NEW INDUSTRY TRENDS IN HEALTH INSURANCE

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New Industry Trends in Health Insurance

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This course will address the following topics:

- A Market in Need
- Comparing Personal Disability Income Policies
- Recurrent Disability
- Cost of Living Adjustment Option
- Business Overhead Expense Policy
- Understanding Long-Term Care
- Medicare
- Understanding Major Medical
- HMO's ~ Health Maintenance Organizations

This course includes:

• Nine Chapters
• 1 Online Final Exam

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TRENDS IN LONG-TERM DISABILITY INSURANCE

Long-Term Disability Insurance ~ I

A Market in Need

Some believe that long-term care is a looming crisis for our country. It is not just an issue for older people**. It is EVERYBODY's issue.**

It can be a mistake to view long-term disability as only an issue for older people.

- **Long-term care needs can be financially devastating at any age.**
- One in five persons has some kind of disability and one in ten has a severe disability.
- Millions people of all ages have disabilities so severe that they require personal assistants to carry out daily activities.
- Close to half of those who require long-term care today are between the ages of 18 and 65.
- When a family member becomes ill or disabled, the responsibility to provide help, or seek help from others falls on one or more family members.
- Care giving can force employees to take time off, pass up promotions, retire early or even quit their jobs.

The long-term disability income market **encompasses virtually all wage-earners**. Here are some statistics on disability that you can use to better **understand the need:**

- People with disabilities are the largest single minority group in the nation.
- Disability is experienced by almost everyone, particularly as they age.
- 29.2% of families have at least one disabled member. Disability affects nearly all families at one time or another.
- Only 1/5 (21%) acquire their disability before age 20; more than ½ (53%) have onset after age 40.
- Disability is largely a social phenomenon **that should be addressed by the entire community** – with a focus on enabling people to live independent lives.
- At age 42, a person is four times more likely to be seriously disabled than he is to die during his working years.
- A 25 year old has 58% probability of becoming disabled for 90 days or longer at some point in their working years.
- Between the ages of 35 and 65, a person has a 50-50 chance of being able to work for more than three months.
- During the course of a person's career, he is **3.5 times more likely to be injured and need disability coverage than he is to die and need life insurance.**

The Risk of Disability

Most people associate disability with accidents or workplace injuries. But the reality is:

Disability is more common than one may think**. It can happen to anyone.**

- ∇ **Long-term disabilities are primarily caused by illnesses** such as cancer, heart disease and diabetes. According to the Centers for Disease Control and Prevention, these diseases cause major limitations in daily living for more than 25 million Americans.
- ∇ Arthritis and back pain are also main causes of disabilities.
- ∇ **Personal behavior and lifestyle choices that lead to problems like obesity are rapidly growing factors in causing long-term disabilities**. About a quarter of all adults in the U.S. are obese, according to the Centers for Disease Control and Prevention.

Conditions Causing Disability

- ∇ **Brain injury is a serious problem in our country.** The American Academy of Neurology reports that as many as 1.5 million people have brain injuries in the United States, and it is **a major cause of death and disability for children and**

adults. More children die of brain injury each year than of any other cause. Most brain injuries are accidental, and most occur as the result of a car accident. Unfortunately, brain injuries resulting from ATV and motorcycle accidents (with and without protective gear) are on the rise.

∇ **Many students who sustain brain injuries have resulting learning disabilities**. The type and severity of the disability depends on the seriousness of the injury and the part of the brain affected. If the student had a learning disability before the brain injury, it is possible that learning disability may worsen.

∇ **Low vision is a visual impairment that is occasionally seen on social security disability and SSI disability applications.** Unfortunately, it is also another one of those impairments that most disability examiners might have difficulty defining. Low vision, also called partial sight or limited sight, is an impaired level of visual functioning that cannot be completely corrected by the application of conventional glasses, contacts, or surgery. Low vision can result from glaucoma and macular degeneration which affects nearly two million Americans who are older than the age of 40 (macular degeneration is the leading cause of blindness for those over 65).

∇ **Approximately 700,000 Americans have disabilities of the spinal cord**. These disabilities include traumatic spinal cord injury, multiple sclerosis, spina bifida, poliomyelitis, amyotrophic lateral sclerosis (Lou Gehrig's disease), and syringomyelia, among others. United Spinal Association's membership is open to all these individuals, regardless of their ages.

- Every 41 minutes a person in the United States sustains a spinal cord injury; there are about 11,000 new cases of spinal cord injury reported in the United States each year.
- The total number of people with spinal cord injuries in the United States is estimated to be 222,000 to 285,000.
- In the first year after a spinal cord injury, when medical intervention is most intense, costs range from $209,000 to $710,000. Every year thereafter, spinal cord injured people will incur annual costs of between $14,000 and $127,000.

∇ **Limb disability** pertains to loss of limbs (arms, legs, etc.) or the serious injury of limbs. A loss of limb or serious limb injury can take place when a person is at home, work, or in a public area. According to a recent study by the U.S. Centers

for Disease Control and Prevention) about 1.9 million Americans live without a hand, arm, foot, or leg.

- **Disfigurement** is the state of having one's appearance deeply and persistently harmed medically, as from a disease, birth defect, or wound. Disfigurement, whether caused by a benign or malignant condition, often leads to severe psychosocial problems such as negative body image; depression; difficulties in one's social, sexual, and professional lives; prejudice; and intolerance. This is partly due to how the individual copes with looking 'visibly different', though the extent of the disfigurement rarely correlates with the degree of distress the sufferer feels.

Over the past two decades, improvements in medical technology have prolonged lives dramatically. Heart bypass surgery, angioplasty, transplant surgery and many modern forms of cancer treatment did not exist twenty years ago.

Though people with illness are living LONGER**, they are living longer DISABLED lives.** The risk of disability is greater than the risk of death at all ages between 20 and 65.

Human Life Value

Long-term disability income insurance is designed to replace the economic value of a wage-earner's **whole work life.** In other words, **the disability income coverage should replace all the after-tax income he or she would have earned had no disability occurred.**

This concept is somewhat similar to the human life value concept developed and associated with life insurance sales. **An individual's human life value is his or her work life economic value to his or her dependents.**

- To determine the individual's human life value, we first project his or her earnings over the number of years remaining in the wage-earner's work life.
- We then reduce this total figure by certain amounts:

    - The wage-earner's personal expenses.
    - Income taxes.
    - Sums paid out for pure insurance risk protection.

- These expenses are subtracted from the individual's lifetime earnings because neither the wage earner nor his or her dependents would have access to sums paid in taxes or for insurance protection for support. Nor would the dependents have access to sums spent on the wage-earner's personal needs, even if the wage earner lived all those years.

- The sum remaining, then, is equal to the after-tax earnings that would be available for support of the wage-earner's dependents over a period equal to the wager earner's remaining work life.

- To find out how much life insurance the wage earner should purchase to provide an equal amount of economic benefit for dependents in the event of his or her premature death, we ask ourselves, how much would have to be deposited into a bank account right now, earning a reasonable long-term rate of return, to provide this economic benefit?

Disability Instead of Death

The assumption in these calculations is that the wage earner dies. The problem is that in many cases a wage earner **will stop being able to earn income**, **but he or she will not die**. Rather, **he or she will be disabled.**

When attempting to determine the economic value that is lost by an individual who becomes disabled, we do the same initial calculation we would do to determine the wage-earner's human life value, **but, because of the nature of the disability income insurance policy, we treat our answer differently**.

First, we may reduce the amount for income taxes paid.

- **Disability income policy payments are generally income-tax free when received if policy premiums have been paid for by the disabled individual personally.**
- Not all disability income coverage, however, requires the individual to pay. For example, employer-provided group coverage may not.
- If the individual will receive payments tax-free, we reduce total earnings for income taxes.

We will not reduce the remainder by an amount equal to what the individual would have spent on personal expenses. These will not stop. They will continue. They may even increase based on the nature of the disability.

We do not discount the total amount required based on the fact that the disabled individual will receive long-term disability benefits in a lump sum that can be deposited somewhere to earn interest over the period of his or her disability. **Disability income payments don't generally come in a lump sum; they come a month at a time.**

In addition, instead of discounting the total amount of replacement income the individual will need, we have instead to increase it if we are to maintain a level standard of living for the disabled individual and his or her family.

Inflation over a long period of disability will erode the purchasing power of a fixed income

The nature of an individual's need for life insurance protection and disability income protection **differ the longer the individual lives**. Every year a worker remains alive and healthy, he or she will continue to earn income to provide some of the dependent support that was supposed to be provided by his or her life insurance in the event of premature death.

- He will accumulate additional wealth that can provide support for dependents in a number of ways.
- Current bank and investment accounts grow, real estate values, which may be realized on sale of the property by dependents, may go up.
- He may have made contributions to an IRA.

- His employer made contributions to a retirement fund to provide a benefit that would also be available to dependents in the event of the wage-earner's premature death.

The same wage-earner's disability income needs will probably increase.

- **Disability income coverage is sold on the basis of a monthly income replacement need**. The longer the wage earner works, the higher his salary should go.
- **As salary increases, frequently so does the cost to maintain the individual's lifestyle**. The individual and spouse have a second or third child, buy a bigger house with a bigger mortgage, buy a second care on time, replace older furniture with items of higher quality, take more expensive vacations, provide their children with more and more life enhancements, like summer camp, dance or music lessons, special school trips, a personal computer, their own telephones.
- While the period over which benefits might be required is reduced, **the actual monthly need increases.**

The **need for disability income insurance in the marketplace is high for a number of reasons.**

- ✓ Though many employers are required to provide employees with state-mandated short-term disability benefits and worker's compensation coverage, **many do not provide their employees with additional long-term disability benefits.**

- ✓ **State-mandated disability benefits** cover disabilities that result from both work-related and non-work-related causes. They are, however, generally short-term: usually for only six months and usually provide only about 50% of an employee's weekly salary. At the end of 26 weeks, the individual has run out of benefits.

- ✓ **Workers' compensation coverage** only provides benefits in the event the individual's disability results from a work-related cause.

- ✓ An employee whose disability resulted from a non-work-related cause would have no other disability coverage available after 26 weeks but Social Security, **which may take up to two years to obtain.**

- ✓ Under the Social Security definition of disability, an individual must be unable to perform any work for which he or she might earn income, and the disability itself must be seen to be such that it will either last more than twelve months or will end in premature death.

- ✓ A substantial number of Social Security claims are denied initially, only to be validated after appeal and review, including perhaps a personal hearing. It is the appeal and review process that may take many months.

Filling a Financial Planning Gap

The **financial consequences of disability include**:

Potential loss of earnings ~ for most workers, the ability to earn a living is their most significant resource. **A disabling illness or injury STOPS INCOME**.

Disruption of retirement savings ~ nearly half (48%) of Americans say they would probably have to STOP making CONTRIBUTIONS to their retirement account should they become disabled.

Inadequate savings ~ another survey shows that 50% of consumers have three months or less of their living expenses saved.

Studies have shown:

- Americans rank long-term care second, behind saving for retirement, when prioritizing financial needs.
- For most people it is quite likely that the cost of care would be greater than either the amount saved or the amount that could have been saved.
- Many home care agencies have shut down because of financial problems.
- Nursing home owners have been filing for bankruptcy.
- There is a severe shortage of both home care and nursing home staff due to low wages.
- No federal or state agency is prepared either to finance, or deliver services that are anywhere near adequate for the increasing number of older Americans needing care.

American businesses need to really pay attention to what long-term disability and care giving is going to mean for them.

- It is not only an emotional issue, but a financial one, too.
- One study estimated supervisors spend 55.7 million hours of company time per year dealing with the concerns of employed caregivers, for a total cost to business of $800 million annually.

The term "financial planning" means many different things to many different people.

- For some individuals, **it encompasses all phases of an individual's financial life,** including wealth accumulation, personal and business retirement planning risk management and estate planning.
- Other individuals who call themselves financial planners may specialize **in wealth management only,** which, at its lowest level, is mere budgeting; or **wealth accumulation planning**, which includes systematic investment of discretionary income and efficient management of accumulations toward the primary goal of building wealth.
- Many individuals who specialize in **risk management** specialize in risk management at the property/casualty end of the insurance business, though a broader definition of risk management could certainly include consideration of major medical, disability income, life and long-term care insurance.
- Much **estate planning** is done by lawyers, many of whom are more involved in planning through legal documents, such as wills, powers of attorney, and trusts than through insurance of any sort.
- Other individuals who provide estate planning services may focus principally on future transfer of assets, **overlooking some important financial planning needs, such as the need for disability income insurance**. They may simply take for granted that the wage earner will remain healthy and capable of generating additional discretionary income for wealth building (and life insurance policy premium payments) until such time as—deep in old age—he or she dies and his or her transfer plans take effect.

The insurance professional will find that a great many individuals with whom they work have never been approached to discuss the benefits of personally-owned disability income insurance. **This is a financial planning gap that insurance professionals can fill.**

Underwriting for Disability

Field Underwriting

Underwriting is the process of assessing and *classifying the degree of risk* that a proposed insured represents. The persons responsible for researching – and then accepting or declining the application in light of the risk assessment – are called **underwriters.**

- The information that is gathered is usually submitted to home-office underwriters for acceptance, rejection, or rating. This data is transmitted by way of the application, agent's report, data sheet, and any other related documents.
- The agent's judgment is not usually accepted as final until the home-office underwriter can make a decision.
- The life insurance contract that is written in the field is cancelable if the home-office underwriters find the health risks to be unacceptable to the company.

The individual who undertakes to sell disability income insurance has certain **field underwriting responsibilities.**

- ✓ **Accuracy on applications**. This implies not only that the applicant's name is spelled correctly, his address is right, his Social Security and telephone numbers are correct, but that all the information required is provided in its most complete form.
- ✓ Field underwriters also have **an obligation to be observant**. This implies looking at a prospect and making some assessment of his or her health from appearances. It implies taking note of an individual's lifestyle, noting what might give him information about his activities.

Field underwriting generally refers to the agent's research and gathering of data from the proposed insured, rather than the actual evaluation of the data.

This type of field underwriting helps home office underwriters, and it also helps the field underwriter to manage prospect expectations.

- ✓ The underwriter should alert someone who is overweight that he might not be able to obtain preferred or non-medical underwriting, that the policy the company will issue may be subject to some restriction, or perhaps they might not be able to obtain a policy at all.
- ✓ Visits to a chiropractor for back problems will generally signal to a home office underwriter that an applicant is a higher-than-usual risk for back and spine-related disabilities.
- ✓ Someone who has recently seen a psychotherapist, psychoanalyst or counselor will probably also be seen as a higher-than-usual risk for disabilities resulting from mental or nervous disorders.

Statistically, such assumptions have been accurate, regardless of the number of individuals that the underwriter may personally know who are extremely active and healthy people, or the number of individuals he may know in psychotherapy or psychoanalysis who are socially and interpersonally fully-functioning people.

The field underwriter should make sure **that prospect expectations about how much of his or her income can be replaced are realistic**. He should know that companies generally provide somewhere between 50% and 60% of gross income.

A self-employed individual should understand that **his disability benefit must generally be based on net Schedule C income.** That is **income after all business expenses have been deducted, rather than gross income.** A field underwriter must, especially in the case of a self-employed individual, be sure the income figures he gets are net income figures.

In all of these and any similar circumstances, **the field underwriter's job is to prepare the prospect for what might occur.**

Home Office Underwriting

Home office underwriting is principally designed to determine, from the information on an application:

- Whether or not **additional information** is required about any situation or condition presented.
- Whether or not the individual applying for disability income coverage in fact qualifies for the coverage for which he is applying.

Additional information might include:

- Attending Physician's Statements regarding particular aspects of an applicant's health.
- Additional financial information in the form of income tax returns or current earnings statements.

The home office underwriter prizes **ACCURACY** and **COMPLETENESS** above all else.

- ✓ ALL information should be **ACCURATE**: names, addresses, Social Security and phone numbers, dates of employment, medical treatment, conditions, medications, etc.
- ✓ "**COMPLETELY"** means not only that all the questions on an application have been filled in. It means that all possible appropriate and relevant information has been provided.

The home office underwriter should have all the information **that he needs to contact the prospect if necessary.**

The home office underwriter does NOT want a surprise. He does not want to discover that a seemingly healthy prospect had cancer four years ago. He does not want to find out on an Attending Physician's statement about an unrelated condition that the applicant is a recovering alcoholic. When prospects do not tell everything, the underwriters cannot avoid the surprises. At that time, the underwriter should not censor what the prospect says.

Financial Underwriting

Financial underwriting helps uncover cases of speculation and anti-selection by assessing the relationship between the amount of coverage and the real and identifiable need for insurance. **Financial underwriting takes place both in the field and in the home office.**

The financial underwriting process zeros-in on **two basic questions**:

- What is the insurable interest?
- How was the need for the coverage determined

Insurable interest means reviewing the financial loss to the beneficiary in the event of the insured's untimely death. The underwriter looks for reasonability in the coverage and seeks to avoid creating a financial windfall for the beneficiary.

To facilitate the financial underwriting process, these simple guidelines should be followed when submitting an application.

- ✓ **For non-related beneficiaries** ~ Provide full details as to the beneficiary's financial interest in the life insured.
- ✓ **When submitting large cases** ~ Include a memo that explains the basis for the sale and justifies the amount of insurance. Attach copies of presentations made to the client in selling the case. Provide relevant financial statements.
- ✓ **For disproportionate coverage within a family** ~ Supply an explanation when there is an imbalance in coverage between the parents and children.

The home office underwriter may want additional support before approving a policy providing a particularly large monthly benefit, or he may simply not feel comfortable with the income the applicant has provided in relation to the type of employment he is supposed to be engaged in.

The field underwriter must do his or her financial underwriting as well. This entails not selling inappropriate benefits to individuals. As mentioned earlier, **one must be sure to get accurate income numbers, especially from self-employed individuals.**

It is also important to make sure that an individual understands that he or she may purchase one benefit at the time of policy issue, **but that benefit is not guaranteed, under most disability income contracts**, UNLESS the individual **has actually been earning an income that, at the time of disability, substantiates policy payment amounts**.

- At the time of disability claim, an insurance company will **require verification of current income.**

- Since not all disabilities occur in a single moment, and since not everyone is earning his highest income every year, **a company may allow an individual to provide earnings information over a two-, three-, or even five-year period to substantiate entitlement to the benefit payable under the policy.**
- **If long-term earnings are consistently below what is required** to support the payment level of the disability income contract, then **the actual payment to the disabled policyholder will be lower than stated in the contract.**

Medical Underwriting

Medical underwriting is the process that a health insurer uses **to balance potential health risks in its pool of insured people against potential costs of providing coverage.**

To conduct medical underwriting, an **insurer asks** people who apply for coverage (typically people applying for individual or family coverage) **about pre-existing medical conditions.** In most U.S. states, insurance companies are allowed to ask questions about a person's medical history in order to decide:

- Whom to offer coverage.
- Whom to deny.
- If additional charges should apply to individually purchased coverage.

From the insurers' point of view, **medical underwriting is necessary to prevent people from purchasing health insurance coverage only when they are sick, pregnant or need medical care**.

This tendency is called **adverse selection** - a system which attracts high utilization users while discouraging low utilizers from participating.

Proponents of underwriting believe that, if given the ability to purchase coverage without regard for pre-existing medical conditions (i.e., no underwriting), people would wait to purchase health insurance until they got sick or needed medical care.

∇ **Waiting to obtain health insurance coverage** until one needs coverage then creates a pool of insureds with "high utilization," which then increases

the premiums that insurance companies must charge in order to pay for the claims incurred.

- In turn, **high premiums further discourage healthy people** from obtaining coverage — particularly when they realize that they will be able obtain coverage when they need medical care.

- **Proponents of medical underwriting argue** that it ensures that individual health insurance premiums are kept as low as possible.

