to the insured. This uniform language requirement helps assure a consistent understanding of policy terms and provisions.

THE 12 REQUIRED (MANDATORY) UNIFORM PROVISIONS

The Entire Contract Clause

- In a health insurance policy, the entire contract clause defines the entire contract as the policy, the insured's application, and any papers that are attached to the policy document.
- Nothing outside of the contract (as described above) can be considered part of the contract.
- It assures the policy owner that no changes will be made without the policy holder's written consent.

[EXAM TIP: Remember WYSIWYG. "What you see is what you get!"]

Time Limit on Certain Defenses (Incontestability)

- The **time limit on certain defenses** provision declares the policy to be incontestable after it has been in force for three years.
- Fraud on a health insurance application is always grounds for termination unless the policy is guaranteed renewable or non-cancellable.
- A number of states reduced the time limit on certain defenses to two years.

[EXAM TIP: Assume a time limit of three years unless the test references state law or integrates law and general questions. In other cases, check the law, and assume three years if no specific reference is given.]

Grace Period

- Insurers must include a **grace period** following the premium due date, during which time the insured may make the delayed premium payment without penalty or loss of coverage. The specified minimum grace periods are:
  - Seven days for policies with weekly premium payments (i.e., industrial policies)
  - 10 days for policies with premiums payable monthly, and
  - 31 days for other policies

Reinstatement

- The **reinstatement provision** restricts reinstatement payments to premiums that are due within the previous 60 days.
- Reinstatement is automatic if the insurer accepts the delinquent premium and doesn't require an application.

- If the insurer requires an application, the insurer must respond to the application within 45 days, or the policy is automatically reinstated.
- Reinstated policies cover accidents immediately and impose a 10-day probationary period on losses due to sickness.

Notice of Claim

- The **notice of claim** provision describes the policy owner's obligation to notify the insurer of loss within a reasonable period—20 days after the occurrence or as soon as reasonably possible after that.
- For long-term disability claims, an insurer may request notice of claim every six months to ensure a continuing disability.

[EXAM TIP: Assume 20 days unless the exam specifies a disability claim.]

Claim Forms

- The company must supply a **claim form** within 15 days after receiving notice of claim or accept information in any format that the insured provides.

Proof of Loss

- An insured claimant must provide **proof of loss** with 90 days of the occurrence.
- If the insured is legally incapable of doing so, she can provide proof within one year.

Time of Payment of Claims

- The **time of payment of claims** provision provides for:
  - Immediate claim payment after notification and proof of loss
  - At least monthly payments for disability income claims

[EXAM TIP: If an exam references the required frequency of disability payments, it may describe the minimum requirements as "no less frequently than monthly." An accurate reading is essential.]

Payment of Claims

- The **payment of claims** provision states that health insurance benefits must be payable to the insured.

Physical Exam and Autopsy

- The **physical exam and autopsy** provision gives the insurer the right to require a physical examination or autopsy of an insured, at its own expense, before paying a claim.
- This physical exam or autopsy is allowed unless it's forbidden by state law.

Legal Actions

- The **legal actions** provision states that neither the policy owner nor the insured can sue an insurer regarding a claim until 60 days after the insured provided proof of loss.
- The NAIC Model language also states that any such lawsuit must begin within three years after proof of loss was given.

[EXAM TIP: Assume three years unless your state-law information specifies another time frame.]

Change of Beneficiary

- The change of **beneficiary provision** states that the insured—as a policy owner—may change the beneficiary designation at any time if the beneficiary is revocable.
- However, an irrevocable beneficiary cannot be changed without that beneficiary's written consent.

THE 11 OPTIONAL UNIFORM HEALTH INSURANCE PROVISIONS

- Although there have been modifications over the years, the original NAIC Model Act established the following *optional* provisions.

Change of Occupation

- The **change of occupation** provision addresses the situations in which an insured changes occupations without notifying the insurance company.
  - If the new job has a higher degree of risk, the insurer will decrease the BENEFIT.
  - If the new job has a lower degree of risk, the insurer will decrease the PREMIUM.

Misstatement of Age

- If an insured misstates her age, the **misstatement of age** provision allows the insurance company to adjust benefits accordingly to reflect the insured's correct age.

