GROUP INSURANCE
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CHAPTER 1 A POPULAR BENEFIT

In the recent past, group insurance was a basic fringe benefit taken for granted by most employees of large and medium companies. In this day of climbing medical cost, life insurance premium hikes, and life style choices, people are more concerned than ever about their employer's insurance benefits.

Individual policies in some cases are so expensive that some people are becoming desperate for coverage and even marrying insured participants with good group coverage in order to obtain coverage for themselves. Yet a survey of small businesses in this country shows that less than half of the businesses surveyed have group insurance in force. T**here are more than five and a half million small businesses (those with 50 employees or fewer) in the United States, there are obviously a lot of companies without group plans, and an abundance of workers not covered by a group plan.**

Group insurance is the simplest and most popular of business insurance products. It is an accepted idea with employers that can sell itself. It lets employers use money that would otherwise go for taxes to benefit themselves by attracting and keeping good employees with group insurance benefits.

The premiums the employer pays for group insurance to the insurance company are tax-deductible as an ongoing current business expense to the company. The employer's premium payment, when properly structured, does not create a tax burden for the employee. For example: federal income tax regulations currently state that the employer's premium is not taxable to the employee unless the total amount of the group life insurance exceeds $50,000. If the total amount of the group life insurance does exceed $50,000, only the portion of the premium that accounts for the excess death benefits is taxable.

The minimum number of individuals necessary to make up a group, the eligibility requirements of the group, and the kinds of groups that can be provided group insurance are generally regulated by state government through the states' insurance departments or boards. Compliance with the various state laws is part of the many group underwriting tasks. Plan participation, nondiscrimination, and benefit structure are also important underwriting factors taken into account.

The group cannot be established and bound together for the sole purpose of buying group insurance. The insurance plan must be incidental to the group planning to purchase group insurance. Trade associations, employer-employee groups, unions, and creditor-debtor groups are eligible under most state laws.

A trade association or professional association can purchase group insurance for the benefit of its members. Some individuals will join the trade association or the professional association exclusively to be eligible to receive the group insurance benefits at a lower cost than if that individual had to purchase insurance coverage through several individual policies.

The employer-employee group is by far the most common type of association eligible for group coverage. The employer can be a corporation, a partnership, or a proprietor. The group insurance plan can be established at anytime during the solvent life of the employer as long as the employer is not exclusively created in order to obtain and provide group insurance. The employer must be an ongoing business with valid employees that provide goods or services.

Union members can be eligible for group insurance. The group insurance plan may be a union membership benefit, or it may be a benefit provided through contractual bargaining. If the plan is a union membership benefit the group insurance policy is issued to the union and the union is responsible for the union member's benefits. If the group benefits have been contracted through union negotiations with the company the union member works for, the employing company owns the policy since the employing company pays the premiums.

Examples of creditor-debtor groups are leasing companies, mortgage companies, and banks. The creditor obtains a group policy and the debtor receives life or health insurance on a group basis. Creditors often require that the debtor purchase the group credit life insurance in order to protect the creditor if the debtor dies before the debt is paid. If the debtor dies, the insurance company will pay the deceased's unpaid balance to the creditor. The group health insurance is actually in the form of a disability income benefit. If the debtor becomes disabled before the debt is paid to the creditor the creditor does not have to worry about getting paid during the time the debtor cannot work. The debtor's installment payments are made to the creditor by the insurance company when the debtor becomes totally disabled.

Plan participation and enrollment qualifications are regulated by law. This helps to realize a proper spread of risk and to avoid adverse selection by plan participants in favor of the insurance company. Also, statutory discrimination must be avoided when establishing group insurance plans. In a nondiscriminatory manner, the classes of insured employees must be established. Some employee groups can be excluded from participating in the plan and still be in legal compliance. For instance, the plan could legally exclude non-union employees. Guidelines such as job description, salary classification as well as other criteria for employment can be used to establish legal discrimination in plans. The participant's lengths of service, earnings, or job titles are some of the criteria that can be used to establish plan benefit structure. Group plan benefit structures are regulated by the states. The states help to safeguard against anti-selection through regulation of plan benefit structure.