- **Critics of medical underwriting believe** that it unfairly prevents people with relatively minor and treatable pre-existing conditions from obtaining health insurance.

Medical underwriting in health insurance focuses on medical expense insurance. However, similar circumstances apply for other forms of individually purchased health insurance, such as disability income and long-term care insurance.

Chapter 2
Long-Term Disability Insurance ~ II

Comparing Personal Disability Income Policies

Long-term disability income insurance will pay a monthly benefit for a benefit period specified in one's policy, or for the duration of the disability, whichever is shorter.

- A company provides short-term disability income insurance to its employees to pay a percentage of salary for a short amount of time, usually up to six months.
- Business-overhead-expense insurance is disability insurance that steps in and pays the business expenses of a business owner while he is disabled.
- Disability buy-out insurance provides money to enable one partner to buy out another in the event one becomes disabled.

Generally disability income policies are of three types:

∇ A **non-cancelable policy** is one that the insurance carrier cannot cancel for any reason other than fraud. The policy premium on this plan is fixed. The company cannot increase the premium over the life of the policy.

∇ A **guaranteed renewable policy** is one which the company cannot cancel either, but the company reserves the right to adjust future premiums. Coverage is guaranteed, but the future price for it is not.

∇ A **conditionally renewable policy** is one which can be continued based on the company's annual decision to do so. Most people would not purchase a conditionally renewable policy unless it was the only one available to them. It

has, however, a special use with respect to key employee disability income insurance, which is discussed later in this class.

A policy that **provides an insured with control over how long it will remain in effect,** and, by locking in the premium, **how much the policy will cost, is more desirable than a policy in which** premiums may increase or coverage may be terminated at the company's discretion.

If all other features are the same, the policy with the most substantial premium and coverage guarantees will also have the highest premium.

Definition of Total Disability

The **definition of total disability in a disability income policy** is the **trigger that determines whether or not the policyholder is eligible** to obtain benefits under the plan.

Definitions vary from contract to contract.

The Social Security definition of total disability is: "*the inability to engage in any substantial gainful activity by reason of any physical or mental impairment which is expected to last for at least 12 months and/or end in death."*

The definition of total disability used by Social Security, that an individual **is totally disabled only if he or she cannot engage in any employment whatsoever to earn income**, is the harshest possible definition. Under this definition, nothing matters but whether or not a person could do the work.

A **less harsh definition** initially **takes into account the actual occupation that the individual is currently engaged in** his or her "own" occupation and provides benefits for a certain period if the individual is unable to perform the material duties of that occupation.

Frequently, a policy will provide for disability benefits if the policyholder cannot perform the material duties **of his own occupation**, for a period of two years. Sometimes this period is longer.

Beyond this period, **the individual must usually be unable to earn income in an occupation for which he is suited by education, experience or training.**

- This is a more liberal definition of total disability because it does not consider an individual employable in virtually any occupation at all, including the most medial or low-paying simply because the person is physically capable of performing it.
- **Appropriate occupation is stressed in this definition.**

An even more liberal definition of disability **focuses solely on the individual's own occupation, frequently even more finely on an individual's specialty within an occupation.**

- Many companies have abandoned this definition either for the longest benefit periods, such as to age 65 or for life, or have severely curtailed those occupations for which they will issue such a policy.

- Under this definition, which was not available to everyone and for which a policyholder may have paid an additional premium, the individual was considered disabled if he or she could not perform the material duties of his own occupation.

- If the individual were capable of performing the duties of another occupation—even one for which he had been prepared by education, experience or training—if it were not his own occupation, he could continue to collect full disability income policy benefits while engaging in this other occupation, regardless of how much he might have earned.

- Sometimes, specialties were indicated. A surgeon, for example, might purchase a policy with a surgery specialization. If she developed a nerve problem that caused her hands to shake, then performing surgery was not longer possible. The surgeon would collect a full benefit under a disability income policy, even if she then went on to teach surgery or to assist in the operating room, or began another equally lucrative practice as a cardiologist.

Other disability income policies do not make use of definition of total disability. Rather, they provide benefits based on a loss-of-income standard, generally paying a percentage of policy benefits equal to the percentage of income lost.

- A loss of income policy generally provides a disability benefit when a policyholder has lost 20% of his current income because of an accident or illness.
- Such policies frequently pay a minimum benefit of 50% of the maximum policy benefit for the first six months of eligibility for benefit payments. Subsequent to this, the policy would pay a pro rata benefit depending on how much income was

actually lost. That is, a 40% loss of income would make the policyholder eligible for a 40% benefit.

- Generally, when loss of income is 75% or greater, the policy pays a full 100% of the benefit under the policy.

Presumption of Disability

The definition of **presumptive disability** varies among contracts. Some contracts do not even have a presumptive disability insurance provision. **This is not a provision for which one pays an extra premium; it is built into most contracts.**

Presumption of disability is the presumption that the insured is totally disabled, (even if still at work), if sickness or injury results in the total and complete loss of sight in both eyes, hearing in both ears, power of speech, or use of any two limbs.

The basic idea of presumptive disability is to protect against drastic disabilities that occur suddenly. They generally protect one against the loss of hearing, sight, speech, or the use of any two limbs.

The elimination period is waived from the date of the loss and total disability benefits are payable while such loss continues until the end of the benefit period.

A presumptive disability benefit is a benefit payable under certain specified situations, following the occurrence of which the policyholder is assumed to be totally disabled.

- Benefit payments will then be made to the individual, regardless of whether or not he or she returns to any kind of employment.
- Benefits are generally payable for the total and irrecoverable loss of speech, sight in both eyes, hearing in both ears, use of both hands, use of both feet or use of one hand and one foot.
- Frequently this benefit will be payable for life if they occur before a specified age, such as age 65, regardless of the actual policy benefit period.

Capital Sum

Not every policy offers a presumptive disability benefit. Some offer instead what is called a **capital sum benefit.** A capital sum benefit substitutes a lump-sum payment to a policyholder in the event of certain occurrences, rather than providing the full policy disability benefit payment for life.

EXAMPLE

The policy might pay a **capital sum** of twelve times the monthly benefit for loss of speech, hearing in both ears, sight in both eyes, loss of both hands, loss of both feet, or loss of a hand and a foot. It might then offer half that benefit for loss of hearing in one ear, sight in one eye, or loss of use of one hand or one foot.

This benefit will be in addition to any other monthly benefit that might be due the policyholder based on any level of disability that might also result from the injury he has sustained.

Classifications of Disability

Temporary Disability

If one's injury is so serious that he must miss work, he will be entitled to receive payments from workers compensation to partially reimburse him for lost wages. He will be entitled to receive payments as long as he cannot work, or until he is determined to have "healed" as much as he is going to. At this point, he may be entitled to permanent disability or other payments.

Total Disability

If one's injury is so serious that he is found to be totally disabled, he will receive lifetime payments. The size of these payments will be approximately the same as temporary disability benefits.

Sometimes, the insurance company makes a lump-sum cash payoff instead. In such cases, the size of the lump sum will depend on an actuarial determination of what the disabled worker can expect to receive over his lifetime.

Permanent Partial Disability

More often than becoming totally disabled, workers find themselves permanently disabled but not so badly injured that they can never work again. In these circumstances, workers compensation will usually have a preset schedule of benefits that specifies what the worker is to receive based on the injury.

If one's injury is not listed on the schedule, a hearing officer will usually decide on the amount one will receive based on factors such as his reduced earning capacity or his

"percentage of disability." If one is partially but permanently disabled, he should look into his rights to receive vocational rehabilitation.

Occupational Classifications

Some occupations are more dangerous than others.

- If one is in a particularly dangerous trade, such as coal mining or race care driving, his chances of becoming disabled are much higher than average.
- **People in dangerous occupations are usually denied normal disability insurance coverage**.
- If there is one available, the premiums will be very high.

If one already has a disability policy that is non-cancelable and guaranteed renewable, and the client changes to hazardous occupation, the insurance company cannot terminate his coverage.

Each company has its own definition of hazardous occupation. The underwriter must assess not only the proposed insured's occupational title, but also the nature of the duties performed in that occupation. If the person wanting insurance is required to perform several different tasks, the occupational classification is based upon the most hazardous duty performed.

Executive and Professional ~ This class includes persons in those professional and managerial occupations within select business and professional sectors of the economy where favorable underwriting and claims experience have been demonstrated. These occupations require extensive education, training and experience. All work is performed in an office setting with only incidental travel and no direct supervision of persons with manual duties.

This class includes persons in professional, managerial, and technical occupations within select business and professional sectors of the economy. These occupations require extensive education, training, and experience. All work is performed in an office setting with less than 20% of the person's time spent out of the office and no direct supervision of persons with manual duties.

Clerical and Administrative ~ This class consists primarily of those professional, managerial, and technical occupations which are not generally eligible for our most

favorable classes. Work may involve more than 20% of the person's time being spent outside of the establishment. Occupational duties involve no direct supervision of persons with manual duties.

Skilled Workers ~ This class is made up of social service, clerical, medical support and select commissioned sales occupations in which stability and potential high earnings qualify individuals for long-term benefits. It also includes those medical and dental occupations that have demonstrated less favorable experience than classes 4 and 4P. Work is performed in a hospital, office, or retail setting and involves only light manual duties.

This class consists of certain skilled trades, some medical support, and supervisory occupations. Work is performed in a shop, medical facility, retail establishment, or outdoors and may involve use of light machinery or direct supervision of persons with manual duties.

Skilled and Unskilled ~ This class includes both skilled and some unskilled occupations requiring heavy manual duties or presenting real accident or environmental hazards.

Uninsurable ~ Some occupational classification guides would consider these uninsurable: Athlete (Pro or Semi-Pro), Bar Owner / Nightclub Owner, Floor Broker (Securities), Heavy Equipment Operator, Military (Active duty), Writer (Free-Lance)

Elimination/Waiting Period

Disability policies have **designated waiting periods** before they will pay benefits. **These waiting periods are often called elimination periods**.

- They act as **a form of deductible**, only expressed in time rather than dollars.
- If one regains his ability to work during the waiting period, **the company will owe him no benefits.**

The elimination period will vary from policy to policy. Usually, the wait is rather long, ranging from a few months to even years. Some policies allow for immediate benefits if the disability was caused by an accident.

Generally, a disability income policy will require an individual to wait for a specified period, during which he or she must be total disabled, before becoming eligible to receive benefit payments under the policy.

- The shorter the elimination or waiting period, the higher the premium for the coverage.
- Common elimination or waiting periods include 15, 30, 60, 90, 120, 180, 365 or 730 days.

The elimination or waiting period is also frequently the point at which a company's waiver of premium policy feature is triggered. This feature requires a totally disabled policyholder to continue to make premium payments until the trigger date of the benefit, at which time the company will refund premiums paid during the elimination or waiting period and will require no further premium payments while the policyholder remains totally disabled.

Split Elimination Periods

Some disability plans will let the policyholder choose a 30, 60, 90 or 180 days, or a one or two-year elimination period, or waiting periods - that is the amount of time between the beginning of the disability and the date he qualifies to begin receiving benefits.

Chapter 3
Long-Term Disability Insurance ~ III

Recurrent Disability

A recurrent disability is exactly as it sounds. The insured is disabled once, re-covers, and then has a recurrent disability. Most contracts have a recurrent disability provision built in. The average provision will say something like this:

"For a recurrent disability, within six months, from the same or related cause, the insurance company will waive the elimination period."

The recurrent disability insurance provision is designed to make sure that a person does not have to go through more than one elimination period within a certain period of time. It is important for the policyholder to know that the six-month, same or related cause definition is the generic definition.

A recurrent disability provision is more important than one might think. Many times people will think of this miscellaneous feature that is not as important as some of the other features like non-cancellable, and own-occupation.

A policy's definition of recurrent disability is important in that it is the prime determinant of:

- Whether or not a policyholder must satisfy a new elimination or waiting period before receiving disability income benefits again.
- How much an individual may actually receive in total benefits.

Case Study

Suppose an individual becomes disabled. He satisfies a 180-day waiting period on a policy with a five-year benefit period before becoming eligible for benefits. He begins to collect. Two years later after having received benefits for 24 months, he is able to return to work full time. After eight months, his disabling condition reasserts itself and the individual is no longer able to work.

If the individual's policy contained a definition of recurring disability that required the periods of disability due to the same source to be separated by 12 months before being considered totally separate periods of disability, this individual would have been considered to have suffered from only a single, recurrent disability.

- The result of this would be that he would not have to satisfy another elimination or waiting period.
- Benefits would be payable immediately upon determination that he was again totally disabled.
- Benefits would be payable for only three more years, since he had already received two years of benefit payments for this same disability already. At the end of three additional years of benefit payments, his benefits would stop.

Suppose that his policy had a definition of recurrent disability that called for only a six-month break between periods of disability to qualify the disabilities as two separate disabilities rather than one.

- In this case, the re-lapse into disability would be considered a separate disability because it had occurred eight months after his return to work.
- On the downside, he would have to satisfy a new elimination or waiting period.
- On the upside, he would receive, not three years' worth of benefits, but a full five years' worth, since any individual disability under the plan could trigger a five-year benefit payment period.

Residual/Partial Disability

A large percentage of all disability insurance claims either start or end in a residual claim. The basis of a residual claim is that a person is still actively engaged in their occupation, but because of a sickness or injury is suffering a loss of time and duties and is suffering a loss of income of at least 20%.

Partial or residual disability benefits may be paid in some policies when the impairment allows the insured to perform only a portion of his pre-disability duties. This provision may also pay benefits in the case where the disability reduces the insurer's income by a specified amount, from pre-disability levels.

Most disability insurance policies define **partial disability** as **an inability to do some of the duties of one's job or profession.** He may be considered partially disabled if he can do his job on a part-time basis or if he can work at a different full-time job for less pay.

Under a plan with partial disability benefits, a person may have more difficulty getting total disability benefits. If his plan does not have partial disability benefits, he is defined as totally disabled if he can't work full time. If his plan has partial disability benefits, however, he may only get partial disability benefits, which pay less, under the same circumstances.

A **residual disability** insurance policy pays a person if he cannot work full-time or if he is unable to perform all the duties that he routinely performed prior to his disability. Residual benefits are generally payable when a person's income loss is 20% or more and he is under the care of a physician. The greater his income loss is, the higher his residual benefits payments will be.

For example, if he returned to work but he made 40% less than before his disability, he receives 40% of his disability benefits. Most residual disability plans provide a minimum benefit of 50% of covered compensation.

Some policies define residual disability simply as a loss of income, while **others require a loss of income and a loss of time or duties**. **Other contracts combine these elements**, requiring a loss of time or duties during the elimination period only.

Guaranteed Insurability

This describes an insurance policy in which the insurer is required to renew the policy for a specified amount of time regardless of changes to the health of the insured.

Guaranteed insurability is also called:

Guaranteed renewable.
Conversion privilege.
Convertible term.

The agreement requires that premiums are paid on time and that the insurer makes no changes except if a premium change is made for an entire class of policyholders.

If the applicant wants to add more insurance in the future without more medical qualifying, the guaranteed insurability option is best for him. With guaranteed insurability, he can buy more insurance as his need goes up without having to prove that he is still in good health.

Often, a guaranteed insurability option is just that, it is **a policy feature that provides a policyholder,** usually at specified ages, such as 28, 31, 34, 37, 40, 43 and 46, **a right to apply for additional disability income coverage without having to provide additional medical evidence of insurability.**

- All that will be required is **financial justification** for the additional benefit the policyholder seeks.
- Consequently, the individual's "**insurability" is guaranteed.**
- The company **cannot find him uninsurable**, only insurable on a limited basis, determined **not with reference to health, but to financial qualifications**.

With a guaranteed insurability option, **the policyholder has the right on each of the option anniversaries to either exercise the option or let the option expire**. He or she **does not lose the right to exercise the option** on the next option anniversary date **just because one or more previous options have not been exercised.**

Future Increase Option

Future increase option is an optional rider offered by most carriers to protect the insured's future earnings. Without this rider, or an automatic increase rider, there is **no way to protect an individual's future earnings.**

- A disability insurance policy by itself only protects the amount of income that one makes at the time they take out the policy. **It does not grow automatically** unless a person has this, or an automatic increase rider.

This rider locks in/guarantees his insurability for a certain period of time. So as he increases in age, and increases his income level, he can increase his monthly benefit regardless of any health changes. Usually the only thing a person needs to provide when increasing his monthly benefit is a copy of the most recent tax return to prove his new income level.

A future increase option usually provides a broader benefit than a guaranteed insurability option. Under this benefit, the company offers to increase the policyholder's disability income coverage by some percentage, frequently 5% on each policy anniversary.

The insured does not have to provide medical evidence of insurability to take advantage of any individual option. Nor does he have to provide additional financial evidence of eligibility.

- Underlying this aspect of the benefit is the idea that an individual's income will continue to grow at or near the percentage rate of benefit increase.
- One way to think of this benefit is that the company is offering the individual an annual option to have his benefit increased to keep pace with cost of living or inflation-based salary increases.

It is usually possible for a policyholder to decline any single annual increase, but if he declines more than one in succession, then the future increase option is often withdrawn. Reinstitution of the future increase option after it has been withdrawn by the company generally requires that the policyholder provide full current evidence of insurability.

Chapter 4
Long-Term Disability Insurance ~ IV

Cost of Living Adjustment Option

Often referred to as a COLA rider, this rider only kicks in if the insured actually goes on a disability insurance claim, and then only if the disability lasts for more than one year. Depending on the percentage option he elected when he took out the policy, it will increase his monthly benefit every year while he is on a claim along with the CPI up to the maximum he elected. **It is quite often the most expensive rider available on a disability insurance policy.**

A cost of living rider is something many insurance and financial experts recommend when a person is purchasing life and/or total disability insurance. The rider itself does not have a life of its own, and can only be an add-on to an already purchased plan. It rides with the plan purchased and cannot be purchased on its own, hence its unusual name.

The cost of living rider allows the insured to upgrade or purchase additional insurance to cover the rising cost of living.

- If he purchases a specific insurance that will pay an amount that seems great in today's market, it has a basic problem.
- It will not keep pace with the cost of living, and what may seem like a great deal today can down the road be inadequate to meet the insured's needs.

This is especially the case if he is permanently disabled, which some life and term life policies have provisions for. A person may purchase insurance that would essentially cover his current salary after a disability. If he was not disabled, and had continued to work, it is likely his salary would rise slightly with cost of living increases.

Many financial experts recommend that the cost of living rider is an especially important add-on if the insured is young.

- As an individual nears retirement or end of life, the cost of a living rider can be less important, because though cost of living changes, **it may not increase so dramatically that payout on his policy would make an appreciable difference**, either if he becomes disabled, or if he plans to use a payout to support a surviving spouse.

There are perils in not having a cost of living rider if the insured has three or more decades left of expected life span.

- Should he become disabled, the insurance he purchases will pay out on the amount agreed when he signed the policy.
- This could be much less than he will need ten or twenty years from now, so it is definitely worth checking out this option when he purchases life and/or disability insurance.
- He will not automatically be offered this option, so an applicant should ask about the rider if the insurance broker does not mention it.

It is also important for the customer to understand how the insurance company offering him a policy assesses cost of living.

- Some companies allow a flat fee increase of between 3%-6% per year.
- Others offer adjustment of payout based on the Consumer Price Index (CPI).
- It is usually better to look for a policy that bases cost of living increases on the CPI, because a set rate of increase may still be lower than what it really costs to survive comfortably.

Benefit Period

The benefit period is the maximum length of time benefits will be paid. A person's choices are typically 2 years, 5 years or to his normal retirement age. Generally, the longer the benefit period is, the higher the premium will be. The benefit period dictates how long benefits continue. Many people stipulate that they want their payments to stop at age 65 when they begin receiving Social Security checks.