Other Insurance with This Insurer

- The **other insurance with this insurer** provision states that if the insured is already covered by more than one policy with the same insurer, only the maximum benefit from one policy is payable.
- The insurer terminates the other policy and refunds the premium.

Insurance with Other Insurer (Reimbursement Policy)

- If the policy owner has duplicate coverage with another insurer on "an expense incurred (reimbursement) basis," the **insurance with other insurers** provisions states the insurers share responsibility for paying any claim.
- The benefit payable is limited to the total loss.

Insurance with Other Insurers

- This form of the **insurance with other insurers** provision applies to benefits that are provided on an "other than expense incurred basis," such as disability insurance.
- This provision allows an insurer to pay benefits to the insured on a pro-rata basis when the insurer was not notified prior to the claim that the insured has other health coverage.

Relation of Earnings to Insurance (Average Earnings) Clause

- The **relation of earnings to insurance** provision prevents over-insurance in disability income policies.
- It states that the maximum benefit paid by all insurers combined cannot exceed the amount of income lost.
- Applicable policies pay on a pro-rata or proportionate basis.

Unpaid Premiums

- The **unpaid premiums** provision states that the insurer may deduct any unpaid or owed premium from the benefits that are payable by the policy.

Cancellation

- The **cancellation** provision is prohibited in most states, and it's not in the current version of the NAIC Model Act.
- It stated that the insurer could terminate or cancel the contract at any time with five days' written notice to the insured.

Conformity with State Statutes

- The **conformity with state statutes** clause "modifies the policy to comply or conform with minimum state requirements."

Illegal Occupation

- This clause allows insurers to deny claims if an insured is injured while committing an illegal act or engaging in a felonious occupation.
- If an insurer discovers the illegal occupation after paying the claim, the company will attempt to recover the payment.

Intoxicants and Narcotics

- This clause relieves the insurance carrier of liability for losses while the insured was under the influence of non-prescribed drugs or alcohol when the loss occurred.

ADDITIONAL NECESSARY POLICY PROVISIONS

- These provisions are necessary, but the language is not regulated, and the uniform provisions law doesn't mandate their placement.

FREE-LOOK (RIGHT TO EXAMINE CLAUSE)

- The most common provision provides the insured with 10 days to examine the policy from the policy's delivery date.
- If the insured decides to return the policy during the free-look period, the insured will receive a full premium refund.

INSURING CLAUSE

- The **insuring clause** is the part of the health insurance policy that primarily states:
  - The benefits provided and
  - The circumstances under which they're payable
- The clause defines the insurance company's promise to pay benefits.

CONSIDERATION CLAUSE

- The consideration clause defines the insured's consideration.
- The policy owner's consideration consists of the following two elements:
  - The premium paid, and
  - The statements (legal representations) that are made on the health insurance application

WAIVER OF PREMIUM

- The **waiver of premium** provision waives the payment of premiums after the insured has been totally disabled for the specified period (as stipulated in the policy).

MILITARY SUSPENSE PROVISION

- This provision temporarily suspends coverage for an insured who's called up to activity duty, but coverage resumes when the period of service ends.

RENEWABILITY PROVISIONS

- Health insurance policies have one of the various renewability clauses that define the circumstances under which an insurer may change or terminate an existing contract.
- The insured can cancel the policy at any time.

NON-CANCELLABLE POLICIES

- A **non-cancellable** policy is one that cannot be canceled as long as the policy owner pays the premium.
- Some contracts refer to this type of policy as "**non-cancellable and guaranteed renewable**."
- The insurer can neither modify the policy's terms nor increase the premium.
- This type of renewal provision is the most advantageous renewal provision for a policy holder but is also the most expensive.

GUARANTEED RENEWABLE POLICIES

- Insurers cannot terminate a **guaranteed renewable** policy as long as the premium is paid.
- The insurer cannot change policy benefits, conditions, or terms in any way.
- The insurer is allowed to increase premiums on a class basis (not on a specific policy) in response to a general change in the class's aggregate risk level.