The size of the group to be covered is regulated by most states. A minimum of ten individuals was most often the minimum size of an acceptable group. A plan with fewer than 10 participants was acceptable in some states, and other states had no specific size requirement. This requirement could be waived in most states, however, if the master contract applied to a group of more than ten insured through an association group or multiple employer trust. The Health Insurance Portability and Accountability Act of 1996, along with the phase-in of health insurance premium deductibility for the self-employed, have changed the entire thrust of group insurance in the last few years.

Group Insurance Systems

Under a group insurance plan, the employer enters a contract and pays premiums to an insurance company. The insurance company, in return, provides health and disability benefits for the employer's staff. Benefits can also be provided through the plan for the employee's family. Most plans include death benefits that will be paid to the family if the employee dies. The

cost of the group insurance, the premium, is locked in for a set period of time, as are the plan benefits. The insurance provider normally supplies the benefit structure, claims review and processing, and other general administrative services at no additional cost. A group plan is not complicated or difficult for the employer to implement within the company.

Many of the largest life and health insurance companies sell various forms of group insurance. Some insurance companies will market only group life products while others have many kinds of group insurance packages available. Group life insurance is one of the top money makers of all of the group products since the insured can assume the risk and realize a profit over a greater length of time. Group health insurance may not even produce a company profit with inflated medical costs and high claim expenses. These are the reasons that an insurance company may not want to provide group health products to the public.

The many variables involved with health coverage could devastate an insurance company. Accordingly, many providers may not choose to write group health coverage. The companies that do offer group health products stay solvent by careful planning, effective management organization, and stringent underwriting requirement. They must strive to keep their policy related expenses low, choose insureds with good claims experience.

There are a variety of group health insurance contracts that an employer can enter for the benefit of the employee. **Three of the standard contracts that are offered by insurance companies are the basic medical insurance contract, the major medical insurance contract, and the disability income insurance contract.** There are also a variety of group life product benefits an employer can choose from when implementing a company group plan. Some of the benefits include employee life insurance benefits, dependent group life insurance benefits, and accidental death and dismemberment insurance benefits.

Alternative to Group Insurance

Individual insurance coverage is one alternative to a group insurance plan. The same insurance products offered in a group plan can be purchased by an individual or by the employer of the individual. There are individual policies offering product coverage similar to coverage found in group plans, but the cost of individual policies are many times prohibitive. This is especially true when contrasting individual life insurance with group life insurance. With increased costs and premiums due to the rising price of medical care today, group health insurance may not be more costly than an individual policy. The group plan usually includes more for the dollar than individual coverage. Through group purchasing power the premiums for group policies afford a far more encompassing product than individual policies contain. The main difference between individual policies and group policies is the method of risk selection. Age, sex, occupation, and medical history are a few of the factors requiring review in individual underwriting.

Individual proof of insurability and medical underwriting are not usually considerations for participant of a group insurance plan. A large number of participants are covered under one group insurance policy whereas only one person or family is covered under an individual policy. The group participants are not individually issued an insurance policy. The company receives a master policy, and the terms and conditions of the group insurance plan are issued to the worker in an employee insurance booklet.

The insured on the individual policy receives the policy for safe keeping. Individual insurance policies usually have a shorter duration than a group insurance policy. A group insurance plan can remain in force longer then the lifetime of an individual or plan participant.

Another alternative for providing coverage to employees is through a self-insured plan administered by the employer company. Most companies with self-insured plans are large financially secure companies. Self-insured plans are not a viable insurance alternative for comparatively small companies with few employees. The small company cannot estimate with certainty how much money will have to be paid out in benefits or the claims the company will experience over a certain period of time. Also the small company cannot afford to have the program administered by an independent contractor and cannot afford to hire the professional staff required to administer the program.

Large companies that establish self-insured plans assume the risk for health care costs instead of transferring the risk to an insurance provider. The company sets aside funds in the plan. The funds are used to pay benefits to employees when claims are filed or benefits are due. The company does not pay any insurance premiums, instead the self-insured company places sums of money in a secured account to provide health care for employees.