The benefit period is another important feature to look at when comparing disability income policies. Principally, **this feature is a function of the occupational class of the individual being insured.**

- **The higher the individual's occupational class**, the broader the range of benefit-period options that will be available to him or her.
- **The longer the benefit period,** the higher the premium since more extensive benefits are being promised by the company as the benefit period becomes longer.

The usual benefit options are:

- 2 years.
- 5 years.
- To age 65.
- Lifetime benefits.

Sometimes the benefit period offered for disability due to accident will be different from that offered for disability due to illness.

- A typical arrangement might provide lifetime benefits for disability due to illness with no regard to when the disability began, and lifetime benefit for disability due to accident only if the disability begins prior to the policyholder attaining a specified age, such as 55.
- If disability did occur because of an accident after age 55 under this arrangement, then benefits would only be payable until the policy anniversary of the year in which the policyholder reaches age 65.

Some companies today have ceased to offer lifetime benefits for either accident or illness.

- This may be a reaction to unanticipated losses experienced because of claims in higher occupational classes and may at least in part recognize that financial security and economic status are linked in some meaningful ways to longevity.
- That is, companies will pay longer for wealthy individuals who actually do become disabled for whatever reason.
- Wealthier people, individuals high on the economic ladder, are more able to provide themselves not only with adequate medical care for more of their lives,

but are also able to provide themselves with the most advanced as well as the most expensive types of medical care available.

Policy Limits

Every disability income insurance carrier sets policy limits on how much disability income insurance it is willing to write on any single individual in a given occupational class.

Such limits are established with an eye toward total profitability of a block of business.

EXAMPLE

A company would not write policies in which the maximum benefit limit was such that any small deviation from their expected disability benefit payout percentage could not be more than offset by the company's cash flow from and reserves for that particular block of business.

In addition, policy limits apply with regard to how much coverage any single individual is eligible to purchase based on his or her actual annual income.

It is important to remember that this type of policy is an income replacement policy designed to maintain a disabled individual's lifestyle during his or her long-term disability.

- There should be a **clear incentive for the individual to return to work**.
- The policy should not provide a disincentive to return to work as soon as possible by providing more of an after-tax income than the individual could earn.

It should also be noted again that **policy benefit issue limits will also be integrated not only with state-mandated short-term disability benefits coverage**, **but also with any other type of disability income insurance coverage the individual might have** through his or her employer, such as group short-or group long-term disability coverage.

In addition, it should be noted that **when attempting to provide the highest level of disability income benefits possible to owners and key employees of businesses**, coverage should be provided by **a combination of personal and group insurance.**

- The personal insurance should be purchased first since a group long-term disability income plan is underwritten on the characteristics of the group—age,

gender, occupation—without taking into account any individual disability income coverage anyone in the group might have.

- By having owners and highly compensated key employees purchase personal coverage first, the combination of personal and group coverage will come closer to providing them with the full after-tax income required to replace what they would have earned had they not become disabled.

- This approach means, then that wealthier disabled individuals will be less likely to have to use the unearned income from their other investments to meet current expenses during a prolonged period disability. Those funds can remain invested to meet longer-term, later-life income needs, such as the need for income in what would have been their retirement years, that is, after age 65, when it is likely that their disability income payments will cease.

Exclusions

Policy exclusions refer to disability for which no benefit under the policy will be paid.

- Certain coverage exclusions may be the result of waivers that are added to the policy to eliminate certain pre-existing conditions.

- A disability income policy may have a waiver for all spinal-, lumbar-, sacroiliac-related disabilities when issued to someone with a history of chiropractic back care.

- A practicing psychoanalyst may not be able to obtain a policy without a waiver for all psychological and nervous disorder-related disabilities, despite the fact that he or she is perhaps only in analysis because of his or her training institute requirements.

Certain other exclusions are part of the basic contract for every individual who purchases a disability income policy from the company. These exclusions are generally very broad in nature.

- It is common for many disability income policies to exclude disabilities that result from any accident or illness that occurs before the policy issue date and which is not fully disclosed on the application for a period of time, frequently for one or two years.

- Any pre-existing conditions that are disclosed and for which the company makes no separate exclusion will be covered no matter when disability occurs.

This exclusion is generally further limited only to those accidents or illnesses for which the applicant actually received medical advice, or conditions the symptoms of which would have sent a reasonably prudent person in search of medical advice.

Many policies also have an exclusion for disabilities caused by war while the policyholder is a member of the military or in any civilian non-combatant unit serving with the armed forces.

- Some policies' war exclusion is broader, including any disability resulting from any type of military conflict, including war, declare or not, and any act of war.
- With the risk of domestic terrorism having become more pronounced, the broader exclusion has the potential to lead to denial of benefits and, subsequently, expensive legal battles.

Many policies also exclude payment for more than one disability at a time. Thus, an individual who had two separate disabling conditions, two conditions resulting from two separate causes, **would not collect two disability benefits, but still only one**.

CASE STUDY

Suppose an individual became disabled in an automobile accident in which he broke both legs such that extensive surgery and extensive recuperative time was required. If this disability lasted for a full year, the individual would collect full disability benefits for that entire time. Suppose further that in the eighth month of this disability and while still in the hospital, it was discovered that the individual had cancer and he began a course of chemotherapy that was disabling. Though the individual was after a year able to walk, being no longer disabled by the injuries he sustained in the automobile accident, he was not disabled by the course of chemotherapy in which he was engaged.

During the period of disability caused by the automobile accident, the individual collected a policy benefit. When the accident-related and illness-related disabilities overlapped, he still collected a single benefit. When he was no longer disabled by the accident-related condition, but remained disabled by his illness-related condition, he continued to collect only **a single policy benefit.**

Some types of disability are not covered by individual policies.

2-Year Max for Mental & Nervous ~ This is the most common exclusion within a disability insurance policy. Not every company has this exclusion within the policy. There are companies that put no limits for claims caused by mental and nervous disabilities. If disability is caused by stress, anxiety, depression, dementia, or any other mental-nervous disorder the insured may very well be limited to a two-year benefit period if he has a contract with the 2-year mental and nervous exclusion.

1-Year Max for Alcohol & Drug Claims ~ Many policies have a one-year maximum benefit period for drugs or alcohol, and even more policies have no exclusion for it.

Disability Caused During a Crime ~ This is a fairly common exclusion. If one is disabled while committing a felony the disability insurance policy does not pay a claim.

Act of War ~ There are some disability insurance policies on the marketplace that do not pay claims for disabilities that are a result of an act of war. This is not extremely common, but it does exist in some contracts.

Chapter 5
Long-Term
Disability Insurance ~ V

Business Overhead Expense Policy (BOE)

Business Overhead Expense (BOE) insurance is designed to reimburse a business for overhead expenses during the owner's disability.

- No small business can stay open long while the business owner is not generating new revenue.
- In a very short time, the business will either shut down, or the business will have to be sold.
- An overhead expense policy is made to give a business owner the ability to come back to an existing business if he is able to.
- **Without this coverage the owner does not have this option.**

General Provisions

Reimbursement for Expenses

Disability insurance business overhead expense (BOE) provides reimbursement for the expenses of operating the business if the owner is disabled and cannot work. These expenses may include mortgage payments or rent, electricity, telephone, heat, water, laundry and other fixed costs normal to the operation of the business.

Covered Expenses

The rationale behind BOE insurance is that because the small business owner is so important to the business' operation and profitability, when he or she becomes totally disabled the organization cannot help but suffer economically and could even be forced to close down.

CASE STUDY

A single doctor in a private practice is a good example of this type of situation. If the doctor became disabled and could not work in his or her profession, the business's income would almost certainly be weakened and the employees working in the office would likely eventually lose their jobs. As the income slows, however, the bills generally do not, and the employees still have to be paid. BOE coverage is designed to handle these issues.

Elimination Period

BOE policies generally have elimination periods of fifteen- to thirty days and benefit periods of one- to two years.

Benefit Period

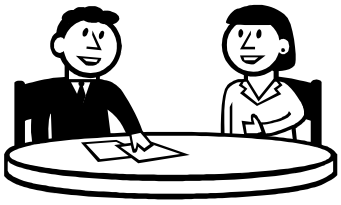
The average eligible overhead expenses of the business determine the policy's benefit amount. If the business owner becomes disabled, the business will receive proceeds from the policy equal to the actual overhead expenses incurred during the period of the owner's disability.

Business owners often incur loans or other financial obligations that require monthly repayment amounts. Unfortunately, the monthly payments can only be made as long as the business owner is well and able to run the business – in other words, as long as the owner is *not* disabled.

- To protect such financial obligations, and the assets that might be lost in the event of default, the business can purchase *disability reducing term insurance*.
- Should the owner become totally disabled, this coverage would provide a monthly benefit amount sufficient to cover the monthly financial obligation until it's paid off.
- The business is the owner and purchaser of the policy as well as the beneficiary, while the owner of the business is the insured party.

- In this coverage 'reducing term' refers to the fact that the monthly benefit amount is payable only for the remaining period of indebtedness or obligation.

Business Overhead vs. Professions Overhead



Business Overhead Expense Insurance is designed for the small business owner. In fact, most insurers limit their BOE policy coverage to small businesses.

The purpose of BOE insurance is to pay for certain overhead expenses that continue after the business owner becomes disabled. The policy indemnifies the business (*not* the owner) for such expenses as rent, taxes, insurance premiums, utility bills, and employees' compensation (the owner's salary is not covered, however). By paying for these expenses when the owner is disabled, the business is given the opportunity to keep its doors open and continue to function.

Professional Overhead Expense Disability Insurance pays some additional costs including the salaries of all regular employees except those who are members of the owner's profession. In a medical partnership, for example, salaries for the receptionist and nurse would be covered, **but not the salary of a physician partner or employee**.

Salary for Insured's Replacement

However, high-quality professional overhead policies will cover at least part of the salary of a professional temporary replacement for the professional, such as a doctor retained to fill in during total disability.

Key Person Disability Insurance

Key-Person Disability coverage is designed to provide a business with income during the disability of a key employee.

- It indemnifies the business for the lost services of the key individual.
- There are potentially severe consequences of a key person becoming permanently disabled.
- The business could purchase and be the beneficiary of a disability income policy to help offset the extra expense of replacing the disabled employee and paying continuing compensation during the disability period.

When a key employee is disabled the loss is experienced in two ways.

- The first is the loss of profits that would have been attributed to the key employee.
- Second is the cost associated with finding a replacement.

The business is the owner of the policy and pays its premiums.

- The policy pays a monthly benefit to the business in order to cover the expenses for additional help or outside services when the essential person becomes disabled.
- The key person could be a partner, working stockholder, or an individual who performs a vital management function for the company, such as a sales or operations manager.

The key person's financial value to the business is determined according to the potential loss of business income which could occur because of the individual's incapacity, as well as the expense of hiring and training a replacement.

This value then becomes the disability benefit amount that would be paid to the business. The benefit can be paid in a lump sum or in monthly installments. The benefit period may be from one- to two years, with an *elimination period* of thirty- to ninety days generally being applied.

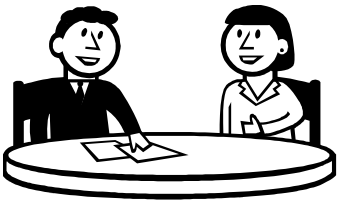
Ownership and Beneficiary Provisions

All companies have key employees but the start-up company more than any other relies on the abilities and skills of a select number of people.

- Based on their past achievements these business executives, salespeople and scientists, etc., bring and instant credibility to a newly founded company.
- These individuals may possess special abilities to raise capital, have established key relationships with suppliers and vendors, hold a technical expertise that is very rare or own an extraordinary track record of past sales.
- **Whatever the specific case, a start-up company's most valuable asset is likely its key employee(s).**

In a start-up company, the death or disability of a key employee will result in significant financial hardship and in many cases business failure.

Therefore, having key man disability insurance on their key people is critical to protecting a company from a potential catastrophic loss. The costs to secure key man insurance are negligible when compared to the economic loss caused by the demise of a company.



Buy and Sell Disability Insurance

A buy-sell agreement is a plan that provides for an orderly change of ownership when a business partner or stockholder in a closely held corporation dies or becomes disabled.

A funded buy-sell agreement can solve many of the problems arising at death or disability of a business owner such as:

- **Predetermine the price** at which the business agrees to buy, and the business owners agree to sell, their interests in the business;
- **Create a market** for each owner's business interest;
- **Establish a value** of each owner's business interest for federal estate tax purposes;
- **Assure creditors and employees** of the continuation of the business in the event of an owner's death or disability;
- **Provide continuous income** to a disabled business owner without adversely affecting the business' working capital; and
- **Provide money to fund the plan** at exactly the time that it is needed

The disability of a shareholder or partner who has been active in the business may trigger a buyout. The agreement would define "disability" and the means of determining the disability.

Disability Buyout Policies

Businesses often use a buy-sell agreement funded with life insurance to buy out the interest of a deceased owner or partner. Such agreements usually also contain a provision for the buyout of the owner's interest in the event of his or her disability. Naturally, this disability provision is funded with *buy-sell disability income insurance*. The business usually owns and pays the premiums for these policies.

One of the most important factors that a company must consider when implementing this type of policy is its elimination period.

Once the elimination period is satisfied, benefits payments are made to the company for the purpose of buying out the interest of the disabled owner or partner.

- Once the buyout process begins, it generally cannot be stopped.

- For this reason **the company does not want to buy out the disabled partner's interest too soon** for fear of the possibility that a recovery from the disability would leave the individual with no job and no business interest.

- **Therefore, elimination periods for disability buy-sell insurance normally run from one- to two years.**

The value – or a method of determining the value – of the partner's business interest is specified in the buy-sell agreement.

- This value is paid to the business following the elimination period.
- As with key person disability, benefits are payable in either a single lump sum or monthly installments.
- If the policy pays a monthly benefit, the payment period usually will not exceed five years.
- The company uses the proceeds of the policy to buy out the interest of the disabled person

Disability buy-out insurance is designed to provide the funds needed to purchase a disabled owner or partner's interest in the business if they become disabled.

- Disability buy-out insurance should be made part of any business continuation plan or business succession plan as it will assure that the disabled business owner receives a fair market value for his or her interest in the business.
- At the same time, it will protect all business owners from the threat that a disability may impose on the company by allowing them to buy-out the disabled owner's interest at an agreed upon price set forth in a buy-sell agreement.

In the event of a disability, there is a "waiting period" called the elimination period that must be satisfied before benefits are paid.

- The elimination period, selected at the time of application, begins at the date of initial disability and can extend out 12, 18 or 24 months depending on the terms of the buy-sell agreement and the needs of the business. The longer the elimination period, the lower the cost of the coverage will be.
- With a disability buy-out, once the elimination period is met, benefits begin and there is no need to confirm continual disability. Once a claim starts, the terms of the buy-sell agreement will be fulfilled and the policy will pay benefits accordingly.
- There are several benefit payment options including a lump-sum payment or scheduled payments over the course of two, three or five years. A buy-out policy can be custom designed to meet the specific needs of each company.

A disability claim buyout involves a lump-sum dollar amount paid by the insurance company to a claimant in lieu of the continuation of a monthly benefit. Since a large sum of money may be involved, it is suggested that the claimant seek advice from an individual experienced in negotiating disability buyouts.

Before a disability buy-out policy can be purchased, the business must be properly valued and a buy-sell agreement must be executed. Once a fair market value for the business has been determined, a sales price can be agreed upon and a disability buy-out policy can be purchased on the life of each business owner or partner to provide the needed funds in the event he or she becomes disabled.

Taxation of Disability Buy-Sell Plans

The premium payments for disability buy-sell policies are NOT tax deductible.

- Therefore, the **benefits received are income tax free**.
- Depending on the type of entity, corporation or partnership, the recipient of the benefits **may be subject to** capital gains taxes, gift taxes or if the company receives the proceeds to disburse, be subject to the Alternative Minimum Tax.

TRENDS IN LONG-TERM CARE INSURANCE

Chapter 6
Long-Term
Care Insurance ~ I

Even though Long Term Care Insurance is considered a form of health insurance, **the coverage it provides is completely different from that of a traditional health insurance plan.** Long-term care insurance provides financial protection from long-term illness by paying the costs for long-term care in a nursing home or in one own home.

Before the insurance professional can answer "what is long-term care insurance" and "who needs it?", he needs to answer the questions:

- **What is long-term care?**
- **Whose problem is it?**

LONG-TERM CARE is EVERYBODY'S issue.

Understanding Long-Term Care

Long-term care is designed to assist with a **broad range of medical, social and personal services,** for those **unable to perform certain activities** of daily living over an extended period of time, due to a cognitive or physical impairment.

Services can be provided in various settings, including nursing homes, assisted living facilities, or in one's own home.

- Many older people and their families are not prepared when the older person develops a need for ongoing care.
- The older person can become disabled suddenly, as in the case of a stroke, or gradually need more and more care, as in the case of Alzheimer's disease.

- Both situations call for major adjustments in the lives of the older person and the people around him or her.
- Many times the older person is still independent but requires some level of help to remain that way.

It is important to keep in mind that long-term care does not necessarily mean nursing home care.

- In fact, that is only the most intense, and expensive, level of support for an older person.
- **Long-term care is any kind of care that helps an older person who can no longer lead a completely independent life**.
- Depending upon the degree and the kind of help needed such as medical attention or help with bathing and eating, long-term care can mean part-time home care, a residential care facility, or anything in between.

Any chronic or disabling condition, which requires nursing care or constant supervision, can bring on the need for long-term care services. Long-term care means not only care in a nursing home, it can also mean nursing care in one's own home and help with the activities of daily living, such as dressing, eating, bathing and taking medicine.

Levels of Care

Custodial Care ~ This care is for individuals needing help with ADLs. This type of care is typically provided in the home or a combination of the home and community-based facilities like an adult day care center. A home health care provider, friends, relatives and adult day care facilities could provide custodial care.

Intermediate Care ~ When skilled care is needed part-time on a regular basis, it is referred to as intermediate care. An individual recovering from a critical illness would need an intermediate level of care. He might not need around-the-clock skilled care, but still require some intermittent skilled care from nurses or licensed therapists. An individual with a degenerative condition may at first only require intermediate care, but as their condition worsens, may end up requiring full-time skilled care.

Skilled Care ~ Skilled care encompasses nursing care, therapy or rehabilitation, performed by or under the supervision of medical professionals such as a registered

nurse, licensed practical nurse or licensed therapist. Depending on an individual's needs, skilled care may be required on a full-time or part-time basis.

Within these groups of caregivers are **two main categories**, skilled nursing care and non-skilled nursing care.

- Skilled nursing care is usually a 24-hour supervised type of care by trained personnel.
- Non-skilled nursing care encompasses a degree of nursing care but does not require the continuous supervision by trained personnel.

Providers of Long-Term Care

When an elderly person cannot live independently and needs 24-hour nursing care and/or supervision, **a skilled nursing facility (SNF) is usually the answer.**

- SNFs offer personal, dietary, therapeutic, social, and recreational services, as well as medical care.
- Nursing care facilities provide care for individuals who need nursing care on a regular basis, but who do not need to be hospitalized.
- Their care is administered by nursing professionals under the direction of a physician.
- Many nursing care facilities offer short-term or respite care for rehabilitation and other short-term services.
- The requirements for operation of these facilities may include licensure by the state, Medicare certification, medical records maintenance, a minimum number of beds, and an on-duty physician and/or a registered nurse.

Though many seniors receive care in nursing homes**, home health care alternatives are growing in popularity**. One national study revealed that of those who live to age 65, one in four will spend one year or more in a nursing home and one in eleven will spend five years or more in a nursing home. Based on this study, it is likely that many more will need some type of home health care.

The range of accepted providers is broad. Some are preferred because they are less expensive and may provide more comfort and security to the individual patient. All have advantages and disadvantages. They include the following:

- Rehabilitation facilities.