  For example, a disability income insurer can raise premiums on all policies that are issued to nurses and other gray collar professionals in response to an increase in back injuries and the rise of new infectious diseases. It cannot increase the premiums paid by a specific nurse because of chronic back problems.

CONDITIONALLY RENEWABLE POLICIES

- An insurer may decide not to renew a **conditionally renewable** policy under certain conditions that are stated in the policy.
- These conditions are typically related to the insured reaching a certain age or losing gainful employment.
- The stated reasons that allow an insurer to terminate coverage are based on general conditions, not individual insurability.
- Carriers can also increase policy premiums at renewal on a class basis only.

OPTIONALLY RENEWABLE POLICIES (RENEWABLE AT COMPANY'S OPTION)

- The **optionally renewal** policy offers no guarantee of continuance beyond the end of the current policy renewal period.
- The insurer also has the option to increase the premiums for any policy class (not an individual policy).

NON-RENEWABLE POLICIES

- Non-renewable policies are typically used to meet short-term health insurance needs.
- These policies remain in force for one year or less.
- Policy holders use them to bridge anticipated coverage gaps.

PERIOD OF TIME

- These policies, such as "short-term major medical" plans—also referred to as term policies—are only renewable for a stipulated term (e.g., six months) or period.

CANCELLABLE POLICIES

- Either the insured or insurer may cancel coverage.
- The renewability provision allows the insurer to cancel this type of policy with a five-day written notice and the return of any unearned premiums.
- An insurer may cancel an individual policy if the insured files too many claims in a policy period.
- Most states don't allow the issuance of cancellable health insurance policies.

POLICY EXCLUSIONS, LIMITS, AND RESTRICTIONS

- Health insurance policies frequently cite a number of exclusions or conditions that are not covered, such as:
  - Injuries due to war or an act of war
  - Injuries sustained while serving in the armed services
  - Self-inflicted injuries, including suicide
  - Injuries while the insured is piloting an aircraft or serving as a crew member
  - Non-commercial air travel
  - Foreign travel, especially extended stays overseas or foreign residence
  - Losses resulting from riots, or the use of drugs or narcotics
  - Injuries sustained while attempting or committing a felony
  - Losses covered by Workers' Compensation
  - Care paid by the Veterans Administration (VA)
  - Cosmetic surgery, experimental surgery, and vision correction

PROBATIONARY PERIOD

- The **probationary period** is a one-time 30-day event that becomes effective when the policy is issued.
- It excludes losses due to illness during the first days of a new policy, asserting the infection occurred before coverage began, even if symptoms did not appear until after coverage began.
- Coverage for accidents is not excluded.

PRE-EXISTING CONDITION PROVISIONS

- The **preexisting condition provision** states that a health insurance policy will not cover any health condition that existed during the period immediately before the policy became effective. Most often, this provision applies to conditions that are not disclosed in an insurance application.
- This provision is essential for group insurance or other contracts with simplified underwriting or none at all.
- This provision helps to protect an insurer regardless of whether an applicant knows he's ill.
- This provision doesn't typically apply to disclosed preexisting conditions. (See "impairment rider" below.)

IMPAIRMENT (WAIVER FOR IMPAIRMENT) RIDER

- An **impairment rider** is also referred to as an exclusion rider, coverage waiver, or a waiver of disability.
- **Impairment riders** allow an insurer to restrict coverage for an illness or injury that's disclosed on an application for the life of the contract.
- Since the rider allows the insurer to exclude a significant source of greater than average risk, the insurance carrier can often provide coverage at the standard premium.
- If an impairment rider is attached to a policy, its restrictions or limitations must be explained to the policy owner at the time of delivery. Generally, the policy owner must sign a statement that he's aware of and understands the effects and limitations of this type of rider.

ADDITIONAL HEALTH INSURANCE POLICY PROVISIONS

OWNER'S RIGHTS PROVISION

- This provision states that the policy holder is entitled to all of the ownership rights under the health insurance contract.

ASSIGNMENT PROVISION

- Unlike life insurance, policy owners don't have an unlimited ability to transfer their rights because health insurance is a personal contract.
- They can assign certain benefits to providers for direct payment of expenses.