The self-insured company does not administer the plan in most cases. The company does not normally have the staff expertise required to make claim payment and perform other insurance-related duties. The company can hire a licensed insurer for administrative services only. The self-insured does not purchase insurance products from the insurance company; it only contracts administrative services from the insurance company. The company will pay a fee to the insurer for services rendered. The insurance provider performs benefit structure, claims processing and review, and administrative support. The self-insured company can alternatively choose to contract a third party administrator to provide benefit structure, claims processing and review, and administrative support. A third party administrator company is usually created in accordance with the state's insurance laws for the purpose of providing administration of insurance plans. The third party administrator may handle several accounts at a time and is not a captive contractor to one plan.

Not all self-insured plans enjoy the same tax advantages that a group insurance plan enjoys. A company establishing a self-insured plan must be careful in structuring the plan so that it may qualify for tax advantages. A self-insured plan must meet the IRS requirements to qualify for tax favor. If the plan does receive tax favor the company funds paid into the plan's secured account, used for claims and benefit payments, are tax deductible to the company.

Group Insurance Advantages

The employer who has a good group plan does not have to worry with the IRS tax complications. The employer who has a good group plan entrusts tax planning problems, and other administrative factors to the plan's insurance company. The insurance company has a professional staff to cope with employee insurance benefit problems. The employer with an in-place group insurance plan will find it easier to recruit well qualified employees from the work force. Potential employees in many cases see group insurance coverage as part of their total compensation rather than as an extra privilege. The more attractive a company's group insurance program is the better a company will be at recruiting successful employees. A well structured group insurance plan will also help the employer keep quality employees.

CHAPTER 2 GROUP LIFE PLANS

The most common life insurance product used to provide employees with a life benefit program is group term life insurance. The employer establishes the group plan to provide the employee with a predetermined death benefit while employed by the sponsor of the plan. Group term is only a death benefit. Group term life insurance does not carry a cash value and accordingly has no living benefits. Coverage is commonly provided to the employee through an annual term life insurance policy. At the end of each policy year, premiums are recalculated. A variety of factors can be used to structure the plan's renewal premium amounts. **Three premium variable structures are as follows;**

1.) Premiums can be calculated using the average age of the group.
2.) Premiums can be calculated using the experience rate of the employer's industry.
3.) Premiums can be calculated using the employer's actual experience rate.

Normally the premium is recalculated based on the age distribution of the current employees that will be participants of the plan. Younger employees enter the group and older employees leave the group. This factor in itself can change an employer's actual experience rate. The age distribution may also coincide with a change in the industry experience rate.

Group Life Employee

Advantages Group life employee advantages-The most obvious of all group life insurance employee advantages is the death benefit that is available. As in other life insurance products, the death benefit is not subject to federal income tax. The proceeds are received by the beneficiary tax free.

Group life insurance provides coverage for those who might otherwise be uninsurable. Group policies are usually issued without any proof of insurability on the part of the group participants. For example, John may have had a serious illness in the past and is currently grossly overweight. The two factors together make it nearly impossible for John to be underwritten on an individual policy. He knows this because he tried to get life insurance and his personal agent said that John was not insurable. After John starts work for the XYZ Company, he receives life insurance coverage through his employer's group plan with no questions asked. John is not required to submit any proof of insurability.

Group insurance can provide peace of mind for those who already have personal life insurance and savings. The group benefit provides added protection for the individual and his or her family. The benefit becomes a part of the individual's personal financial portfolio. It becomes a financial element to his or her personal financial plan. The employee that is covered by group life insurance plans can supplement his or her total life insurance needs and enlarge the person's personal security plan. Accordingly, group life insurance coverage should be included in the asset section of the employees personal financial statements while in force.

Group Life Employee Disadvantages

The most common group life insurance product is term insurance, but it can have disadvantages. Although term insurance can be an excellent product, a group term life insurance plan can have disadvantages and limitations for the employee if the employee is not

aware of the terms and conditions of the plan. One disadvantage is that the employee with group term coverage may feel that he or she has adequate protection for their needs while in reality they do not.