- Adult day care.
- Home health care.
- Home visitor services.
- Informal care at home.
- Residential care facilities for the elderly.
- Congregate housing.
- Retirement housing.
- Assisted living centers.

Who Needs Long-Term Care

- Special needs children and adults.
- Children and adults who have suffered disabling personal injuries.
- Individuals with mental illness.
- Individuals with progressive disabling conditions.
- Individuals and couples facing long-term care.

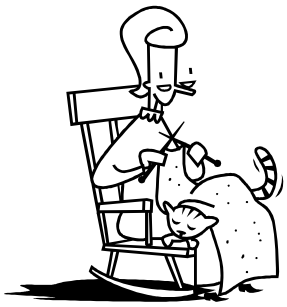
Whose Problem is It?

Long-term care is not a senior issue. It is a multi-generation, individual, family, public policy, *and* workplace issue. **By 2010 almost half of the U.S. workforce**, many of them people in their 40s and 50s, **will be involved in caring for an elderly parent**, with an associated cost of between $1,100 and $2,500 per employee from:

- ✓ Reduced productivity.
- ✓ Lost work time.
- ✓ Extra time off.
- ✓ Stress-related illnesses.

The insurance professional needs to have **a clear understanding of the issues and trends in long-term care** so that he can offer **meaningful solutions** to his clients.

The value of long-term care planning goes beyond individuals. **Long-term care is *everybody's* issue.** Some experts believe that long-term care will become a national crisis in the future.



The Aging of America

We know that **people today are living longer than members of any previous generation** and, as a result, are more likely to experience illness and frailty requiring some form of long-term care.

Studies show that possibly as many as **half of all Americans now in their fifties will need long-term care in their lifetime.** The U.S. Bureau of the Census estimates that **by 2060 as many as 24 million people will need long-term care services.**

In addition, many people are **touched daily by the long-term care issue**, confronted with the challenges and costs of meeting the needs of aging parents, in-laws, and other elderly relatives.

The Baby Boomers

In 2011 the first wave of the Baby Boomers will turn 65, and by 2021 they will be turning 75. Without a doubt, aging baby boomers will have a great impact on demand for long-term care services throughout the country.

In addition to their enormous numbers, there are several demographic trends unique to this group that will affect demand for both publicly and privately financed long-term care services and pose new challenges for the formal long-term care system.

Boomers, on average, have fewer children than their parents. This situation, combined with boomers having higher divorce rates than their parents, our highly mobile society, and the fact that more boomers are remaining single, **is likely to affect the extent to which boomers will have family available to provide the majority of care they need.**

It is also important to note, however, that remarriage rates among divorced boomers will also mean boomers will have more stepchildren and step-grandchildren as part of their

families. While this now common family dynamic could possibly broaden the potential pool of family caregivers, **only time will tell whether these family relationships will translate into willing and available caregivers.**

The comparatively high divorce rate among boomers could also have a negative impact on older boomer women, in particular, in terms of their financial stability and security. Only 40% of boomers may have pensions of their own. This situation combined with an extraordinarily low national savings rate has implications for the ability of many boomers to be financially positioned for their retirement years, never mind positioned to pay privately for their long-term care needs.

Because of Medicare, very few older adults are without health insurance coverage. Older adults rely heavily on Medicare for their health care coverage. Although Medicare covers a limited amount of home health and nursing home care following an acute care episode, **Medicare does not cover on-going long-term care.**

Few Baby Boomers understand what sort of long-term care they might need and who will pay for it. Even those that understand how the system works today probably have not considered what it may look like when they need it, a critical issue when deciding whether to buy long-term care insurance or set up a savings plan to pay for these costs.

Even though there are many things about the future that may be uncertain, there are some facts that we need to face.

- The number of people who will need care will explode as the Baby Boomer generation ages.
- The number of people who are working and paying taxes to pay for Medicaid and Medicare will decline, relative to the older population, so the pool of money that will be available for Medicaid long-term care will rise at a far slower rate than the increase in the older population.
- Many people who do have savings will exhaust most of their funds before they get to a nursing home, and most nursing homes will have 90-100% of their residents dependent on Medicaid, reducing the financial viability of the industry.

As a result of these facts, the government will probably be forced to greatly restrict and reduce the amount of money it reimburses providers for each Medicaid long-term care recipient.

- Long-term care providers will have to develop a strategy to operate with a growing percentage of Medicaid recipients and a sharply declining Medicaid reimbursement rate.
- Nursing home operators will divide into two groups: Medicaid-only and non-Medicaid.
- The Medicaid-only facilities will most likely shave every possible cost and find ways to provide only the bare minimum of services in a very cost-efficient operation.
- Although they will attempt to attract private pay residents, people with resources will not be attracted to their poorly maintained buildings and low service levels.
- Non-Medicaid facilities will accept only those who have the funds to pay for the cost of their care, providing a quality facility and a level of service commensurate with the amount the resident is willing and able to pay, and these facilities will become the facilities of choice for those who have the means to afford them.

Most likely any attempt to make long-term care costs universally available at taxpayer cost **will not happen when the costs are calculated**, since neither the federal nor the state governments **could possibly afford to provide a comprehensive long-term care benefit to the huge numbers of Baby Boomers that will be entering the system.**

Medicaid will be available as a safety net when everything else is exhausted, but it will probably involve forfeiting any inheritance that would otherwise be left to other family members, may require supplementation from family members, and will probably leave the spouse with very limited financial resources. Medicaid recipients will have a limited ability to control where they receive services and what services are available to them.

People who are able to pay for their care with savings or insurance will have the easiest access to services and the most ability to control what kind of care they receive and where they receive it, regardless of what happens to government reimbursement programs. They will be highly attractive to service providers who are likely to compete strongly for their attention.

After looking into the future it would seem that Baby Boomers should be saving and investing enough to be able to pay privately for whatever long-term care they may need, and they probably need to investigate buying long-term care insurance to supplement those investments to ensure they are able to avoid dependence on government long-term care programs.

The Sandwich Generation

Technology and the American culture have created a new generation, known as the Sandwich Generation. **They are the working parents who are caught between the needs of their children and the growing and ever expanding needs of their older adult relatives**. The childhood diseases that used to kill many infants have been virtually wiped out. Where the average life span used to be barely fifty, the fastest growing segment of our society is now the group over 85. The aging individuals who may have escaped an early death by measles and mumps are now experiencing the chronic diseases of old age like arthritis, heart disease and Alzheimer's.

Although they are living longer, old people need some assistance with activities of daily living to get through their day.

- This assistance usually comes from family members. **A startling statistic from a study from the U.S. House of Representatives is that the average woman spends seventeen years caring for her dependent child and eighteen years caring for her elderly parents**.
- For the first time in history, Americans have more parents than children and are experiencing the building pressures of having to care for this growing group of dependent relatives.

While these elderly relatives demand more and more help, **their main caregivers-women-have gone to work.**

- Throughout history, women have been the caretakers of both the old and the young. In the 1960's more and more women began entering the work force. This was a result of the women's movement and the need for the two-income family in order to meet expenses.
- **When women went back to work both children and older adults were left in need of care**. A result of this has been the growth of day care for children and adults. There has also been an expansion of in-home care for children and in-home care providers for adults.

The mobility of the American family has been another factor contributing to the sandwich generation.

- Families used to live next door to each other. In the past fifty years, Americans have increasingly migrated away from their hometowns.

- This migration of relatives has left the elderly without the caregivers who used to live next door to them. One third of adult children live more than sixty miles away from their aging parents.
- This not only leaves elderly relatives without their family supports, but has also **created a whole new species of caregivers-the long distance care provider.**

The sandwich generation's problems extend to the workplace. Studies have found that 57% of all managers took time off for care giving responsibilities, 40% of all caregivers were absent at least once in a two-month period due to eldercare responsibilities, and 9%-28% quit work, retired early or took an extended leave of absence in order to care for an elderly relative. **The future forebodes even more stresses for the sandwich generation such as:**

- More women working.
- More aging relatives.
- More daughters and sons living far away.
- More problems to solve for younger family members.

These trends are accelerated by the growing crisis in American schools, single parenting and the escalation of divorce.

The Elder Generation

Many social policy analysts consider **the coming explosion of the elderly in America the equivalent of a new tidal wave of immigrants**, with the power to **forever change the social and cultural landscape**.

Consider that each day:

- Three thousand people turn sixty-five.
- Only two thousand over that age die making a net daily gain of 1000 elder persons.
- In the next twenty years the sixty-five-plus population in America will grow by 71%, more than twice the growth rate of the general population.
- By the year 2020, one out of every six Americans will be over sixty-five.

A recent study in The New England Journal of Medicine states that the United States may be the healthiest place on earth for old people. The report found that Americans who reach age eighty could expect to live about a year longer than the elderly in four

other industrialized countries. The results were totally unexpected, since the United States trails many other countries in life expectancy measured from birth.

One probable explanation for older Americans' longevity is the quality and availability of their health care. Americans on Medicare get virtually any care they need, which can include new knees, coronary bypass surgery, transplants, whatever- without long waits. Other countries hold down costs by limiting the availability of expensive services and requiring patients to wait, sometimes for many months.

The other major factor is that a generation that has devoted itself to eating right and keeping fit has a far better chance of becoming centenarians than those who by circumstance or decision eat poorly and get little or no exercise. Thus, longevity may well be determined as much by our own desires as by our genealogy.

Regardless of age or health, there is a substantial likelihood that one will need term care services at some point during his lifetime. Even people who take great care to ensure a financially secure retirement **fail to appreciate the value of planning for long-term care expenses**.

Many do not realize that the potential need for long-term care may be their GREATEST financial risk.

- Paying for services is a financial burden on families and public health care programs.
- On average, nursing home care currently costs $50,000 annually, with many nursing home residents paying much of that out of their own pockets.
- A recent study predicts that these costs will more than quadruple by 2030.

Medicaid, the primary government source for long-term care financing, is a welfare program. One must have limited resources to qualify or, like most, he must spend down his assets while in a nursing facility. Medicare pays limited amounts for skilled nursing care provided under strict guidelines while one's condition is improving. The bulk of long-term care services, custodial and unskilled care, are not covered.

An individual can also pay for his long-term care from his own savings. However, most financially wise people choose the peace of mind that comes with shifting this risk to an insurance company.

Long-Term Care and the Family

An estimated 22.4 million U.S. households are providing informal and often unpaid care to a friend or relative over age 50. Unfortunately, the expense of a nursing home is something that often must be planned for. Many nursing homes can cost as much as $50,000 annually, and most health insurance companies do not cover this cost.

Care giving may be one of the most important roles one will undertake in a lifetime.

- It is not an easy role, nor is it one for which many are prepared.
- If the caregiver has a job, and is juggling several responsibilities, he may need additional help with care giving.
- **Care giving takes time, effort, and work**. It challenges the caregiver intellectually and emotionally, teaches him flexibility and strengthens his problem solving abilities.
- Care giving can be very satisfying, even when those being cared for are not able to improve, because the care giver's efforts are enhancing the life of someone that he cares so much about, someone he loves.

The result for some caregivers is a personal crisis. Every time there is a new need, they just volunteer. **The crisis can jeopardize one's family, his work, and the well-being of his loved one.**

The caregiver must admit the reality of his new responsibility.

- The admission means he is not going to accept a new, major role unprepared. Like a new parent, he can begin to learn.
- Aging is a continuing process. There are transitions, changes and challenges that commonly occur. The caregiver can learn about aging, eldercare, care giving and aging services. He can anticipate changes and help loved ones plan ahead.

The caregiver cannot halt the changes that the years will bring. Aging successfully means accepting change, compensating, and continuing to live well. The caregiver can learn to help older persons **manage change**, compensate, and age more successfully.

One of the dynamics causing major changes in the American culture is the mobility of our citizens. No longer do children marry and build a home within five miles of mom and dad, or even next door**.**

- In today's mobile society, most adult children and their aging parents move at some time or other. It is not uncommon to find older relatives living a great distance from family members involved in their care.
- For many, career objectives have them packing-up and moving-out. Others want to escape the unfortunate circumstances of their childhoods. Some people settle down wherever they meet their mates.
- Whatever the reason - business, pleasure, or necessity - adult children of aging parents often live far away from them.

As a mobile society ages, **long-distance care giving is becoming more common**.

- Just when careers peak and parenting duties dwindle, just when life is supposed to get easier, people find themselves scrambling to meet obligations to parents, spouses and jobs.
- Something as seemingly simple as figuring out who handles Medicaid or Medicare in another state can take several long-distance calls. Hiring trustworthy help from a distance is very difficult.
- The stresses, frustrations and responsibilities involved in providing long-distance care for an older family member are different from those encountered when that relative lives in one's home or in his community.
- Long-distance caregivers are unfamiliar with the programs, services and resources in the area where their relative lives. Consequently, they are dependent on others-friends, neighbors, and the religious community who live where their older relatives reside, to provide information, help and assistance.
- A crisis or a new or changing situation may cause the long-distance caregiver to become much more involved, whether or not he is ready to assume the responsibilities of providing long-distance care. At one time one was able to listen to his relative's own reports concerning his or her health situation and general state of affairs. Now he might need to speak directly with the doctors and others concerned with their care.

Care giving efforts will vary depending on the circumstances. Regardless of the extent of the caregiver's involvement, it is very important to be realistic about how much he can do.

The greater his involvement, the greater the impact will be on other aspects of his life. He should not hesitate to enlist the advice and support of other family members, friends, support groups, and the religious community. Professional counselors should be considered to help as the demands of long distance care giving increase. The caregiver

will need to reassess his commitment at various times so that he does not feel locked into a situation that has become impossible for him to cope with.

Whenever an elderly person's health, safety or well-being becomes a concern, it is important to be proactive and address his issues. If the issues come to a point of crisis, families need to call themselves together to discuss the changes which are occurring and that will occur in the future.

Long-Term Care and the Employer

With five million working age Americans receiving long-term care and another fourteen million providing it to elder friends or loved ones, **employers cannot afford to deny the implications of long-term care giving.**

- Care giving responsibilities handled from the workplace cost US business as much $29 billion each year.
- Companies that do not offer practical, easily put-into-practice assistance to their employees may be risking future profits.

Most employers often fail to realize the hidden risks and costs associated with eldercare that are caused by employees being pulled away from their work responsibilities to care for an elder friend or loved one.

Of those receiving long-term care services, 40% or around five million are working age Americans. In addition, one in five people over the age of fifty are at risk of needing long-term care within the next twelve months. What most employers often fail to realize, however, are the hidden risks and costs associated with eldercare that are caused by employees being pulled away from their work responsibilities to care for an elder friend or loved one.

As the population ages, **a growing number of individuals must take time off from work to care for their older relatives.** Increasingly, businesses are shouldering the cost of this trend.

The care giving responsibilities of employees contribute to:

- Absenteeism.
- Workday interruptions.
- The replacement of trained employees (turnover).
- Increased supervisory involvement.

A preoccupied employee means wasted time and reduced productivity, and **when employees are not productive, the employer loses money.** Conservative estimates put the cost of this lost productivity to U.S. businesses at $11.4 billion per year. An employee with eldercare responsibilities costs his or her employer over $3,000 extra a year. Other consequences include high employee turnover, chronic absenteeism and even accidents on the job.

By 2020, one in three workers will provide some type of eldercare.

- 12% of workers balance eldercare responsibilities and full time employment.
- 10% of all caregivers quit their jobs.
- 11% of all caregivers take leaves of absences.
- 59% of all caregivers miss some work.

Many companies have found they can take a proactive stance to support their employees with care giving responsibilities, and keep the cost of this trend in check. They can do this by helping caregivers find the resources they need to assist their older relatives. **One of the best ways to fully grasp the urgency and magnitude of the emotional, physical and financial cost crisis of long-term care is to consider the facts surrounding it.**

Elder care need not have a negative impact on a business. The business can grow, employees can prosper and the employer can have a comfortable retirement even if he, his employees, or his employees' family members encounter health problems. **But he must have a plan!**

- ✓ The employer's **first step is to determine if long-term care poses a threat to his own retirement dreams.** If so, he will want to lock-in valuable coverage immediately.

- ✓ After he has assessed his own needs, his next step is to **consider the advantages of offering long-term care insurance as a perk to his key executives and as a benefit to his employees.**

The employer has **four options for paying for long-term care:**

- **Do nothing** and hope for the best.
- **Spend down to poverty** and let the government pay his bills through welfare.
- **Self-insure** through personal savings.
- **Transfer the risk** to an insurance company.

As a general rule of thumb, the employer should consider private **long-term care insurance** if his net worth falls between $100,000 and $2 million.

- ✓ For many employers, long-term care coverage is the single most important insurance purchase they can make to ensure a secure, worry-free retirement.
- ✓ If one's net worth is more than $2 million, chances are he could afford the cost of care if he were to need it.
- ✓ Even if he falls into this category, he may wish to consider "an asset-based solution" or the attractive tax advantages of securing traditional coverage.

National Crisis

Long-term care may, indeed, be our next national crisis, if for no other reason than because there is still much confusion about what it is. Long-term care is:

- Family-provided assistance.
- Self-insurance through savings or investment.
- A private insurance policy purchased either individually or, through an employer.

Sometimes it is a combination of all of these options. Long-term care is not a Federal government program, although the government currently plays a role in shaping Americans' views of long-term care and may play an even bigger role in encouraging preparedness for long-term care in the future.

While different solutions may emerge in the future, the current most practical solution for many middle-class Americans is private **long-term care insurance**.

Understanding Long-Term Care Insurance

Long-term care (LTC) insurance is defined as coverage available on an individual or group basis to provide medical and other services to patients who need constant care in their own home or in a nursing home.

Long-term care provides a wide range of services for people with a prolonged physical illness, disability or cognitive disorder, such as dementia or Alzheimer's Disease**. Long-term care is designed to help people with chronic conditions compensate for their inability to function independently in their lives.**

Consequently, long-term care insurance is different from major medical insurance.

- ∇ Long-term care insurance **serves to maintain** the individual's level of functioning.
- ∇ Medical insurance coverage which provides services meant **to rehabilitate** an individual or to correct a particular medical problem.

The services provided by long-term care insurance include, but are not limited to:

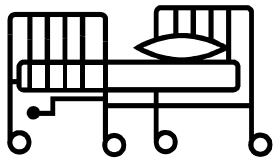
- **In-home help with daily living activities**, such as bathing and dressing.
- **Respite care** to allow individuals who are the primary caregivers for individuals with chronic conditions to spend time away from their care giving chores, to rejuvenate themselves, so they can continue their care giving without their own health suffering as well.
- **Home health care,** under which all required care is provided in the insured's home environment.
- **Adult day care**, under which required services can be provided during the day at a facility specifically designed for this purpose.
- **Nursing home care**.

Another way to describe the services provided by long-term care insurance is to divide them into **two types of care:**

- **Skilled care**, which must generally be provided by medically skilled and/or licensed individuals.

- **Personal care**, which is also often called custodial care, which is designed to help the insured perform activities of daily living, which generally include bathing, eating, dressing, toileting, continence and transferring.

Recognizing the Need



Studies tell us that:

- 40% of people age 60 or older will at some time need these long-term care services.
- 80% of those needing long-term care services receive that care in their own homes.
- 90% of this home care is provided, at substantial personal cost and stress in their own lives, by family or friends.
- About 20% of these individuals will require nursing home care for more than a short stay.
- The average long-term care nursing home stay is 30 months.

Overall demand for LTC is expected to expand massively as the number of US residents over age 85 -- who are most likely to need LTC -- is projected to rise from 5.3 million (in 2006) to **20.9 million in 2050**.

As the costs for all forms of health care continue to rise, the national expenditures for the year 2030 are predicted as follows:

- Home and community-based long-term care costs are expected to more than quadruple **from $41 billion today to approximately $193 billion by the year 2030.**
- Total national expenditures for nursing home care could reach $330 billion. That would be equal to today's entire Social Security budget!