BENEFICIARY PROVISION

- When health insurance includes a death benefit, the Required Uniform Mandatory Provisions include a "change of beneficiary" provision.
- This provision may require detailed information that's most commonly associated with life insurance.

Beneficiary Types

- Insurance gives the insured the ability to deliver benefits directly to named individuals, groups, or institutions without going through the probate process.
- If no beneficiary is named, any death benefit is included in the insured's estate.
  - **Individual beneficiaries:** In this case, the insured names one or more specific individuals to receive a death benefit.
  - **Beneficiary Class:** A beneficiary class or class designation defines beneficiaries by describing them rather than naming them.

Order of Succession

- **Primary beneficiaries:** These beneficiaries receive all of the benefits at the insured's death.
- **Secondary (contingent) beneficiaries:** These beneficiaries only receive benefits if all of the primary beneficiaries have predeceased the insured. They're second in line.
- **Tertiary beneficiaries:** These beneficiaries only receive benefits if both the primary and secondary beneficiaries all die before the insured.
- When there are no named beneficiaries left, the death benefit goes to the insured's estate

MODES OF PREMIUM PAYMENT PROVISION

- The provision governing the **premium mode** allows the policy holder to select the frequency of their policy premiums, such as:
  - Monthly
  - Quarterly
  - Semiannually, or
  - Annually
- The annual mode is the least expensive mode of premium, while the monthly premium is the most costly.
- A "single-premium" is not an option for health insurance policies.

REDUCTIONS IN COVERAGE

- The **reductions in coverage** provision states that health insurance policies don't reduce coverage amounts following a loss.

BENEFIT PAYMENT PROVISION

- The **benefit payment provision** states how benefits will be paid.
- The benefit payment provision will differ depending on the policy involved.

NO LOSS / NO GAIN PROVISION

- This provision states that the purpose of insurance is primarily to "indemnify" a person for a loss.

RESTORATION OF BENEFITS PROVISION

- The **restoration of benefits provision** states that the amount paid out for a loss doesn't reduce the total available benefits for future claims. Some policies include this provision automatically, while others offer it as an optional rider. Some policies condition the restoration with a requirement to be claim-free for a specific period following a covered loss.

COORDINATION OF BENEFITS

- The coordination of benefits provision is found in group insurance, but it also applies to social insurance programs (e.g., Medicare).
- The provision limits the total amount of payments from all insurers that cover the claim to no more than the total cost of care (e.g., avoids duplication of benefits).
- The COB provision also establishes which plan is primary and must pay all of the benefits specified by the contract. Once the primary insurance plan pays benefits as if it were the only available coverage, the secondary provider is liable for the remaining costs.
- Employer-sponsored group insurance is the primary coverage for workers who are the age of 65 or older if the employer is a "COBRA group" of 20 or more employees.
- If a group has fewer than 20 employees, Medicare is the primary insurer.
- Medicare is always the primary coverage for any person with an individual policy or group retiree medical insurance.

THE PURPOSE AND CHARACTERISTICS OF UNDERWRITING INSURANCE

- The underwriting process determines an insurer's ability to insure a loss exposure by reviewing and evaluating an applicant's information and applying the carrier's guidelines for insurability.
- Once underwriters determine whether a loss exposure is insurable, they determine the required premium rate.

Risk Factors in Health Insurance

- The risk factors for life and health insurance are similar, but health insurers deal with a broader range of risks.

Insurable Interest

- Insurable interest is a prerequisite for issuing a health policy.
- It exists if the applicant will suffer a loss in the event the insured incurs medical expenses or becomes disabled.

Physical Condition and Health History

- An applicant's physical condition, which refers to his health and body build, is of primary importance when evaluating health risks.
- Typically, an insurer is just as concerned with an applicant's health history as it is with his current health. An applicant's medical history can help predict future healthcare needs, as can his family's health history.

Moral Hazards

- Applicants' habits or lifestyles also indicate the potential of additional risks for the insurer. These factors are referred to as moral hazards. Examples include excessive drinking or drug use. Other signs of moral hazard can be a low credit rating or dishonest business practices.