For example: Sally began work with the ABC company as a graphic designer as a graduate from college when she was 22 years old. She immediately received $10,000 term life insurance through the company's group insurance plan. During years of service with the company Sally's life insurance benefit amount had grown to $50,000. Sally never purchased any outside personal insurance since she felt that $50,000 was adequate for a person in her situation. Now Sally is 40 years old. She has resigned her position with ABC and has started her own graphic designs company. Sally needs life insurance. She soon finds out that to enter into a life insurance policy at 40 is much more costly than it would have been when she was 22 years old.

She did not understand that the term insurance was an annual contracted expense, not an investment that moved with her after her former employment. She did not know that when she converted her former group policy into an individual policy her premiums would rise dramatically. Sally, had she known, would have supplemented the ABC company's policy with personal life insurance when she was younger and the insurance premiums were more affordable.

As shown with Sally, employees that are participants of large group life plans do not normally receive personalized counseling and advice from the underwriter of the company group plan. An individual's agent acts more in the capacity of a financial planner than a group insurance agent. The individual's agent continually reviews the insurance in force. The agent gives his or her client advice and explains the client's individual needs at different times during the life cycle. Often the employee does not know anyone with whom to discuss insurance or the demands for current and future cash requirements.

Accordingly, an employee could get a false sense of security. The employee should be encouraged to read the group insurance booklet, and encouraged to ask questions in order to adequately understand the group coverage to help prepare for the untimely event of death or disability. The group insurance agent can help coordinate the employer efforts. The group insurance agent can help communicate important insurance information and limitations to the employee.

The employee should understand that group insurance policies are experience rated from time to time by insurers on the basis of claims and expense experience, and premiums may be adjusted if necessary. Usually group term life policies are up for renewal annually, although some may be guaranteed for longer periods. A group term life policy can have an issue life of two to five years.

Insured employees should understand that they have no guarantee that group coverage will be continued from one year to the next. The employer may decide to discontinue or change the policy if the group plan becomes too expensive or if the employer has financial difficulty. Employees need to understand that are no cash values with term insurance.

When an employee loses his job, he or she loses the group insurance coverage. Most policies do have a conversion privilege clause, but in actual experience relatively few employees take advantage of the conversion privilege. Also, group insurance protection usually ends or is greatly reduced at retirement. It should be communicated to employees that a group life insurance plan has limitations. A group life insurance plan should not be confused with a personal savings and protection plan.

In summary group life insurance contributes to employee morale. It gives the employer a competitive edge in hiring well-qualified new employees and retaining old ones. Because it provides a benefit which employees otherwise would need to purchase with after-tax dollars, it can ease the pressure of demands for salary increases. It improves the company's public image and helps prevent further government encroachment into the business world. Of course the biggest advantage is that each dollar spent by the employer on the employee is tax deductible to the employer if the program is qualified by the IRS. In order to be qualified benefits must be offered on an equitable basis to employees.

Group Life Enrollment

All of the participants enrolled in an employer sponsored group life insurance plan are covered under one policy. **It is not necessary to issue each individual a policy. The group life insurance contract is known as the "master policy".**

The contractual relationship between the policy holder and the insurance company is outlined in detail in the master policy. Each participant insured under the policy is issued a "certificates of insurance". The certificate gives information on individual death benefits, identifies the group policy number, and gives claim procedures to follow at the point of death.

Commonly, an announcement booklet accompanies the individual certificate of insurance. The announcement booklet explains the terms and conditions of the employee's coverage. The announcement booklet explains terms and conditions for dependent coverage if such coverage is provided by the group life insurance plan. The booklet will include eligibility requirements for joining the plan, and give the how's, where's and when's of joining the plan. Also announced is the effective date of the life insurance coverage, the amount of the employee death benefit, and the federal tax laws governing the plan. The announcement booklet will cover how benefits are paid, beneficiary designation rules, policy assignability, claim's procedure, conversion features, and other general plan information. Under federal law, the Employee Retirement Income and Security Act of 1974 (ERISA), the announcement booklet is required to state the employee's rights to the group life insurance plan.

If the business installing the group plan is a corporation, the company will have additional requirements at inception. In addition to the master policy, the corporation must provide a formally drafted resolution detailing the eligibility requirements for employees, the amounts of coverage provided retirement and disability provisions, and other details. The resolutions must be passed by the board of directors of the corporation offering the group plan before the plan becomes effective.