With these predictions, the breakdown costs in 2030 for the following would be:

- Adult daycare = up to $220 per day.
- Assistance by a home health aide = up to $260 per visit.
- Assisted living facility = up to $300 per day ($109,300 per year).
- Nursing home care = over $500 per day ($190,600 per year).

Policy Features

Benefit Period

A benefit period may range from two years to lifetime. A person can keep premiums down by electing coverage for three to four years—longer than the average nursing home stay—instead of lifetime.

Elimination Period

Long-term care policies typically include "elimination periods" or "waiting periods" which are stated in numbers of days. This is a period that begins when a person first needs long-term care and lasts as long as the policy provides.

- During the waiting period, the policy will not pay benefits.
- If a person recovers before the waiting period ends, the policy doesn't pay for expenses he incurred during the waiting period.
- The policy pays only for expenses that occur after the waiting period is over, if he continues to need care.

Similar to a deductible, **an elimination period is the number of days between the beginning of qualified care and the time the company begins paying daily benefits**. It is a time frame in which the insured is self-insured and personally responsible for the claim.

- This "time deductible'" must be satisfied before any benefits will be paid. These elimination periods can be days numbering anywhere from zero to 180 days, often with selections of 20, 30, 90, 100, and 180 days. The most common selections are numbered 100 days or less.
- The number of days selected has a direct impact on the policy premium. The longer the elimination period, the lower the premium will be. However, longer elimination periods and lower premiums may mean greater potential for out-of-pocket costs.
- Once the elimination period requirement has been met, the next time frame to consider is the benefit period--the length of time that benefits will be payable. Most insurers will offer benefit periods of two to six years. The longer the benefit period selected, the higher the premium.

There are two types of benefit periods available, the traditional benefit period and the lifetime benefit period.

Traditional Benefit Period

The traditional benefit period is set up where policy benefits can be paid within a specified number of months or years. Typical examples are one, two, three, four, five, and six years. The latest nursing home surveys and individual state surveys show that about 20% of nursing home patients at any given time have been there longer than five years.

Lifetime Benefit Period

A popular benefit period, despite its higher cost, is the unlimited or "lifetime" benefit period. This policy will cover the costs of care as long as the insured needs covered long-term care services. **Though some would say that this is very expensive and not affordable, there are several considerations for selecting a lifetime benefit.**

- The need for long-term care for younger people can be due to many factors; for example, trauma from accident, debilitating diseases such as multiple sclerosis or muscular dystrophy, mental incapacities, and strokes.
- One-third of all stroke victims are under the age of sixty-five.
- Cognitive impairment can begin early and continue for years. The span of Alzheimer's disease can be anywhere from 3 years to 20 years.

Taking an average care cost of $50,000 per year and adding an inflation rate of 5%, compounded, the total cost would be just over $1 million for 20 years of care. **The potential return might justify the extra 35% in premium if the client can afford it.**

The lifetime benefit period is not measured in time increments, but in dollars. This is a "pool of money" plan and is a concept that is gaining a reputation among insurers, agents, and consumers.

The pool of money concept just means that any difference between the cost of care and the daily benefit selected remains in the pool and can extend the benefit period chosen. These benefits for long-term care services are paid from a single lifetime maximum number of dollars and are payable for as long as the maximum amount lasts. This concept certainly is suitable for SNF policies as well as for policies that cover home- and community-based care.

Indemnity vs. Reimbursement

There are two methods of paying a claimant the benefit amount:

- **Indemnity -** The benefit in this method is a set dollar amount and one in which the insurance company pays benefits in the amount specified in the policy directly to the patient, regardless of the actual amount of the costs for services. For example, if the policy has $150 daily benefit and the actual charge is $120, the policy will pay $150 even though the benefit payment exceeds the charge.

- **Reimbursement** - This method is one in which the client submits claims that the insurance company pays either to the patient or to the provider for the actual expenses charged, up to the limits contained in the policy. Using the example above, a reimbursement policy would pay no more than $120, which is the actual charge. The company will pay benefits only for services covered in the policy. This is the most common method for payment of benefits in policies bought today.

Companies using the reimbursement method may apply a weekly or monthly limit. Weekly and monthly limits provide the greatest flexibility for the insured because there is no limitation to the specific amount per day. The entire weekly or monthly benefit could be used, as needed, for day-to-day expenses as long as the total amount used does not exceed the weekly or monthly benefit amount. This is of particular importance when home health care is the type of service needed.

For example, election of a benefit amount under the reimbursement method will be based on the average cost of nursing facilities in the client's area. These costs and the benefits to be paid will be based on room and board fees of nursing home facilities. Sometimes there is no consideration made for additional needs. Things like prescription drugs, personal hygiene items, and other miscellaneous supplies could add as much as 20% to the room and board rate resulting in significant out-of-pocket expenses for the client. **These factors should be considered when selecting the benefit amount.**

Policy Limits

Long-term care policies have a total maximum benefit they will pay out over the life of the policy. The maximum benefit limit is expressed in terms such as "total lifetime

benefit," "maximum lifetime benefit," and "total plan benefit." Some plans offer unlimited lifetime benefits.

Policy limits are classified by the following benefits:

Maximum facility daily benefit – The maximum daily benefit is the maximum benefit allowed per day. The maximum daily benefit may not exceed the daily rate actually charged for the care received in an SNF or alternate facility. Maximum daily benefits for facilities range from $40 to $300 per day.

- *Maximum home and community-based care daily benefit* **– The maximum benefit for home and community-based care is usually** established as a percentage of the maximum facility daily benefit typically, 50%, 75%, or 100%.

- *Maximum lifetime benefit* **– The maximum lifetime** benefit is the amount of benefits that will be paid during the insured's lifetime. This benefit limit applies to any combination of long-term care services for which a benefit is paid under the policy.

- *Maximum monthly benefit* – The maximum monthly benefit is the maximum allowed during a given month for any combination of home care, home health care, and adult daycare. The maximum monthly benefit may not exceed the actual charges for all covered services received during the month.

Inflation Protection

Inflation protection is an important feature, especially if a person is under 65, when he buys benefits that he may not use for 20 years or more. A good inflation provision compounds benefits at 5% a year. Without inflation protection, even 3 annual inflations will, over 24 years, reduce the purchasing power of a $150 daily benefit to the equivalent of $75.

Inflation protection in a long-term care policy is offered on a periodic, simple, or compound basis. An inflation rate compounded at 5% per year beginning the year after the policy is purchased is beneficial for younger buyers. Simple inflation adjustments of 5% annually may be appropriate for buyers in their 70s.

These accounts assume that the adjustments are made in advance, not at the time the benefits are used. The following illustrate the ways in which various inflation adjustments are made.

- **Periodic inflation adjustment** – Under the terms of this option, every number of years specified in the policy, typically two to five, the policyholder will be offered the opportunity to increase the policy's benefits. If the policyholder accepts the offer, the daily maximum benefit increases by at least the percentage specified such as 5%.

- **Simple inflation adjustment** – **When a policyholder chooses a simple inflation adjustment,** benefits automatically increase annually on the anniversary date of the policy. The amount of the increase will equal a specified percentage, perhaps 5%, of the original daily or monthly maximum benefit selected. The adjusted benefit does not take into consideration compounding. **Some states do not permit insurers to offer the simple inflation protection option**

- **Compounded inflation adjustment** – Under the compounded inflation adjustment, benefits automatically increase annually on the anniversary date of the policy and the benefit adjustment takes into consideration a compounded calculation. The increase will equal the specified percentage of the current daily or monthly maximum benefit in effect.

An average investment return of 10% barely keeps up with the rapidly rising cost of care. Financial advisers sometimes suggest beginning younger long-term care clients with about $30 more daily benefit than the actual cost in the area in which the client lives. This will compensate for any deficit in the 5% inflation rate.

Free Look Period

Long-term care policies, like all insurance policies, must provide a "free look" period. The free look period is the time during which the policyholder may return the policy, if not completely satisfied with the contract, and receive a complete refund. The free look period allows the policyholder to review the policy. In order to receive a refund of any premiums paid, the policy must be returned before the free look period expires. Typically, a free look period is 30 days for policies purchased through the mail and 10 days for policies purchased from an agent.

Guaranteed Renewability

"Guaranteed renewability" means that an insurance policy cannot be canceled, terminated, changed, or have its coverage decreased if all renewal premiums are paid on time. The insurer cannot take into consideration the insured's state of health, claims history, or any other factor and use this information to alter coverage. All long-term care policies must be renewable for life.

Of course, guaranteed renewability for life does not guarantee that premiums will not increase. The insurer is entitled, with approval from the state, to raise premium rates on a class-wide basis. This means an approved increase will apply to every policyholder in a certain category; for example, insureds who have reached a certain age.

Waiver of Premium

A waiver of premium benefit allows the insurance company to suspend the premium payment requirement while policy benefits are being paid. Electing the waiver of premium benefit prevents the insured from having to make payments during the time he or she is receiving long-term care services. Under most policies, premiums can be waived after 90 days of care.

Third-Party Notification

The third party notice benefit, also known as the "authorized designee" benefit, allows the policyholder to name a third party who will be notified by the insurer that the policy is about to lapse because of nonpayment of the premium. The third party may be a relative, friend, or a professional, such as a lawyer. After receiving notice, the third party has a stated period of time to pay the overdue premium or see that the overdue premium is paid.

The third party notice benefit option is beneficial for those with cognitive impairments who may forget to pay their premiums. With this option, a policy lapse can be prevented. In many policies, there is not an additional charge for this option. In fact, some states require that insurers provide policyholders with the opportunity to name a third party.

Benefit Triggers

Benefit triggers are standards for eligibility that apply before benefits begin.

- The policy may provide that before the insured can receive long-term care benefits, he or she must suffer an impairment of two of the six activities of daily living.
- Some policies require an impairment of three of the listed ADL while others allow qualification for benefits with only one impairment.
- Most policies immediately qualify the insured for benefits due to cognitive impairment, such as Alzheimer's disease.

The types of care and the benefit triggers in the policy will determine whether or not the policy is tax-qualified.

Nonforfeiture Benefits

Many insurance companies offer nonforfeiture options which guarantee benefits equal to the premiums paid, even if the policy lapses. Nonforfeiture provisions protect the policyholder if the policy lapses for some reason after a long period of time. Without the nonforfeiture option, if the policy lapses, all premiums paid into the policy would be given up.

Nonforfeiture options are very popular and also very expensive. It is suggested that if a person purchases a long-term care policy, he or she must be committed to the policy and plan to keep it in force.

Nonforfeiture provisions take several forms.

- **Cash surrender value option** – This option gives the policyholder the option of surrendering the policy for some cash value in the event the policy should lapse.
- **Return of premium option** – This option allows the policyholder to receive some return, expressed as a percentage, of the premiums paid if the policy lapses.
- **Shortened benefit period option** – This option allows the policyholder to shorten the benefit period in order to make up for the premiums missed.

Restoration of Benefits

An optional restoration of benefits feature will bring a policy's maximum benefit amounts back to the level that would apply if the policy had not lapsed. This benefit provides for the maximum amount of the original benefit to be restored even if

the policyholder has previously received benefits through the policy. If the policyholder receives long-term care benefits and then, for a stated period of time, goes without receiving services, the benefit amount reverts to the amount originally purchased.

EXAMPLE

Suppose a policyholder uses $20,000 of his long-term care benefits from a maximum available amount of $100,000. After this initial round of care, he does not require long-term care services for a specified period of time. The $20,000 already used would not affect the maximum amount of benefits available. Instead of having only $80,000 of benefits remaining, the policyholder would still have the original $100,000 benefit available.

Cost-of-Living Adjustment (COLA)

A COLA bumps up the chosen daily benefit each year, usually at a fixed percentage, to keep up with rising health care costs. A $100 daily benefit today, with a 5% annually compounded COLA, would provide $550 in daily benefits in 35 years.

Tax-Qualified vs. Non-Tax-Qualified

A tax-qualified policy is one that conforms to certain standards in Federal law which offer Federal income tax advantages.

The long-term care policies marketed today are either tax-qualified or non-tax-qualified.

Several generations of policies had evolved in the long-term care market when in 1996, after numerous proposals to Congress, legislation was finally passed on the taxability of long-term care insurance. Congress gave the insurance industry everything it had asked for and more - both premium deductibility AND tax-free benefits.

Clarification of Tax Treatment

The Health Insurance Portability and Accountability Act of 1996 made clarification to the following areas of long-term care insurance:

- ∇ Even though subject to limitations, the premiums would be deductible as a medical expense.

- ∇ Also subject to limitations, benefits would be tax-free to the recipient.

- ∇ Employers would be entitled to deduct premiums paid on behalf of an employee, the same as medical insurance.

- ∇ Premiums would not be treated as income to the employee.

In order to determine which long-term care expenses would qualify under this new tax status, these rules were also added:

- ***Per Diem cap*** – A per diem cap is the maximum amount of long-term care expenses that are deductible (measured in "per day" and "per year" amounts).

- ***Cafeteria plan*** – Long-term care benefits are excluded from a Section 125 cafeteria plan.

- ***Medicare coordination*** – Expense-incurred benefits are allowed to coordinate with Medicare in order to avoid duplicate reimbursement. Medicare pays and the policy benefits are reduced accordingly.

- ***Nonforfeiture benefits*** – Plans with this benefit must be offered in order to qualify for favorable tax treatment. Long-term Care is "term" insurance. When payment stops, the policy stops, unless the policy has a nonforfeiture provision. Insurers usually offer three options:

    1. **Cash surrender value option -** The policyholder can surrender the policy for some cash value.

    2. **Return of premium option –** A percentage of the premiums paid is returned to the insured.

    3. **Shortened benefit period** - A reduced maximum benefit is paid based on the amount paid and the period of time the policy is in force.

Requirements for a Tax-Qualified Contract

When HIPAA was first passed in 1996 there was a fairly even split between the purchase of non tax-qualified and tax-qualified policies. Now, four out of every five

policies sold are tax-qualified. More recently, many companies have chosen to offer only the tax-qualified option.

Benefits received from a policy that is a federally tax-qualified policy form are clearly the predominant factor in making a choice in the long-term care marketplace. Policies sold before January 1, 1997 were "grandfathered" in and considered federally tax-qualified policies, regardless of policy language. Policies sold from January 1, 1997 fall under HIPAA and must contain coverage triggers that are described as:

- Inability to perform at least two of the six common activities of daily living (ADL) of bathing, dressing, grooming, toileting, transferring, and eating.
- Requiring assistance due to a cognitive impairment.

HIPAA requires that a licensed health care practitioner perform the assessment and certification of the inability to perform ADL or the existence of cognitive impairment. **HIPAA regulations permit the insurer to select the licensed individual.**

Certification must state that the patient is chronically ill and expects the need for assistance for at least 90 days. These policies must also meet the National Association of Insurance Commissioners consumer protection standards, which include:

- Guaranteed renewable provisions.
- Guaranteed coverage for Alzheimer's disease.
- A six-month limit on exclusions for pre-existing conditions.

A long-term care policy will not be "qualified" if it does not conform to the standards described above.

Policy Riders and Options

Home Health Care Rider

An applicant for long-term care insurance may need to buy a rider to add home health care coverage if it is not part of a basic long-term care policy. With home health care, the insured may be able to avoid going to a nursing home or assisted living facility even if he is no longer able to care for himself.

- Some experts believe that home health care is a core benefit that should be included in every long-term care policy.
- In contrast, some insurers offer home health care coverage only as a **rider** to a nursing home policy.

Nonforfeiture Benefit Rider

Some state insurance regulations often require that long-term care insurers offer nonforfeiture benefit riders. If the applicant is buying a tax-qualified policy, this option must be offered. This rider assures that the insured will not forfeit all of his benefits even if he stops paying premiums before making a claim.

Some experts question the value of nonforfeiture benefit riders for the following reasons:

- The insured may pay more for a policy with this rider.
- It will probably require that the policy be in force for a specified length of time.
- His benefit will be much less than it would be if he had continued paying the premium

Return-of-Premium Rider

A return-of-premium rider is considered to be a type of nonforfeiture benefit. The insured or his estate will be entitled to the return of some or all of his premiums if the policy is not used during his lifetime.

- With this rider, after a specified number of years, the insured can drop the policy altogether and receive some or all of his premiums back.
- The cost of purchasing this rider is significant, according to some experts, and an individual probably earns more by investing the extra premium money himself.

Policy Exclusions

Some of the more common exclusions in policies covering long term care services are:

- Intentionally self-inflicted injuries
- Alcoholism and drug addiction
- Care in government nursing facilities unless a charge is made in which one is obligated to pay
- Coverage while the insured is outside the United States and its possessions

- Mental disease and nervous disorders, other than Alzheimer's
- Addictions to drugs and alcohol
- Injuries and illnesses caused by war
- Treatment paid by the government
- Injuries that are self-inflicted, such as in suicide attempts

Pre-Existing Conditions

Insurance companies issue life and health insurance policies, including long-term care policies, to people who have minor health problems. However, the company may choose not to pay benefits for conditions related to existing health problems or pre-existing conditions for a period of time after the effective date of the policy, typically 6 to 12 months.

A pre-existing condition is generally defined as a condition for which the policyholder has sought medical advice or treatment or had symptoms within a certain period of time before applying for the policy. If a policyholder does not disclose a pre-existing condition at the time of application and that pre-existing condition is later discovered, the insurer may refuse to pay for the treatment related to the condition and may even terminate coverage.

Pre-existing condition definitions and long-term care insurance coverage varies by company.

- Some companies will not provide long-term care coverage at all.
- Others will limit the benefit period.
- Some companies will not provide long-term care insurance coverage for a certain period.

Most insurance companies will not offer long-term care insurance to individuals already inflicted with illnesses such as Alzheimer's disease, Parkinson's disease, multiple sclerosis or AIDS. Walker and wheelchair use will prevent coverage, as well.

Chapter 7
Long-Term Care Insurance ~ II

Medicare

Medicare is government health insurance for people age 65 or older, under age 65 with certain disabilities, and any age with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

The assumption that Medicare will handle a substantial portion of LTC expenses **is based on faulty logic.**

Medicare Part A (Hospital Insurance) helps cover inpatient care in hospitals. Part A also helps cover skilled nursing facility, hospice, and home health care if a person meets certain conditions.

Medicare Part B (Medical Insurance) helps cover medically-necessary services like doctors' services and outpatient care. Part B also helps cover some preventive services to help maintain a person's health and to keep certain illnesses from getting worse.

Medicare Part C (Medicare Advantage Plans) is another way to get Medicare benefits. It combines Part A, Part B, and, sometimes, Part D (prescription drug) coverage. **Medicare Advantage Plans are managed by private insurance companies approved by Medicare**. These plans must cover medically-necessary services. However, **plans can charge different copayments, coinsurance, or deductibles for these services.**

Medicare Part D (Medicare Prescription Drug Coverage) helps cover prescription drugs. This coverage may help lower a person's prescription drug costs and help protect against higher costs in the future.

Medicare Parts A and B were designed to reimburse acute care situations. It was envisioned that this coverage would be available to relatively short hospitalizations with a modest recovery period afterward.

Long-term care implies a longer length of treatment and one in which full recovery or even some improvement may not be realized.

Medicare only covers skilled facility care and up to 100 days of skilled care in a nursing facility if one is admitted after a three-day hospitalization (not required if one is an HMO member) and his physician prescribes skilled care in a treatment plan.

Many people think that Medicare is the primary payor of nursing facility stays, but Medicare accounts for only 9% of nursing facility expenditures.

- ✓ Long-term care is not covered by Medicare.
- ✓ Long-term care insurance also does not replace a person's Medicare coverage.
- ✓ It is important to think about how to get and pay for long-term care before a person needs it. His health status, risk factors, finances, preferences, and family situation affect his costs and coverage.
- ✓ Before he chooses a long-term insurance policy, he, his family, lawyer, financial advisor, and/or insurance agent should consider these factors.