Occupation and Hobbies

- There's a direct correlation between a person's job and the probability and severity of a disabling injury occurring.
- If an applicant has two jobs, the insurance company will base the benefits and the premiums on the more hazardous one.
- An applicant's hobbies and personal activities can also affect whether a carrier covers a proposed insured. Activities such as mountain climbing or having a license to pilot small planes can affect insurability or, at best, increase the cost of coverage.
- Hobbies are also referred to as avocations.

Age and Sex

- An insured's age and sex (gender) are underwriting factors.
  - Generally, older applicants are more significant risks.
  - Women have higher rates of disability at younger ages, but insurers CANNOT reject prospective insureds based on gender.

Classification of Risk Exposures (Applicants)

- Once underwriters review an applicant's information, they will determine that applicant's level of risk or **risk classification.**
- There are three classifications of those that are insurable. Individuals who are not insurable are classified as declined.

Preferred Risk

- A preferred risk exceeds an insurer's risk requirements.
- Companies issue preferred risk policies with reduced premiums with the expectation of better (lower) than average morbidity experience.

Standard Risk

- Individuals who are assigned a standard risk classification meet the same conditions as the tabular risks on which the insurer's premium rates are based.
- A standard risk is an average risk.

Substandard (Rated) Risk

- A substandard risk is an individual who fails to meet the insurer's standard or average risk guidelines.
- Insuring the substandard application involves taking on a greater-than-average risk of loss.
- The terms "rated policy" and "rated premium" refer to a substandard policy with a higher-than-average (rated-up) premium.

PREMIUM CALCULATIONS

General Insurance Premium Concepts

Premium

- Premium is the initial payment and subsequent periodic payments required to keep a policy in force.

Premium Mode

- The mode refers to the frequency of premium payments.
- Premiums can be paid quarterly, semiannually, or monthly.
- The higher the frequency of payments, the more the policy will cost the insured in total.

Earned Premium

- Earned premium is a pro-rated amount of a paid premium that an insurer has "earned" by providing coverage.

Unearned Premium

- Unearned premium represents the portion of paid premiums that has yet to be "earned" because it's allocated to cover the remaining portion of the policy term.

Policy Term

- This is the period during which a policy remains in existence when a premium is paid.

Policy Fee

- The policy fee is a small transaction fee that's charged by some insurers for the first or subsequent years of an insurance policy, in addition to the regular premium.

Primary Health Insurance Premium Factors

- Health insurance premiums = morbidity - interest + expenses

Morbidity

- Morbidity Tables show the average number of persons within a specific group that can be expected to become disabled within a given year at a given age.

Interest

- Insurance companies invest the premiums they receive, and the interest they earn is one way they can lower premium rates.

Expenses

- The expense factor is also referred to as the **loading charge** or **factor**.
- The expense factor is derived from operating expenses.
- Expenses include commissions, other wages, profits, and the regulatory requirement to set aside **reserves** for future claims.

Secondary Factors That Influence Premiums

Benefits

- The greater the benefits, the higher the premium.

Elements That Influence Morbidity Calculations

Claims Experience

- To set realistic premium rates, underwriters estimate future claims based on past claims experience.
- When determining the appropriate coverage, the insurer's underwriters will use the group's experience rating.

Age and Sex of the Insured

- Health insurance claims costs tend to increase as the age of the insured increases.
- An insured's sex will influence premiums as well.

Occupation and Hobbies

- An insured's occupation will impact rates since more hazardous occupations carry more risk.

Community Ratings

- Smaller group health plans use a community rating method, which applies the identical premium rate structure for all subscribers in a community.
- Insurers base premiums on their overall claims experience and healthcare costs in a geographical area.

PARTIES INVOLVED IN UNDERWRITING

The Producer (Agent)

- Producers perform **field underwriting.** This is the initial step in the underwriting process, in which they gather necessary underwriting information and distribute required disclosures to the buyer.
- A **field underwriter (producer)** solicits appointments, completes, and submits applications, and collects premiums.
- The producer does NOT issue the policy.