Group Life Terms and Conditions

The group policy contains many of the terms and conditions that would be found in an individual life insurance policy. The conditions included on either the individual or the group policy are; settlement options, suicide limitations, and incontestable provision.

Qualified Plan Provisions

As set out by the IRS, to be a qualified group life insurance program the program benefits must be made available to all the employees, or all employees of a particular class of employees, or a majority of the employees of the sponsoring company. **To receive tax benefits, a group life insurance plan must be qualified. This condition assures that discrimination due to gender, age, or race will not occur, if the employer wants to receive tax advantages.**

Probationary Period

After the inception of the group life insurance plan, when a new employee is hired, if all other employee eligibility requirements are met, there is a waiting period before the employee qualifies to join the plan. The amount of service an employee must have before he or she becomes eligible for enrollment into the group life plan can vary with the different policies and groups. The standard probationary period for group life insurance coverage is 30, 60, or 90 days, but it could be longer. The probationary period normally applies just to new employees of the sponsoring company. Commonly, at the inception of the plan all actively employed persons considered "regular, full-time employees" are eligible for enrollment into the plan.

In some group life insurance plans a new employee will be designated as exempt from the probationary time, and others will be designated as non-exempt from the probationary time limits. The exempt employee is eligible to become a member of the Group Life Plan on the date of employment as a regular full-time employee. The non-exempt employee is eligible to become a member of the Group Life Plan on the day his or her probationary period has been completed. The employee must have continuous employment for the stated amount of time as a regular and full-time employee. The insurance booklet usually contains a specific definition of what the Plan considers a "regular, full-time employee."

If dependent coverage is offered in the group life insurance plan, the eligibility date is the same as that of the employee that enrolled the dependent under his or her plan. Each plan offering dependent life insurance coverage will define dependent in the announcement booklet. Commonly, dependents are considered to be employee spouses and employee children below a certain age. The plan may also state guidelines for dependent coverage if both parents are employed by the same company, or if the dependent is employed by the parent's company.

Grace Period

If the premium for a group life policy is not paid during the grace period, the policy will lapse for non-payment of premiums. **The grace period allowed by most insurance companies is 31 days.** Some insurance companies waive the right to cancel by extending the time the employer has to pay the premium. This is important since the policy covers many individuals that are counting on the coverage. The insurance company may help the insured during times of financial difficulty. The insurance company usually will give the employer an extension date

during which the group life plan's premiums can be paid to the insurer. The insurance company may accept partial payment of the premiums in order to keep the policy in force.

Open Enrollment

Once a year the company management or board of directors will review and analyze the current group life insurance plan in force. They will decide if the current plan is satisfactory or if another plan is desirable. The board may decide that they like the current plans benefits, terms and conditions. Even if the management or the board decides the current plan is not to be changed, they still must go through the process of attaining a new master policy. The process discussed earlier for implementing the group life insurance plan and the process for enrolling the "regular, full-time employees" into the plan, and the issuance of new announcement booklets must be repeated.

As discussed, the master policy is a contract for annual coverage. Some plans do have contract periods from 2 to 5 years, but the vast majority of group life insurance plans offer only 12 months of coverage. Accordingly, a new contract must be entered into each year as the old contract expires.

After the new agreement has been entered into the company will again have "open enrollment" for all eligible employees. If the employee fails to enroll in the plan or fails to enroll the dependents in the plan during this 31 day "open enrollment" the employee could have a year to wait until the next "open enrollment", or have to prove insurability to join the plan.

Enrollment for new employees

After the probationary period requirements have been met, there is an enrollment period during which the new employees must submit an insurance application. The enrollment application requires the enrollee's name, address and Social Security number. The application is required in order to join the group life insurance plan. Usually, the employee has 31 days to complete and submit the insurance application. If the employee does not submit his or her application within the stipulated period, he or she may also be required to furnish evidence of insurability before enrollment becomes effective. In some cases, as with existing employees, if the employee does not apply within the stipulated enrollment period, the employee is barred from enrollment until the next "open enrollment" period, which is usually held on an annual basis.