Long-Term Care Providers and Medicare

Skilled Nursing Facilities (SNFs)

Skilled nursing facility sub-acute care units offer a wide variety of medical, rehabilitative, and therapeutic services once provided only by hospitals. Common conditions treated in sub-acute units include brain and spinal cord injuries, neurological and respiratory problems, cancer, stroke, AIDS, and head trauma. Because nursing facility sub-acute care costs are 40% to 60% less than hospital costs, HMOs and other managed care entities have begun moving hospital patients to nursing facilities for sub-acute care.

All nursing facilities are required to provide services to enable the resident to meet the highest practicable level of functioning. Nursing care facilities provide intensive rehabilitative services. These services are designed to enhance the resident's highest functional abilities and encourage discharge to the community at a lower level of care.

Nursing facilities are demonstrating enormous success at providing these services at a lower cost to the consumer.

Skilled Care

Skilled care is health care given when a person needs skilled nursing or rehabilitation staffs to manage, observe, and evaluate his care. Examples of skilled care are changing sterile dressings and physical therapy. **Medicare will only cover skilled care when the patient meets certain conditions.**

- In a SNF (Skilled Nursing Facility) **care that can be given by non-professional staff is not considered skilled care.**

- People do not usually stay in a SNF until they are completely recovered. **Medicare covers certain skilled care services that are needed daily on a short-term basis (up to 100 days).**

- A Skilled Nursing Facility (SNF) could be part of a nursing facility or hospital. **Medicare certifies these facilities** if they have the staff and equipment to give skilled nursing care and/or skilled rehabilitation services and other related health social worker at the services.

- **Skilled care requires the involvement of skilled nursing or rehabilitative staff in order to be given safely and effectively**. Skilled nursing and rehabilitation staff includes registered nurses; licensed practical and vocational nurses; physical and occupational therapists; speech-language pathologists; and audiologists.

If the hospital a patient is in has its own SNF, he may be admitted there if a bed is available. If not, he may need to find an available bed at a separate facility. **Deciding where to get skilled care is an important decision.**

- **If an individual is in the Original Medicare Plan**, he can go to any Medicare-certified SNF if a bed is available.
- **If he is in a Private Fee-for-Service plan**, he can go to any Medicare-certified SNF if a bed is available, but he must let the plan know that he needs SNF care before he is admitted to the SNF.
- **If he does not tell his plan before he is admitted**, he may have to pay more for his SNF care.

- **If an individual is in a Medicare managed care plan**, he may have to get his SNF care from a SNF that belongs to his plan. However, if certain conditions are met, he may be able to get his SNF care from a SNF that does not belong to his plan.
- At his request, his plan may be able to arrange his SNF care from a nursing home or continuing care retirement community (that gives SNF care) where he lived right before he went to the hospital.

Medicare Coverage of Skilled Care

Medicare will cover skilled care only if ALL of the following are true:

- The person has Medicare Part A (Hospital Insurance) and has days left in his benefit period available to use.
- He has a qualifying hospital stay.
- His doctor has decided that he needs daily skilled care.

He can get these skilled services in a SNF that has been certified by Medicare.

Benefit Periods in a SNF

Medicare uses a period of time called a benefit period to keep track of how many days of SNF benefits one uses and how many are still available.

- A benefit period begins on the day he starts using hospital or SNF benefits under Part A of Medicare. He can get up to 100 days of SNF benefits in a benefit period. Once he uses those 100 days, his current benefit period must end before he can renew his SNF benefits.
- An individual's benefit period ends when he has not been in a SNF or a hospital for at least 60 days in a row; or if he remains in a SNF, when he has not received skilled care there for at least 60 days in a row.
- There is no limit to the number of benefit periods one can have.
- Once a benefit period ends, though, he must have another 3-day qualifying hospital stay and meet the Medicare requirements before he can get another 100 days of SNF benefits.

Medicaid

Medicaid is a program funded by both the states and the federal government, but operated by each state individually.

Medicaid was created for the truly poor and not for individuals who have managed to transfer a sufficient amount of their assets in order to qualify “on paper” for Medicaid reimbursement.

Medicaid pays only for covered services performed by a Medicaid-approved provider.

Robert Wood Johnson Foundation (RWJF)

The **Robert Wood Johnson Foundation** is one of the world's biggest philanthropic organizations and the fifth largest in the United States. The foundation is based in Princeton, New Jersey and focuses on improving the health and health care of all Americans. It prioritizes its grants into four goal areas:

- To ensure that all Americans have access to quality health care at reasonable cost.
- To improve the quality of care and support for people with chronic health conditions.
- To promote healthy communities and lifestyles.
- To reduce the personal, social and economic harm caused by substance abuse — tobacco, alcohol, and illicit drugs.

Its interest areas include:

- Addiction prevention and treatment.
- Childhood obesity.
- Quality health care.
- Tobacco use and exposure.
- Nursing.

RWJF and Long-Term Care

Americans are living longer, yet more people can expect to have some sort of disability in their later years of life. Innovative approaches to long-term care, such as re-imagining nursing home care, may improve quality and provide more choices. **Long-term care, which encompasses needs of aging individuals as well as those of younger people with disabilities, is increasingly recognized as one of the most pressing issues facing our nation’s health care system, due to a confluence of factors.**

Many of us have longer life expectancies, largely due to better medical care and technology, healthier lifestyles, and environmental improvements in recent decades. More Americans than ever before can expect to have some sort of disability in their later years of life. As the costs of expenditures for long-term care services continue to rise, policy-makers are seeking innovative approaches to meet increasing demand.

With this challenge in mind, the Robert Wood Johnson Foundation has supported innovative approaches to long-term care reform. For more than 25 years, the Foundation has undertaken efforts to address the health and supportive service needs of older adults and individuals with disabilities of all ages.

Their work has spanned the breadth of long-term care issues, including:

- Expanding Consumer Choice.
- Housing and Service Delivery.
- Caregiving: Direct Care Workforce and Informal Care.
- Financing.
- Quality Improvement.
- Advancing the Long-Term Care Reform Discussion.

As more people live longer with chronic care needs requiring long-term supports and services, it becomes increasingly important to ensure that the nation's long-term care system is appropriately equipped to adapt to this dynamic.

For many of these long-term care programs, the Foundation has conducted third-party evaluations. Through data collection and assessment, innovations that appear to have a positive impact can be replicated, and used as the basis for promoting public policies that may one day improve the quality of care and quality of life for individuals with disabilities of all ages. Some examples of Foundation programs that include an evaluation and public policy assessment are:

- Cash & Counseling
- Independent Choices: Enhancing Consumer Direction for People with Disabilities
- The Green House Project
- Dementia Care and Respite Services
- Medicaid Managed Care

Program to Promote Long-Term Care Insurance for the Elderly

Authorized in 1987, the *Program to Promote Long-Term Care Insurance for the Elderly* (LTCI), a national program of the Robert Wood Johnson Foundation (RWJF), was charged with providing states with resources to plan and implement private/public partnerships (Partnership programs). **The Partnership programs joined private, long-term care insurance with Medicaid to offer high-quality insurance protection against impoverishment from the costs of long-term care — including both nursing home care and/or home care.**

Consumers who purchase such policies are insured for long-term care up to a pre-set dollar level through the private insurer. **Once the private insurance is exhausted, they can continue their long-term care under Medicaid without spending their assets, as is usually required to meet the criteria for Medicaid eligibility**

The key results of this program were:

- By 2000, a total of 104,000 applications had been taken and more than 95,000 had been sold in the four program states — California, Connecticut, Indiana and New York.
- More than 25,000 new applications were received for Partnership policies in 1999.
- Program redesigns in Connecticut, Indiana and California have produced increases in applications received ranging from 324% to 540%, compared to similar time periods prior to those adjustments.
- In New York, where total sales have been the largest in number, updates to its program model are being explored to further program goals. This progress was accomplished despite restrictive language embedded in the Omnibus Budget Reconciliation Act (OBRA) of 1993 which effectively curtailed one of the program's goals: replicating the partnerships in other states

Financing Long-Term Care

In 2003, the National Academy of Social Insurance convened a study panel on the future of the long-term care system. Among the key findings of the panel are:

Three tenets should guide the long-term-care system of the future:

- ∇ The **needs of individuals** should determine the kinds of services available.
- ∇ Service delivery should preserve the autonomy of people receiving services.
- ∇ The costs of services **should be shared equitably** among individuals, families and society, and the services should be similarly available and affordable regardless of the state in which a person lives.

Transforming long-term care requires fundamental reform of its financing and a substantial commitment of federal resources. Because the need for long-term care is a risk, not a certainty, it should be handled like other unpredictable and potentially catastrophic events—through insurance.

Private long-term-care insurance, while growing, is affordable for only 10% to 20% of the elderly. Some degree of federal involvement is essential to assure access to long-term care without impoverishing families.

Partnership for Long-Term Care

As the number of elderly Americans increases, long-term-care (LTC) needs and costs are likely to grow. **Many believe that private long-term-care insurance can and should play a more significant role in the financing of home care and nursing home services.** Wider use of such insurance could shift the burden from individuals, who are often ill-prepared to pay for such care out-of-pocket, as well as from state Medicaid programs, which often serve as a default financier of long-term-care services.

One vehicle for encouraging consumers to invest in LTC insurance is the expansion of the Partnership for Long-Term Care, a unique insurance model developed in the 1980s with support from the Robert Wood Johnson Foundation (RWJF).

- Through the Partnership program **states promote the purchase of private LTC insurance by offering consumers access to Medicaid under special eligibility rules** should additional LTC coverage (beyond what the policies provide) be needed.
- **Medicaid, in turn, benefits by having individuals take responsibility for the initial phase of their long-term care through the use of private insurance**.
- The original demonstration model has been underway since 1992 in California, Connecticut, Indiana and New York.
- The Deficit Reduction Act (DRA) of 2005 lifted the technical barriers Congress had imposed on such programs, allowing for the expansion of the Partnership to other states across the country.

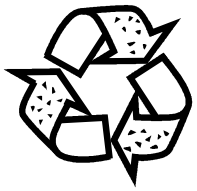
History of the Partnership for Long-Term Care

In the late 1980s the Robert Wood Johnson Foundation supported the development of a new LTC insurance model, with a goal of encouraging more people to purchase LTC coverage. The program, called the Partnership for Long-Term Care, brought states and private insurers together to create a new insurance product aimed at moderate-income individuals or those at most risk of future reliance on Medicaid to cover long-term-care needs.

The Partnership program was designed to attract consumers who might not otherwise purchase LTC insurance.

- **States offer the guarantee** that if benefits under a Partnership policy do not sufficiently cover the cost of care, the consumer may qualify for Medicaid under special eligibility rules while retaining a pre-specified amount of assets (though income and functional eligibility rules still apply).
- **Consumers are thus protected** from having to become impoverished to qualify for Medicaid, and **states avoid the entire burden** of long-term-care costs

Four states—California, Connecticut, Indiana and New York—implemented Partnership programs in the early 1990s.



However, Congress, citing concerns about the appropriateness of using Medicaid funds for this purpose, **enacted restrictions on further development of the Partnership** in the Omnibus Budget Reconciliation Act (OBRA) of 1993.

The four states with existing Partnership programs were allowed to continue, but the OBRA provisions ended the replication of the Partnership model in new states.

The four demonstration states used **two models of asset protection**.

- California, Indiana and Connecticut chose a ***dollar-for-dollar model.*** In this scenario, the amount of insurance coverage purchased equals the amount of assets protected from consideration if and when the consumer needs to apply for Medicaid. For example, a consumer who bought a policy with a benefit of $100,000 would be entitled to up to $100,000 worth of nursing home or community-based long-term care. If further care became necessary, the

individual would be able to apply for Medicaid coverage, while still retaining $100,000 worth of assets.

- In the ***total asset protection model,*** used in New York State, consumers were required to buy a more comprehensive benefit package as defined by the state. (Initially, the state mandated that Partnership policies cover three years of nursing home or six years of home-health care.) Consumers purchasing such a policy could protect all of their assets when applying for Medicaid.

In 1998 Indiana switched to a hybrid model, whereby consumers could choose between dollar-for-dollar or total asset protection. New York also recently added a dollar-for-dollar option for consumers.

As of 2005 more than 172,000 consumers in the four demonstration states had active Partnership policies. Because the program is fairly young and policies are generally purchased well before they are used, relatively few of the policyholders have actually needed long-term-care coverage.

However, of those that have accessed their benefits, the Government Accountability Office reports that, "More policyholders have died **while receiving** long-term-care insurance (899 policyholders) **than have exhausted t**heir long-term-care insurance benefits (251 policyholders), which could suggest **that the Partnership for Long-Term Care program may be succeeding in eliminating some participants' need to access Medicaid."**

The Deficit Reduction Act of 2005 (DRA)

The Deficit Reduction Act of 2005 included a number of reforms related to long-term-care services.

- Of interest to many states is the lifting of the moratorium on Partnership programs.
- **Under the DRA all states can implement LTC Partnership programs** through an approved State Plan Amendment, if specific requirements are met.
- **The DRA requires programs to include certain consumer protections**, most notably provisions of the National Association of Insurance Commissioners' Model LTC regulations.
- The DRA also requires that polices include inflation protection when purchased by a person under age 76.

Questions for Consideration

Some of the concerns that prompted Congress to halt further implementation of the Partnership in 1993 are still relevant.

- Do Partnership programs save states money?
- What consumer protections are needed to ensure that policies will provide meaningful benefits when they are needed 20 years in the future?

The following is a brief overview of some of the major issues states should consider when developing LTC Partnership programs.

Coordination with Multiple Stakeholders

The successful implementation of Partnership programs requires the input and effort of a variety of stakeholders—state policy-makers, private industry and consumers.

- The state should be the primary convener of a Partnership effort, which will necessarily involve many facets of state government.
- The Medicaid agency, Governor's office, state budget office, state unit on aging, state legislature, and the Office of Insurance should all provide input on the design of the program.
- If a state passed enabling legislation prior to the DRA, then modifications to that legislation may be needed to conform to the requirements of the federal statute.
- Consumers and the private insurance industry should also be engaged in the development of a Partnership program from the very early stages.
- Although the DRA mandates a number of consumer protections for Partnership programs, consumer input can be invaluable in helping states determine the best way to implement those protections and whether to offer additional provisions—such as premium protection and non-forfeiture clauses. Consumer groups may also be helpful in designing public awareness or educational campaigns.

The insurance industry plays a key role in underwriting Partnership policies. Insurance companies and the independent agents with whom they work may have extensive experience in the long-term-care insurance market and may be able to provide states with programmatic and fiscal projections, as well as advice on effective marketing strategies for LTC insurance products.

Target Population and State Budget Impact

The success of Partnership programs in reducing state long-term-care expenditures depend on the program's ability to encourage people with moderate incomes, who would otherwise rely on Medicaid for potential LTC needs, to purchase private insurance.

- If the program serves primarily to provide "substitute" insurance for wealthier individuals, who could otherwise afford to pay out-of-pocket or purchase other private LTC insurance, **then state savings will not be realized.**

As states consider the best way to attract those individuals who would not otherwise purchase LTC insurance, the experience of the demonstration states can be illustrative.

- The two models, **dollar-for-dollar** and **total asset protection**, seemed to attract consumers with different levels of assets.
- To qualify for total asset protection, New York mandated a relatively comprehensive benefit package. This increased the premiums and attracted consumers who were financially better off.
- A Congressional Research Service report notes that some Partnership state directors in the original states felt that the dollar-for-dollar model promotes policies that are more affordable, and are thus better able to attract persons with less wealth.

The DRA specifies that all new LTC Partnership programs use the **dollar-for-dollar** methodology. To keep premiums affordable, states should create benefit options that appeal to people with varying levels of assets: less coverage (and associated asset protection) for those with limited means/assets and more generous coverage for those with more to protect. In finding a successful balance between coverage and costs, states should make every effort to ensure that consumers are well informed about what they are purchasing, the level of benefits to be provided, and what is protected.

Consumer and Agent Education

Given the complexity of the long-term-care insurance choices, and the added intricacy of Partnership programs, many people feel strongly that robust **consumer education and insurance agent training should be built into new state Partnership programs.**

The DRA addresses some issues related to consumer and agent education:

- The secretary of Health and Human Services (HHS) is required to establish a National Clearinghouse for Long-Term-Care Information that will educate consumers about the need for and costs associated with long-term-care services and will provide objective information to help consumers plan for the future. HHS launched a Web site, *www.longtermcare.gov* to aid in consumer education.

- Partnership programs must include specific consumer protection requirements of the 2000 National Association of Insurance Commissioners (NAIC) LTC Insurance Model Act and Regulation. If the NAIC changes the specified requirements, the HHS secretary has 12 months to determine whether state Partnership programs must incorporate the changes as well.

- State insurance departments are responsible for ensuring that individuals who sell Partnership policies (insurance agents) are adequately trained and can demonstrate understanding of how such policies relate to other public and private options for long-term-care coverage.

Consumer and insurance agent education are closely aligned.

- Insurance agents play a vital role in ensuring that consumers understand their options as well as the terms and conditions of any given policy.
- Of primary importance is guaranteeing that consumers understand the criteria that will allow them to become eligible for both private LTC coverage and, if necessary, Medicaid.
- Consumer advocates point out that exhausting Partnership policy benefits is no guarantee that an individual will qualify for Medicaid: the state's income and functional eligibility criteria must still be met.
- Consumers should also be aware that, although a Partnership policy may cover home-based care, Medicaid coverage may (depending on the state) only entitle them to care in a nursing facility.

The DRA specifies that **"any individual who sells a long-term-care insurance policy under the Partnership receives training** and demonstrates evidence of understanding of such policies and how they relate to other public and private coverage of long-term care."

- To ensure that insurance agents are well schooled in the intricacies of long-term care and the Medicaid program, **states may want to require a specific number of hours of training on each.**
- The four current Partnership states require LTC insurance agents to undergo a number of hours of initial training specifically devoted to the Partnership program, in addition to other general training and continuing education requirements.

Inflation Protection

Inflation protection is a provision written into a LTC insurance policy that stipulates that benefits will increase by some designated amount over time.

- Inflation protection ensures that long-term-care insurance products retain meaningful benefits into the future. Because policies may be purchased well before they are needed, and long-term-care costs are likely to continue to increase, inflation protection can be a key selling point for consumers interested in purchasing private LTC coverage.

The DRA requires that Partnership policies sold to those under age 61 provide compound annual inflation protection. The amount of the benefit (e.g., 3% or 5% per year) is left to the discretion of individual states. Policies purchased by individuals who are over 61 but not yet 76 must include some level of inflation protection, and policies purchased by those over 76 may, but are not required, to provide some level of inflation protection.

Reciprocity between States

In 2001 Indiana and Connecticut implemented a reciprocity agreement allowing Partnership beneficiaries who have purchased a policy in one state—but move to the other—**to receive asset protection if they qualify for Medicaid in their new locale**.

- Although prior to this agreement the insurance benefits of Partnership policies were portable, the asset protection component was state-specific.
- The asset protection specified in the agreement is limited to dollar-for-dollar, so Indiana residents who purchase total asset protection policies would only receive protection for the amount of LTC services their policy covered if they moved to Connecticut.

Reciprocity is an attractive feature for many consumers, especially those who do not currently know where they will reside in future years. The DRA requires the HHS secretary (in consultation with National Association of Insurance Commissioners, policy issuers, states, and consumers) to develop standards of reciprocal recognition under which benefits paid would be treated the same by all such states. States will be held to such standards unless the state notifies the secretary in writing that it wishes to be exempt.

The Future for the Partnership Model

Many states are interested in the opportunities related to expansion of the Partnership model.