Agent Responsibility

- Agents have a fiduciary responsibility to consumers during insurance transactions.
- Agents act in a fiduciary capacity for the insurers when collecting premiums.
- Agents complete the following essential tasks:
  - Engaging in proper solicitation
  - Completing the application properly
  - Obtaining appropriate signatures
  - Collecting the initial premium, and
  - Issuing the correct premium receipt

Proper Solicitation

- Agents have a duty to solicit profitable applications.
- Agents are responsible for following the highest professional standard when working with consumers.
- Agents must obtain authorization forms to gather third-party investigative reports.
- Where required, agents must obtain signed forms to verify that applicants received necessary disclosures.

Unfair Discrimination

- No insurer may engage in unfair discrimination based on any protected category such as sexual orientation, religious preference, or geographical location.

The Applicant

- The applicant is the person who's requesting the insurance.
- Typically, the applicant is also the proposed insured.

The Proposed Insured

- The proposed insured is the person who's obtaining the insurance.
- The policy holder retains all of the rights and options that are conferred by the policy. The policy holder is also typically the payor.

The Underwriter

- An underwriter reviews insurance applications, classifies the degree of risk, and determines insurability and premium rate.

THE UNDERWRITING (APPLICATION) PROCESS

- The most common underwriting information sources include the following:
  - The application
  - The medical report
  - An attending physician's statement
  - The Medical Information Bureau
  - Special questionnaires
  - Inspection reports, and
  - Credit reports
- For some smaller policies, insurance carriers use a ***non-medical*** application that requires no additional information other than the application.

The Application

- The principal source of underwriting information is the application.
- It's the agent's responsibility to ensure that an applicant's answers are both thorough and accurately recorded.
- There are three essential parts to a typical health insurance application:
  - Part I: General Applicant Information
  - Part II: Medical and Health History, and
  - Part III: The Agent's Report or Statement

Part I – General Applicant Information

- Part I of the application asks general questions about the proposed insured.
- Part I also describes details about the requested coverage, including policy type, benefit amount, beneficiary name(s), existing insurance, and any other needed information.
- It also inquires as to whether the proposed insured uses tobacco.

Part II – Medical and Health History

- Part II asks about the proposed insured's health and health history, as well as the health history of the proposed insured's family.
- The insurer may require a medical exam.
- The prospective insured may be required to provide a blood test or urine specimen.
- Any exams and lab work are done at the insurer's expense.

Part III – The Agent's Report (or Statement)

- Part III is referred to as the agent's report or agent's statement.
- The agent's report includes personal observations about the proposed insured.
- The agent can provide additional information about the applicant's financial condition and character.
- If a new policy replaces an existing one, states require agents to follow specific procedures to protect consumer rights.

Completing the Application

- If an agent fails to ensure that an application is completed fully and accurately, several consequences may follow:
  - Several delays will follow
  - The applicant may also decide to do business elsewhere
  - The insurance company will return the application to the agent if it's incomplete.
- Applicant answers to application questions are considered **representations**.
- Representations are statements that are made with the belief that they're substantially true to the best of the applicant's knowledge.
- Misrepresentations are considered fraudulent only when they're material to the risk and made with fraudulent intent.

Application Signatures

- All insurers require the producer to sign the application. If not, it will not be underwritten.
- Each application also requires the signatures of the proposed adult insured and the policy owner (if different from the insured).
- Where required by state law, the agent also must sign a form attesting that a disclosure statement has been given to the applicant.

- Additionally, a form that authorizes the insurance company to obtain investigative consumer reports or medical information from investigative agencies, physicians, hospitals, or other sources generally must be signed by the proposed insured with the agent as a witness.

Minor Applicants and Proposed Insureds

- In most states, any person who's under the age of 18 is considered a minor. This age is also referred to as the age of majority.
- Companies require the signature of a parent or guardian if the proposed insured is under the age of 18.

Changes To the Application

- If applicants make mistakes when completing applications, they can have their agent correct the information, but they must initial the correction.
- When attached to the insurance policy, the application becomes a part of a legal contract.

Additional Laws, Disclosures, and Sources of Underwriting Information

- Insurers must obtain the applicant's permission to legally receive necessary additional information from third-party sources.

The Medical Report

- For policies that provide substantial benefits, a medical report may be needed to provide further underwriting information.
- Medical reports may come from the insured's physician, or an examination done during the application process.