- Before the passage of the DRA, 21 states had anticipated a change in the law and proposed or enacted authorizing legislation.
- A recent survey of state Medicaid directors found that 20 (of 40 total) respondents indicated that they planned to propose a Long-Term Care Partnership program within the year.

As momentum behind the program grows, the issues and considerations outlined here, as well as others raised by consumer advocates, state budget officials and those who purchase Partnership policies will need to be carefully examined to determine the ultimate outcomes of this unique and innovative policy option.

TRENDS IN MAJOR MEDICAL INSURANCE

Chapter 8
Major Medical Insurance ~ I

Understand Major Medical Insurance

The theory of major medical coverage is that the insured person pays smaller bills out-of-pocket, or uses other insurance to cover them. **Major medical then takes over when the bills reach catastrophic proportions.**

Major medical insurance is a form of health care coverage that provides benefits for most types of medical expenses that may be incurred.

- Offering more complete coverage with fewer gaps, major medical insurance covers a much broader range of medical expenses – including those incurred both in and out of the hospital – with generally higher individual benefits and policy maximum limits.
- These more extensive medical insurance policies are divided into **two general groups:**

    - *Comprehensive major medical insurance*, in which the traditional basic coverages and essentially any other type of medical expense are combined into a single comprehensive policy

    - *Supplemental major medical insurance*, in which coverage begins with a traditional basic policy that pays first, with the major medical coverage added to pick up expenses left uncovered by the initial basic policy.

Let's look at each of these groups and examine how the generally operate.

Comprehensive Major Medical

Most major medical policies begin paying benefits after the *deductible* is satisfied. The policy's deductible is considered satisfied as long as the insured individual can show evidence of having incurred and paid the necessary covered expense.

There are essentially two classes of comprehensive major medical plans: those that provide first dollar coverage, and those that do not.

- With ***first dollar coverage***, as soon as covered medical expenses are incurred, the policy immediately begins to pay benefits.
- Consequently, policies with first dollar coverage effectively have a deductible amount of zero.
- Without first dollar coverage, the insured must first pay out-of-pocket a specified deductible amount, and when that amount of incurred covered expenses has been paid, the policy will then begin to pay benefits.

CASE STUDY

Let's assume that before Mr. A's major medical policy will pay anything, he must pay the first $400 of medical expenses each year. Mr. A does *not* have first dollar coverage; in other words, he must pay a deductible. Conversely, as soon as Mr. B was hospitalized with an acute illness, his major medical policy began paying for his expenses. **He, therefore, *does* have first dollar coverage, and incurs no deductible.**

Another important feature of major medical coverage is the concept of *coinsurance*, which is the sharing between the insurance company and the insured of any covered expenses that exceed the deductible amount. (In some regions, this is also known as *percentage participation*.)

The insurer always carries the bulk of these expenses, usually paying 80% while the insured is responsible for the remaining 20%. Other proportions (as stipulated in the particular policy) may also be used, such as 75/25.

Coinsurance works in this manner:

CASE STUDY

Ms. C's major medical policy has a $200 deductible and 80/20 coinsurance. She incurs covered medical expenses totaling $1,200. Ms. C must first pay the $200 deductible. This leaves $1,000 of expenses to be shared on an 80%/20% basis, she being responsible for the lower amount, or an additional $200. The insurance company must pay $800 of remaining $1,000 (the 80% share). Ms. C, therefore, has to pay $400 of the total $1,200.

In some policies, certain types of medical expenses are not subject to the deductible, while others are.

- It is not unusual, for instance, that the deductible be waived for initial hospital or surgical expenses up to a specified amount; say, for example, the first $5,000 of such expenses.
- In this case, the insured would pay no deductible (in essence receiving first dollar coverage on the first $5,000 of hospital and surgical expenses), but would then be required to pay the deductible amount before his or her major medical policy covered any further expenses.
- After satisfaction of the deductible, the insurer and the insured would share in paying the remaining expenses on an 80/20 allotment (or whatever percentage the policy states).

Most major medical policies today also include a *stop-loss limit* (or *out-of-pocket limit*), which is a dollar amount beyond which the insured no longer has to participate in the payment of covered expenses.

- After the insured's total deductible and coinsurance payments reach that amount, the insurance company picks up the entirety of any further covered expenses, up to a stated *maximum benefit amount*.
- Lifetime maximum benefit limits on current health care policies may range from $100,000 to $2 million, with some policies even having unlimited benefits. And just as the maximum benefit amount can vary considerably, so can the stop-loss limit, depending upon the individual policy and insurer.

Supplemental Major Medical

When a supplemental major medical policy is used, it typically backs up and enhances a basic policy that usually includes hospital, surgical and medical coverage along with an additional policy covering the broader range of medical expenses.

- Generally, the basic plan will pay covered expenses with no deductible, up to the policy's limit.
- Above that limit, the supplemental policy kicks in, operating in exactly the same manner as a comprehensive policy that does *not* provide first dollar coverage.
- In simpler terms, after the basic policy's limits are reached, the insured must pay a deductible, after which the supplemental major medical coverage begins to pay.
- Since the deductible actually occurs *between* the basic and supplemental policies, it's often referred to as a *corridor deductible*.
- Like the comprehensive major medical plan, a supplemental policy is likely to include a stop-loss limit and a maximum lifetime benefit limit.

Types of Deductibles

There are a number of ways that deductibles can be administered in major medical policies. Some plans have a **per-cause (injury or illness) deductible**, while others may use an **all-cause deductible**.

With a **per-cause deductible**, the insured pays **one deductible for all expenses incurred from the same illness or injury.** The benefit period for each "cause" (or occurrence) begins when the deductible for that particular injury or illness has been satisfied, and may run for one- to two years.

CASE STUDY

Suppose that Ms. D suffered a major illness early in the year from which she continued to incur medical expenses through July. Then, in September, she was injured in an automobile accident that hospitalized her for two weeks. In addition to being quite unfortunate, Ms. D had to pay **a separate deductible for each of these incidents because her policy has a per-cause deductible.**

If Ms. D's policy had contained instead an ***all-cause deductible*** (which is also known as a "cumulative" or "calendar year" deductible), **her incurred covered expenses for any number of occurrences (whether differing or incidences of the same type)**

would have been accumulated to meet the deductible during a single calendar year. Once enough covered expenses were been paid by the insured to meet the stated deductible, all other covered charges during the remainder of the calendar year would have been paid according to the coinsurance schedule.

- **Policies that cover entire families usually have a family deductible rather than deductibles that apply to each individual**. For example, although a policy's individual-person deductible is, say, $200, the family deductible amount might be $400. Thus, even a family with six members would pay no more than a total of $400 in deductible expenses, as opposed to the $1,200 that would be required if every member had to meet the $200 individual deductible.

- **The time, during which benefits are paid, known as the *benefit periods*, are generally dependent upon the deductible and any internal limits that may be included in the major medical policy.** For instance, when a deductible amount has to be paid, the policy's benefit period could begin either on the first day of the illness (or accident) or on the date that the insured satisfies the full deductible (if this is later than the date of the occurrence), and may extend for up to two years. In other cases, the benefit period ceases at the end of the calendar year and begins anew with a new deductible.

- ***Internal limits* are benefit limitations placed on specific coverages within the major medical policy**. For example, the policy might limit both the hospital room and board benefit and the number of days that benefits will be paid. In such a case, the benefit period for room and board would be the number of days that have been specified as the limit. Other examples of internal limits might be restrictions placed on convalescent care days, mental health care, the number of X-rays per claim, etc.

Covered Expenses

All major medical policies, whether comprehensive or supplemental, provide a wide range of benefits. The precise services covered may vary somewhat from policy to policy, but most major medical plans include coverage for many of the following services and procedures:

- Hospital inpatient room and board including intensive and cardiac care
- Hospital medical and surgical services and supplies
- Physicians' diagnostic, medical, and surgical services
- Other medical practitioners' services
- Nursing services including private duty service outside the hospital
- Anesthesia and anesthesiologist services
- Outpatient services
- Ambulance service to and from a hospital
- X-rays and other diagnostic and laboratory tests
- Radiological and other types of therapy
- Prescription drugs
- Blood and blood plasma
- Oxygen and its administration
- Dental services resulting from injury to natural teeth
- Convalescent nursing home care
- Home health care services
- Initial purchase of prosthetic devices
- Casts, splints, trusses, braces, and crutches
- Rental of durable medical equipment (DME) such as hospital-type beds and wheelchairs.

Individual Coverage

Individual coverage means that the insurance is not connected to a business or to the self-employed. **A person can purchase an "individual" policy that covers his whole family**. People enrolled in individual plans pay premiums that are more in line with their expected health costs.

- Individual plans are medically underwritten and the insurer **may reject** a person's application or attach exclusions to his policy if he has health problems.

- However, **some states do not allow this practice** and require that any insurer selling individual health plans must offer an applicant a policy, no matter what medical problems he has. **This kind of law is called "guaranteed issue."**

However, the premiums are still likely to be substantially higher. People enrolled in individual plans pay premiums more in line with their expected health costs, so the premiums will be higher for those who are older or less healthy. Each agent should be aware of the law concerning individual coverage in his state. The rules and regulations about individual health insurance vary from state to state.

The person who is faced with finding individual health insurance may find the market confusing.

- The premiums for similar products from different insurers can vary by as much as 50% for the *same person*.
- Finding the right balance of coverage and cost can be challenging, but it is a necessity. The first step for a person to take is to evaluate his needs and understand his health insurance options.
- The landscape varies from state to state and the rules are constantly evolving.
- That's why it's imperative to compare multiple companies when one is shopping.
- An agent well-versed in individual health policies can help a person sort through his options and find the policy that is right for him and his family.

The person shopping for individual health coverage will find that the individual health market offers the same plans as the group market, including health maintenance organizations (HMOs), preferred provider organizations (PPOs), point-of-service (POS) plans, and traditional fee-for-service arrangements.

Guidelines for estimating a person's future health care costs and comparing several policies include the following:

- Consider the annual premiums, the deductibles, co-payments, annual limits, and maximum out-of-pocket expenses. This will give you a good idea of what your yearly costs will be for each policy.
- Make sure that the policy that appears to be the best buy will give you access to the kinds of services you might require.

Options vary from state to state and some states have more options than others.

For Those without Coverage

Millions of Americans are without health insurance. Some lost their insurance when they lost their jobs. Others work hard, but their jobs don't provide health insurance benefits. Whatever the reason, finding health insurance can be difficult.

The reasons for not having insurance can include:

- Losing a job that provided insurance.
- Losing job because of trade policy.
- Retiring early and losing health coverage.
- Unable to afford health insurance.
- Serious medical condition or disability.
- Unable to get it through his employment.

The solutions to finding individual health insurance **depend on the reason** the individual does not have insurance.

Solutions to these reasons include:

- *If a person recently lost his job, had health insurance at that job, and his former employer had at least twenty workers*: Under the federal law COBRA if his former employer had at least twenty workers, he has the right to stay in the health plan he had at that job. **However, he must pay the total premium himself, which can be very expensive.** And he generally only has sixty days from the time he loses his job to sign up for COBRA. COBRA usually guarantees eighteen months of coverage, but under special circumstances he can get twenty-nine or thirty-six months of coverage. Some states provide assistance with COBRA premiums to people with disabilities or low incomes.

- *If his former employer had **fewer than twenty employees***: **In some states**, former workers of small businesses have a right to pay for continuation coverage for 18 months. A former employer (the human resources or personnel department) is required to tell an employee about his COBRA rights.

- *If a person recently lost his job because of trade policy*—for example, increased imports or jobs moving overseas a federal law called the Trade Adjustment Assistance Reform Act may pay 65% of the cost of his health insurance for up to 3 years. He might qualify for this help, for example, if his employer laid off workers because the company's products are being replaced by products from other countries or because the company is using more workers in other countries.

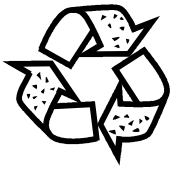
- *If a person is an early retiree who has lost his health coverage* the same law, the Trade Adjustment Assistance Reform Act may help him.

- *If he is a retiree aged 55 or older, his former employer no longer provides his pension, and his pension benefit is paid by the federal Pension Benefits Guaranty Corporation,* he can receive help with 65% of the cost of health insurance until he is eligible for Medicare.

- *If a person cannot afford health care or insurance* there are programs that provide health insurance coverage to people who cannot afford to buy it on their own. The person without coverage or his family members may qualify, even if he works. **However, these programs have income and asset limits.**

Generally, a woman can get coverage IF she is any of the following:

- Pregnant.
- A parent with a child living at home.
- A person with a disability.
- A person who spends most of his/her income on health care.



Children can often get coverage—**even if their parents don't qualify**—because the income limits are usually higher for children.

If a woman is pregnant and meets the income limits required, she can get coverage during her pregnancy and for up to 60 days after her baby is born. **Often, the baby will then have guaranteed coverage for at least one year.**

If a person is not a U.S. citizen, he might be able to qualify, **depending on his immigration status and how long he has lived in the U.S**. If he can't afford health care, it is best to apply rather than trying to guess whether or not he is eligible, because the income rules are complicated.

If a person has a **serious medical condition or a disability** there are **three main programs** that may help him.

Those programs are Medicare, Medicaid, and a state-run high-risk pool.

Medicare ~ A person might qualify for Medicare, even if he is under age 65, if he has a disability that is expected to last at least a year or is expected to cause his death. In order to get Medicare because he is disabled, he has to apply for Social Security Disability Insurance (SSDI), and he must receive SSDI for 24 months before he can enroll in Medicare.

Medicaid ~ If a person is blind or has a disability and his income is low or he spends most of his income on health care, he may qualify for Medicaid. People who have a disability usually qualify for Medicaid because they get Supplemental Security Income (SSI), but he may be able to get Medicaid while he is waiting to find out if he is eligible for SSI. Even if he does not qualify for SSI, he may still be able to get health insurance through Medicaid.

High-risk pools ~ These are state-run programs that sell health insurance to a small number of people who are turned away by insurance companies or are offered very limited or expensive policies because they or a family member have an existing health problem.

If a person is looking for health insurance but cannot get it through his job he may have to look for an individual health insurance policy in the private market.

Rights under Federal Law

HIPAA (the Health Insurance Portability and Accountability Act) is a federal law that may give an individual the right to buy coverage and prohibits insurance companies from refusing to cover pre-existing conditions.

To be eligible for these protections, a person must have:

- Had at least 18 months of group coverage (usually through a job).
- Used up any COBRA continuation coverage rights and had no gaps in coverage longer than 63 days, so he must act quickly.

Group Coverage

Group insurance is a health care coverage plan in which individual employees or members are included under one 'master policy' owned by their employers.

- Because the group insurance plan has so many contributors, **the policy often provides coverage for more services at a much lower cost per participant**.
- Group insurance may be provided by other organizations besides for-profit companies. Labor unions, churches and other service groups can also obtain group insurance for recognized members and possibly their dependents.

Individual members of a group insurance plan receive insurance certificates which demonstrate their eligibility for benefits.

- If the master policy held by the employer requires participation in an HMO (health maintenance organization), then individuals are also registered as members.
- Other group insurance policies may be associated with major medical groups such as Blue Cross/Blue Shield.
- **A major medical policy may or may not restrict an individual's choice of primary physician and specialists**.
- HMO policies often require a patient to use a specified physician, who must approve any visits to eligible specialists.

Financing for a group insurance policy is commonly a flexible payroll deduction, although some companies will absorb the entire cost of the policy as a benefit for employees.

- As with many insurance policies, however, the cost of premiums can rise significantly without warning.
- If a few participants receive expensive treatments for serious medical conditions, the rest of the group may have to absorb the higher premium costs over time.
- Group insurers don't always require physical exams before issuing a master policy, so some participants may benefit from treatments for pre-existing conditions.

Group insurance benefits can vary widely from company to company.

- Almost all policies cover emergency and routine medical procedures such as regular doctor's appointments and hospital treatment for accidents.
- Most cover extended care in hospitals or rehabilitation centers.
- However, group insurance may or may not cover the employee's spouse or dependents.
- Some offer assistance for vision care or dental work, but coverage may be limited to specific procedures.

- Mental health needs may also be covered under group insurance.
- Prescription drug expenses often fall under group insurance benefits, but most likely with a co-pay provision.
- Under a co-pay plan, the covered individual must pay an established price out-of-pocket for name brand and generic medications.

Group insurance is definitely more affordable than a similar number of individual policies, but there are a few drawbacks.

- Some members find their choices of physicians and treatments very limited under an HMO insurance plan.
- Even major medical plans can restrict the list of approved physicians, often called the PMD (preferred medical doctor) policy.
- Employers who fear large increases in premiums may take an unusual interest in their employees' private health issues.
- Companies may suddenly implement stringent 'no smoking' policies or strongly encourage other preventative health care programs.
- Some may find this interest in their personal health to be intrusive.

Many employees see group insurance coverage as a major perk for faithful company service.

- The premium payments are usually deducted automatically and pay for themselves after one typical trip to the emergency room.
- Extended coverage for spouses and dependents also bring peace of mind and a feeling of security.

Group insurance is usually cheaper per person involved than comparable individual insurance because an insurance company can administer group insurance more efficiently than individual insurance.

- In most group health coverage, a person’s health condition does not affect his or her rates or eligibility.
- If a business has fewer than ten employees, it may not be able to purchase that type of group policy. The employer with fewer than 10 employees will most likely be able to provide only the type of group insurance that uses a health questionnaire for each employee.
- Employees with health problems may be ineligible for the plan, or they may be charged a higher rate.

COBRA (Consolidated Omnibus Budget Reconciliation Act)

COBRA continuation coverage gives employees (and their dependents) that leave an employer's group health plan the opportunity to purchase and maintain the same group health coverage for a period of time (generally, 18, 29 or 36 months) **under certain conditions**. Workers in companies with twenty or more employees generally qualify for COBRA.

Congress passed the landmark Consolidated Omnibus Budget Reconciliation Act (COBRA) health benefit provisions in 1986. The law amends the Employee Retirement Income Security Act, the Internal Revenue Code and the Public Health Service Act to provide continuation of group health coverage **that otherwise might be terminated.**

COBRA provides certain former employees, retirees, spouses, former spouses, and dependent children the right to temporary continuation of health coverage at group rates.

- This coverage, however, is **only available when coverage is lost due to certain specific events.**
- Group health coverage for COBRA participants **is usually more expensive than health coverage for active employees,** since usually the employer pays a part of the premium for active employees while COBRA participants generally pay the entire premium themselves.
- It is ordinarily **less expensive, though, than individual health coverage**.

Qualifying for COBRA

There are three elements to qualifying for COBRA benefits. COBRA establishes specific criteria for:

- Plans.
- Qualified beneficiaries.
- Qualifying events:

Plan Coverage

Group health plans **for employers with 20 or more employees** on **more than 50% of its typical business days in the previous calendar year** are subject to COBRA.

- **Both full and part-time employees are counted** to determine whether a plan is subject to COBRA.
- Each part-time employee counts as a fraction of an employee, with the fraction equal to the number of hours that the part-time employee worked divided by the hours an employee must work to be considered full time.

Qualified Beneficiaries

A qualified beneficiary generally is **an individual covered by a group health plan on the day before a qualifying event who is either an employee, the employee's spouse, or an employee's dependent child.**

- In certain cases, a retired employee, the retired employee's spouse, and the retired employee's dependent children may be qualified beneficiaries.
- In addition, any child born to or placed for adoption with a covered employee during the period of COBRA coverage is considered a qualified beneficiary.
- Agents, independent contractors, and directors who participate in the group health plan may also be qualified beneficiaries.

Qualifying Events

Qualifying events **are certain events that would cause an individual to lose health coverage.**

- The type of qualifying event will determine who the qualified beneficiaries are and the amount of time that a plan must offer the health coverage to them under COBRA.
- A plan, at its discretion, may provide longer periods of continuation coverage.