Attending Physician's Statement

- Underwriters may request an attending physician's statement (APS) from the applicant's physician if the application's medical section raises questions about a particular medical condition.
- The statement will provide details about the medical condition in question.
- The completed report is forwarded to the insurer, where its medical staff reviews the information.

The Medical Information Bureau (MIB Group)

- The Medical Information Bureau (MIB) is another source of information about an applicant's medical history.
- The MIB is a clearinghouse of health information that's supplied by insurers from previous applications.
- The MIB helps to detect any undisclosed adverse health conditions.
- The MIB report will identify insurance in force with other carriers and will disclose lifestyle habits (e.g., drug use).
- The MIB's purpose is to help expose fraud cases and unintentional acts of misrepresentation or concealment.
- An MIB report by itself cannot be the basis for declining an application; instead, it's the basis for initiating an investigation.
- The MIB may release information to the proposed insured's physician.

Privacy Notice

- According to the HIPAA statute's privacy rule, when an agent submits an application that contains personally identifiable health information, the agent is responsible for providing the applicant with privacy notices.
- Producers must also secure HIV consent forms to conduct applicant blood tests, despite the fact that they may be part of the standard underwriting process.

USA PATRIOT Act

- The USA PATRIOT Act requires insurance companies to establish formal anti-money laundering programs.

Special Questionnaires

- Special questionnaires gather more detailed information about a non-medical aspect of the applicant's life, such as avocations (e.g., mountain climbing).

Inspection Reports

- **Inspection reports** provide a picture of an applicant's general character and reputation, mode of living, finances, and any exposure to abnormal hazards.
- Investigators or inspectors may interview employees, neighbors, and associates of the applicant, as well as the applicant himself.
- It may also include a credit report.

Credit Reports

- Since some applicants may be poor credit risks, credit reports from the credit bureaus are a valuable underwriting tool.
- Applicants with questionable credit ratings can cause an insurance company to lose money by allowing their policies to lapse shortly after they're issued.

The Fair Credit Reporting Act (FCRA) of 1970

- The FCRA protects the rights of consumers for whom a credit report is requested.
- The FCRA established procedures for collecting and disseminating consumer credit information.
- Let's assume that an insurer declines a consumer due to poor credit. In this case, the FCRA requires the insurer to notify the applicant that a copy of the credit report is available through the appropriate credit bureau.

Information and Privacy Protection Act

- According to the Information and Privacy Protection Act, insurers must conform to state and federal laws regarding the dissemination of a consumer's private information.

The Initial Premium and Premium Receipts

- The nature of a receipt is that it denotes the payment of funds for goods or services. In this case, it denotes the good faith payment of an initial premium in return for the company's promise to pay. Premium receipts are important because they can establish a person's protection under the terms of a policy before the insurer issues the contract.

Premiums Paid with the Application

- The proposed insured benefits from paying the initial premium with the application. Insurance protection becomes effective immediately; however, it comes with significant limitations.
- If the first premium is not paid with the application, the policy will not become effective until the initial premium is collected.
- An application without a premium is referred to as a trial application.
- When an agent collects a premium with an application, the agent must give the applicant a premium receipt.
- The type of receipt determines when coverage is effective.

Premium Receipts

- Applicants who pay a premium with the application are entitled to a premium receipt.
- Two types of receipts exist—*conditional receipts* and *binding receipts*.
- The date on a receipt is always earlier than the policy's issue date.
- Today, the most common type of premium receipt is a conditional receipt.

Conditional Receipts

- Conditional receipts generally provide coverage as of the date of the receipt as long as a specific condition is satisfied.
- Coverage is provided if the proposed insured demonstrates insurability.
- Insurability may be accomplished simply by submitting the application and supporting documentation, or it may require a medical exam.
- Coverage is effective on the condition that the applicant proves to be insurable, either on the date on which the application was signed or the date of the medical exam.
- If the applicant proves to be uninsurable, no coverage takes effect, and the premium is refunded.

Insurability Type Conditional Receipt

- Coverage is effective if the proposed insured is found to be insurable as applied for (i.e., standard or better).
- Coverage is effective as of the application date or the date of any required medical exam, whichever is later.
- Policy delivery is not necessary for coverage to be in effect.

[EXAM TIP: If the test refers to a conditional receipt with no further qualification, assume it's an "insurability type conditional receipt."]

Approval Type Conditional Receipt

- Approval type conditional receipts provide coverage only after the insurer has approved the application.
- Approval type conditional receipts only provide coverage between the issue date and the delivery date.

Binding Receipts

- Binding receipts are often referred to as temporary insurance agreements.
- Binding receipt guarantees coverage unless the insurer formally rejects the application.
- Even if uninsurable, the applicant is covered until the application is rejected.
- A binding receipt typically stipulates the maximum amount that's payable under the terms of the receipt.
- Binding receipts are far more common for auto or homeowner's insurance than life or health insurance.

Temporary Insurance Agreement

- A "temporary insurance agreement" is similar to a binding receipt.
- In some jurisdictions, they're used interchangeably.
- In contrast to a binding receipt, this agreement can offer a level of additional protection.

Offer and Counter-Offer

- If an applicant completes an application and pays the first full premium, the applicant has made a legal offer.
- If the insurer issues a policy as requested, it has accepted the applicant's offer and a contract is in force.

If the insurer declines the application, it has rejected the offer.

- If the insurance company is willing to issue a "rated" policy at a higher than requested premium, the carrier has rejected the applicant's initial offer but is making a counter-offer.
- The applicant can accept the counter-offer by paying the additional premium and providing a statement of continued good health.

POLICY ISSUE AND DELIVERY

- ~~Once issued, the policy is sent to the agent for delivery to the applicant.~~
- In most states, an agent is required to deliver an outline of coverage to the applicant.
- In some cases (e.g., when selling long-term care insurance), agents must also deliver a Shopper's Guide or Buyer's Guide (generally before the agent accepts the applicant's initial premium).
- The outline of coverage describes (in simplified language) the key elements of the specific policy being delivered.

Policy Effective Date

- Determining a policy's effective date is important because it identifies when the coverage begins and establishes the due date for future annual premiums.
- If a premium receipt were issued, the receipt's date would generally become the policy's effective date.
- If the applicant doesn't pay an initial premium with the application, the insurance company will determine the policy's effective date, which will generally be the issue date. (Coverage will not truly be in force until it's delivered, the first premium is paid, and a Statement of Good Health is obtained.)

Constructive Delivery

- **Constructive delivery** means that an insurance carrier can legally deliver a policy without physically delivering the contract into the policy owner's possession.
- Constructive delivery occurs if the insurer intentionally relinquishes all control over the policy and turns it over to a person who's acting for the policy owner, including the company's own agent.
- Mailing the policy to the agent for unconditional delivery to the policy owner also constitutes constructive delivery.
- If the company requires a delivery receipt or statement of continued good health, there's no constructive delivery.
- Possession of a policy by the client doesn't establish delivery if all conditions have not been met.

Inspection Receipt

- Some proposed insureds may want to review a policy before purchasing it.
- In this situation, the policy owner will sign an inspection receipt rather than a statement of continued good health and will not pay a premium.
- The prospective insured will examine the policy and then pay the first full premium.
- The free-look period makes this receipt obsolete.

Explaining the Policy and Ratings to Clients

- Most applicants will not remember all of the essential elements of their policies; therefore, agents should deliver them in person.
- By personally explaining the policy, the agent can avert misunderstandings, policy returns, and potential lapses.

- When the policy is a “rated” or substandard contract, the agent can discuss the reasons for it being so, including the insured’s increased need for protection.

Obtaining a Statement of Insured's Good Health

- If the initial premium is not paid until delivery, the agent must collect the premium and obtain from the insured a signed statement attesting to the insured’s continued good health.
- Because there can be no contract until the premium is paid, the company has a right to know that the policy holder has remained in reasonably good health from the time the policy holder signed the application until receiving the policy.

Delivery (Policy) Receipt

- When a producer delivers a policy to an insured, the insurance company often wants a delivery receipt as proof of delivery.
- The delivery receipt is important because it designates the start of the policy’s free-look period.