Qualifying events **for employees** include:

- Voluntary or involuntary termination of employment for reasons other than gross misconduct.
- Reduction in the number of hours of employment.

Qualifying events **for spouses** include:

- Voluntary or involuntary termination of the covered employee's employment for any reason other than gross misconduct.
- Reduction in the hours worked by the covered employee.

- Covered employee's becoming entitled to Medicare.
- Divorce or legal separation of the covered employee.
- Death of the covered employee.

Qualifying events **for dependent children** include:

- Loss of dependent child status under the plan rules.
- Voluntary or involuntary termination of the covered employee's employment for any reason other than gross misconduct.
- Reduction in the hours worked by the covered employee.
- Covered employee's becoming entitled to Medicare.
- Divorce or legal separation of the covered employee.
- Death of the covered employee.

COBRA coverage begins on the date that health care coverage would otherwise have been lost by reason of a qualifying event.

Eligibility for COBRA Continuation Coverage

To be eligible for COBRA coverage:

- An individual must have been enrolled in his employer's health plan when he worked.
- The health plan must continue to be in effect for active employees.

COBRA continuation **coverage is available upon the occurrence** of a **qualifying event that would, except for the COBRA continuation coverage, cause an individual to lose his or her health care coverage.**

The law generally covers health plans maintained by private-sector employers with 20 or more employees, employee organizations, or state or local governments.

Process to Elect COBRA Continuation Coverage

- ∇ **Employers must notify plan administrators of a qualifying event within 30 days after** an employee's death, termination, reduced hours of employment or entitlement to Medicare.

- ∇ A **qualified beneficiary must notify the plan administrator of a qualifying event within 60 days** after divorce or legal separation or a child's ceasing to be covered as a dependent under plan rules.

- ∇ Plan participants and beneficiaries generally **must be sent an election notice not later than 14 days** after the plan administrator receives notice that a qualifying event has occurred. The individual then has 60 days to decide whether to elect COBRA continuation coverage. The person has 45 days after electing coverage to pay the initial premium.

Qualified beneficiaries must be given an election period during which each qualified beneficiary may choose whether to elect COBRA coverage.

- Each **qualified beneficiary may independently elect COBRA coverage**.
- A **covered employee or the covered employee's spouse may elect** COBRA coverage **on behalf of all other qualified beneficiaries**.
- A parent or legal guardian may elect on behalf of a minor child.
- **Qualified beneficiaries must be given at least 60 days for the election**. This period is measured from the later of the coverage loss date or the date the COBRA election notice is provided by the employer or plan administrator.
- The election notice must be provided in person or by first class mail within 14 days after the plan administrator receives notice that a qualifying event has occurred.

Health plan rules must explain how to obtain benefits and must include written procedures for processing claims. **Claims procedures must be described in the Summary Plan Description.**

- The insured should submit a claim for benefits in accordance with the plan's rules for filing claims.
- If the claim is denied, he must be given notice of the denial in writing generally within 90 days after the claim is filed.
- The notice should state the reasons for the denial, any additional information needed to support the claim, and procedures for appealing the denial.
- He will have at least 60 days to appeal a denial and he must receive a decision on the appeal generally within 60 days after that.

If a qualified beneficiary waives COBRA coverage during the election period, he or she may revoke the waiver of coverage before the end of the election period. A

beneficiary may then elect COBRA coverage. Then, the plan need only provide continuation coverage beginning on the date the waiver is revoked.

Extension of COBRA

Disability can extend the 18 month period of continuation coverage for a qualifying event that is a termination of employment or reduction of hours.

To qualify for additional months of COBRA continuation coverage, the qualified beneficiary must:

- Have a ruling from the Social Security Administration that he or she became disabled within the first 60 days of COBRA continuation coverage.
- Send the plan a copy of the Social Security ruling letter within 60 days of receipt, but prior to expiration of the 18-month period of coverage.

If these requirements are met, the entire family qualifies for an additional 11 months of COBRA continuation coverage. Plans can charge 150% of the premium cost for the extended period of coverage.

Divorced Spouse's Entitlement

Under COBRA, participants, covered spouses and dependent children may continue their plan coverage for a limited time when they would otherwise lose coverage due to a particular event, such as divorce (or legal separation).

- A covered employee's spouse who would lose coverage due to a divorce may elect continuation coverage under the plan for a maximum of 36 months.
- A qualified beneficiary must notify the plan administrator of a qualifying event within 60 days after divorce or legal separation.
- After being notified of a divorce, the plan administrator must give notice, generally within 14 days, to the qualified beneficiary of the right to elect COBRA continuation coverage.

Benefits Covered Under COBRA

Qualified beneficiaries must be offered coverage identical to that available to similarly situated beneficiaries who are not receiving COBRA coverage under the plan (generally, the same coverage that the qualified beneficiary had immediately before qualifying for

continuation coverage).

- ✓ **A change in the benefits** under the plan for the active employees **will also apply** to qualified beneficiaries.
- ✓ Qualified beneficiaries **must be allowed to make the same choices** given to non-COBRA beneficiaries under the plan, such as during periods of open enrollment by the plan.

Time Frame for Coverage

COBRA establishes required periods of coverage for continuation health benefits.

- ✓ A plan, however, **may provide longer periods of coverage** beyond those required by COBRA.
- ✓ COBRA beneficiaries generally are eligible for group coverage during a maximum of 18 months for qualifying events due to employment termination or reduction of hours of work.
- ✓ Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.
- ✓ Coverage begins on the date that coverage would otherwise have been lost by reason of a qualifying event and will end at the end of the maximum period. **It may end earlier if:**

    - Premiums are not paid on a timely basis.
    - The employer ceases to maintain any group health plan.

- ✓ After the COBRA election, coverage is obtained with another employer group health plan **that does not contain any exclusion or limitation with respect to any pre-existing condition of such beneficiary.**
- ✓ However, if other group health coverage is obtained **prior to the COBRA election**, COBRA coverage may NOT be discontinued, **even if the other coverage continues after the COBRA election.**
- ✓ After the COBRA election, a beneficiary becomes entitled to Medicare benefits. However, **if Medicare is obtained prior to COBRA election**, COBRA coverage may NOT be discontinued, **even if the other coverage continues after the COBRA election.**
- ✓ Although COBRA specifies certain periods of time that continued health coverage must be offered to qualified beneficiaries, **COBRA does not prohibit**

plans from offering continuation health coverage that goes beyond the COBRA periods.

Some plans allow participants and beneficiaries to convert group health coverage to an individual policy.

- ✓ **If this option is generally available from the plan**, a **qualified beneficiary who pays for** COBRA coverage **must be given the option of converting** to an individual policy at the end of the COBRA continuation coverage period.
- ✓ The option must be given to enroll in a conversion health plan within 180 days before COBRA coverage ends.
- ✓ The premium for a conversion policy may be more expensive than the premium of a group plan, and the conversion policy may provide a lower level of coverage.
- ✓ **The conversion option, however, is not available if the beneficiary ends COBRA coverage before reaching the end of the maximum period of COBRA coverage.**

Paying for COBRA

Beneficiaries may be required to pay for COBRA coverage. The premium **cannot exceed** 102% of the cost to the plan for similarly situated individuals who have not incurred a qualifying event, including both the portion paid by employees and any portion paid by the employer before the qualifying event, plus 2% for administrative costs.

- ✓ For qualified beneficiaries receiving the 11 month disability extension of coverage, the premium for those additional months may be increased to 150% of the plan's total cost of coverage.
- ✓ **COBRA premiums may be increased if the costs to the plan increase but generally must be fixed in advance of each 12-month premium cycle**.
- ✓ **The plan must allow the insured to pay premiums on a monthly basis if he asks to do so,** and **the plan may allow him to make payments at other intervals (weekly or quarterly).**
- ✓ The initial premium payment must be made within 45 days after the date of the COBRA election by the qualified beneficiary.
- ✓ Payment generally must cover the period of coverage from the date of COBRA election retroactive to the date of the loss of coverage due to the qualifying event.

- ✓ Premiums for successive periods of coverage are due on the date stated in the plan with a minimum 30-day grace period for payments. Payment is considered to be made on the date it is sent to the plan.

If premiums are not paid by the first day of the period of coverage, the plan has the option to cancel coverage until payment is received and then reinstate coverage retroactively to the beginning of the period of coverage.

If the amount of the payment made to the plan is made in error but is not significantly less than the amount due, **the plan is required to notify the insured of the deficiency and grant a reasonable period** (for this purpose, 30 days is considered reasonable) to pay the difference. **The plan is not obligated to send monthly premium notices.**

COBRA beneficiaries remain subject to the rules of the plan and therefore must satisfy all costs related to co-payments and deductibles, and are subject to catastrophic and other benefit limits.

Traditional Indemnity Plans

Health insurance today can be divided into two broad categories:

- ∇ Traditional indemnity plans.
- ∇ Managed care plans.

While both provide health insurance cover**, they are very different in terms of both the cover that they provide and the manner in which they are administered.**

- **Indemnity plans** are designed to provide cover for unexpected medical bills arising mainly through accident or illness.
- **Managed care plans** are based upon the principle of supporting care that is designed to prevent illness from developing in the first instant, or upon detecting and treating it at an early stage when treatment is often relatively simple and costs are low.

Indemnity plans are also designed to provide the policyholder with immediate care of his or her own choosing and place much of the responsibility for administration on the policyholder.

Because indemnity plans give the policyholder choice and access to immediate treatment and are designed to cover medical events that are often in themselves very expensive, the cost of indemnity insurance is generally high.

Accordingly, **indemnity insurance should only be purchased when an individual considers that it will best suit his own personal needs**, based upon his medical history and current state of health, and when he is happy that he will be able to afford the policy, not only today but in the years to come.

Indemnity plans will normally be issued as basic health insurance, major medical insurance or comprehensive insurance, which is a combination of both basic and major medical insurance.

- ∇ **Basic medical insurance** can normally be expected to cover such things as visits to the doctor (other than for routine check-ups and preventative care), hospital care (including room and board and some services such as x-ray and medication) and surgery performed either in hospital or at a surgical center or doctor's office.
- ∇ **Major medical insurance** is designed to cover treatment for extended periods of high-cost illness or major injury and will normally cover all hospital costs, as well as subsequent out-patient bills.

Traditional Indemnity plans were at one time just about the only option people had.

- Modern medicine has improved to the point where people are more healthy now.
- Medical care also costs more today. Insurance companies found that they were losing money. They had to find some way to make a profit, and developed the Managed Care plan.
- **It seems that the Traditional Indemnity plan has fallen out of favor somewhat** as people have begun to prefer the coverage and choices from a Preferred Provider Organization.

Chapter 9
Major Medical Insurance ~ II

HMO's (Health Maintenance Organizations)

An HMO (Health Maintenance Organization) is a specific type of health care plan found in the United States.

- Unlike traditional health coverage, an HMO sets out guidelines under which doctors can operate.
- On average, health care coverage through the use of an HMO costs less than comparable traditional health insurance, with a trade-off of limitations on the range of treatments available.

The HMO has its roots sometime in the early part of the 20th century.

- Many businesses began offering their employees prepaid medical programs, under which their care was looked after as long as it fell within the scope of allowed procedures.
- The HMO did well throughout the mid-part of the century as well, until its use began to decline drastically in the late 1960s and early 1970s. In 1973, the U.S. Department of Health and Human Services passed the HMO Act, which helped cement the HMO as a part of the American medical universe.

The ways in which an HMO is able to offer cheaper health care are twofold.

- First, by contracting with specific providers of health care and dealing with large quantities of patients, the HMO is able to negotiate for more affordable health care than the patients would otherwise receive.
- Secondly**, by eliminating treatments that the HMO views as unnecessary**, and **by focusing on preventative health care** with an eye toward the long-term health of their members, the HMO reduces costs.

When one joins an HMO, one is usually asked to choose a primary care physician.

- This doctor then acts in part as the HMO's agent in determining what treatments the patient does and does not need.
- When the primary care physician determines that the patient needs care they cannot offer, they give a referral to a specialist that can address the patient's concerns.
- Emergency visits are exempt from this referral limitation, of course, and in many cases women are able to choose an OB/GYN as well.

The long-term benefits of the HMO structure are a subject of much debate.

- **Proponents point out** that they offer low-cost health care to those who otherwise might be without.
- **Critics say** that restrictions placed by the HMO, and a general atmosphere encouraging practitioners to avoid referring patients when possible, results in many serious illnesses and medical conditions going untreated.

PPO's (Preferred Provider Organization)

PPO or Preferred Provider Organization is a group system of health care organized by an insurance company.

- Physicians, health care providers of all types, hospitals and clinics sign contracts with the PPO system to provide care to its insured people.
- These medical providers accept the PPO's fee schedule and guidelines for its managed medical care

The insured members pay a co-payment at the time of each medical service.

- For example, at the time of an office visit to a physician, the patient pays $20.
- Each person will also have a yearly deductible to pay out of his/her pocket, before the insurance company will start paying medical fees.
- The insurance usually pays a percentage of the medical fees (often 80%) for the in-network doctor, with the patient responsible for the remainder of the bill.
- If the person wants to see an out-of-network doctor, he/she may do so without permission; but the deductible for out-of-network services may be higher and the percentage the insurance will pay may be lower.
- In other words, the patient will be responsible for a greater part of the fee. This encourages the people insured with a PPO to use the physicians, other medical providers and hospitals in their network

Advantages of a PPO include the flexibility of seeking care with an out-of-network provider if so desired, even though it is more out-of-pocket expense for the patient.

- PPO networks also have prescription services which provide prescription drugs at a reduced cost.
- The overall premium for a PPO is less than for individual health coverage and will often include more covered medical services.
- There is a large network of medical providers representing large geographic areas

HMOs vs. PPOs

Health maintenance organizations (HMOs) and **preferred provider organizations (PPOs)** are both types of **managed health-care systems**. There are differences between the corporate structures of each, but they are typically not important to the average consumer.

However, several other important distinctions exist, including the following:

- **HMO members must choose a primary care physician (PCP)** from among the HMO member physicians. The PCP provides general medical care and must be consulted before a person can see a specialist, who must also be part of the HMO.
- **PPO members do not choose a primary care physician** and can refer themselves to specialists.

- HMOs typically **provide no coverage for care received from non-network physicians** (with exceptions for emergency care while traveling, etc.).
- PPO members **are not required to stay within the PPO network**, but there is usually a strong financial incentive to do so. For example, the PPO may reimburse 90% of costs for care received within the network, but only 70% of costs for non-network care.

- HMOs typically **do not set deductibles** that must be met before insurance benefits begin (e.g., $5 or $10). Instead, HMO members often pay a nominal co-payment for care.
- In contrast, PPOs **sometimes require members to meet a deductible** (especially for hospitalization) and may have larger co-payments than HMOs.

The best choice depends on a person's particular needs.

- ✓ If he is considering an HMO, it's important to make sure that his physician is part of the HMO network (unless he is willing to see another physician).
- ✓ If not, a PPO might be a better choice, because he can still receive at least partial coverage regardless of network affiliation.
- ✓ He might also prefer a PPO if he has a medical condition that requires specialized care, because PPO members do not need a referral before seeing a specialist.
- ✓ However, if ongoing out-of-pocket costs are a major concern, an HMO is often a better choice, because there are no deductibles and co-payments are typically lower.

Point of Service Plans

Point of service plans (POS) are sometimes called an 'open ended HMO' or an 'open ended PPO'. This is because a point of service plan offers **an approved network of medical care facilities and physicians** for their policy holder's to choose from just like HMOs and PPOs.

A major difference is that point of service plans allow for their policyholders to receive their medical care outside of the network, though use of facilities and physicians within the network is encouraged.

Based upon the idea that medical costs may be offered at a lower cost in exchange for limited choices in medical care facilities and physicians, point of service plans have several variances from similar plan types.

- For example, newly enrolled policy holders of a point of service plan are required to choose a primary care doctor to keep tabs on their health. This doctor becomes the new policy holder's point of service and is chosen from the list of pre-approved doctors in the provider's approved medical care network.

- The point of service doctor may refer the policy holder to doctors not included in the network. However, the claim will not be covered in its entirety as it would have been had procedures and appointments been performed by a health care facility within the approved network.

To encourage policy holders to choose facilities and physicians from within the approved network, all paper work for doctor visits within the network are completed for the policy holder, as a courtesy. For medical care visits outside of the network, paper work is expected to be completed by the policy holder. Full documentation of bills, prescriptions, and receipts are required.

Pre-Existing Conditions

Traditionally, many employer-sponsored group health plans and health insurance issuers in both the group and individual markets **limited or denied coverage of health conditions that an individual had prior to the person's enrollment in the plan**. These types of exclusions are known as **pre-existing condition exclusions**.

Although such exclusions were problematic for those trying to secure health coverage in the past**, HIPAA and other recent federal laws bring some relief to this problem in certain situations**. To best understand the protections provided by the law, we need to remember the following:

- HIPAA establishes requirements and limits under which a pre-existing condition exclusion can apply.
- If an individual has a pre-existing condition, HIPAA helps minimize the impact of that exclusion on his access to health coverage.
- If an individual is a HIPAA eligible individual in the individual market, no pre-existing condition exclusion can be applied to his coverage.

Limits for Exclusions

Even if an individual's family member had a medical condition in the past, it is possible that the group health plan cannot use it as the basis for pre-existing condition exclusion.

HIPAA limits pre-existing condition exclusions to those medical conditions for which medical advice, diagnosis, care or treatment was recommended or received **within the six-month period before the individual's enrollment date** (his first day of coverage or, if there is a waiting period, the first day of his waiting period).

This is typically the date of hire. **This six-month period is often called "look-back" period.** Some State laws shorten this look-back period if the individual's group health plan is an insured plan.

The Impact of Exclusions

In many instances, HIPAA **can reduce the impact of the pre-existing condition exclusion**. **HIPAA does this in two principal ways:**

- ✓ The law **limits the time** over which an exclusion can keep an individual from getting coverage.
- ✓ HIPAA generally **allows an individual's previous health insurance coverage to reduce the amount of time** the exclusion can apply, or, in some cases, can totally eliminate such exclusions.

In addition, **no pre-existing condition exclusion is permitted for newborn and adopted children who are enrolled within thirty days, or for pregnancy.**

The Exclusion Period

The exclusion period must begin on the enrollment date. It can generally last no longer than twelve months.

- If an individual does not enroll **when he is first eligible** and does not enroll **when he has special enrollment rights**, the plan can refuse to cover pre-existing conditions for up to eighteen months after he enters the plan.

Before a pre-existing condition exclusion can be applied to an individual's coverage, the plan's consumer materials must tell him if the plan imposes pre-existing condition exclusions.

- ✓ His group health plan must send him a **written notice that an exclusion will be imposed on him.**
- ✓ The notice should describe **the length of the exclusion period.**
- ✓ The notice also should describe how he can demonstrate how much creditable coverage he has.

Once he understands that he has a pre-existing condition that is subject to exclusion, it is important to remember that his previous health insurance coverage might reduce or eliminate the length of the pre-existing condition exclusion.

- ✓ Under HIPAA's group market rules, creditable coverage can be used to reduce or eliminate pre-existing condition exclusions that might be applied to him under a future plan or policy.
- ✓ In general, if he had other health coverage (for example, under another group health plan or under an individual health insurance policy, Medicare, Medicaid, an HMO, or a state high-risk pool) his new plan's pre-existing condition exclusion period must be reduced by the period of his other coverage.

This earned credit for previous coverage that can help him reduce his exclusion period is called creditable coverage.

- ✓ The exclusion period must be shortened by **one day for each day of creditable coverage that he has.**
- ✓ If the amount of creditable coverage he has **is equal to or longer than** the exclusion period, **no exclusion period can be imposed on him.**

- ✓ When figuring out how much creditable coverage he has, however, he receives no credit for previous coverage that has been followed by a significant break in coverage - a period of 63 or more days in a row during which he had no creditable coverage.