If the employee's premiums are paid 100% by the employer, a formal enrollment application is not required. If the employee elects coverage for his or her dependents, a formal enrollment application must be made and submitted within the 31-day time limit no matter if enrollment for the employee is formal or informal.

Group life beneficiary designation: The employee, at the time of formal or non-formal enrollment into a group life insurance plan, must submit a beneficiary designation form. The beneficiary designation names the person that has the right to the employee's death benefit even though the employer is the owner of the group life insurance mater policy. The employer is not allowed, by law, to be the beneficiary of an employee's group life insurance.

Eligibility Dates

Employees' effective coverage eligibility dates: **Group policies require that the employee's coverage will begin on the date of eligibility if the employee is then actively at work**. If the employee is not actively at work on the date of eligibility his or her coverage will begin on the day the employee returns to active work. If dependents have been enrolled for coverage, the dependent coverage will become effective on the date the person becomes an eligible dependent or on the employee's effective date, whichever is later.

Employee Benefits

Employee benefit amounts are determined in a variety of ways. The master policy will include a predetermined schedule of benefits as will the employee insurance announcement booklet. One of the most common methods of determining benefits is the flat rate method. Each employee's beneficiary in this case would receive the same amount of predetermined benefits. All job classifications in the company will receive the same coverage.

Another method to determine benefits involves employee earnings multiples. The beneficiary would receive a benefit calculated using a multiple of the employee's earnings at a specified time during the policy period. For example: All employees will receive two times base annual salary. The maximum amount of coverage in the plan will be $700,000. The base salary is the salary the employee made as of October 1st and does not include bonuses, commissions, overtime pay, shift differential and any other extra compensation.

Annual Base Salary	**Amount of Insurance**
$25,000	$50,000
$30,000	$60,000
$40,000	$80,000

The group life coverage may be based on an occupational classification method. For example:

Job Classification	**Amount of Insurance**
Officers of the Company	$80,000
Supervisors	$60,000
Support Personnel	$40,000

The group life coverage can be a combination of the above methods. For example: As an eligible employee, coverage might be provided as follows:

Commissioned employees: $40,000
All others employees: 2 times base annual salary not to exceed the aggregate $700,000.

The amount of coverage that will be offered the employees in the group life insurance plan is determined by the business owner or the board of directors, before the inception of the policy.

Changes in Benefit Amounts: The group life plan will state whether the employee is eligible for increased coverage through the year if there is a change in salary. Most plans lock in the

benefits the employee is entitled to for a specific amount of time. The employee cannot request a change of the benefit amount until a specified time.

Beneficiary Designation: Under the terms of a group life insurance plan, the employer sponsoring the plan is the owner of the life policy, but the plan participant must have the right to designate his or her beneficiary.

Group Life Dependent Coverage

If the employee already has dependent coverage, any child born after the effective date of the coverage will be covered automatically by the plan. **New coverage for the first dependent child requires in most cases that the employee complete a new enrollment card within 31 days of the child's date of birth.** Similar rules usually apply for new spouses of employees covered by the group life insurance plan. The covered employee must complete and submit a dependent enrollment card within 31 days of the marriage to attain coverage for the new spouse. If the employee becomes divorced from the covered dependent or the dependent child reaches any imposed age limits, the employee must submit a new enrollment card, eliminating the dependent that is no longer qualified for membership in the life insurance plan.

When the group life insurance plan provides for dependent life insurance benefit coverage the group life insurance master policy and the employee insurance announcement booklets will include a short paragraph describing the benefits. The information will briefly include the amount of the benefit available for the dependent spouse. The dependent children coverage is stated and is usually less than the coverage available to the covered employee's spouse.

Misstatements

Misstatement of Age or Sex: The insurance company has the right to adjust the policy premium or the death benefit paid if a participant misstates his or her age. If by error the sex of the participant is misstated the policy premium or the death benefit can be adjusted by the insurance company issuing the group life insurance policy. The insurance company can make the required changes at any time the error is discovered.

Group Life Claims Procedure

In the master policy for the group life insurance plan standards for paying claims will be established. The employee insurance booklet will state the procedure for making a claim, what documents are needed in making a claim, and where a claim should be sent.

There is included a statement of the system that will be employed if the claim should be denied, and what the beneficiary's right and recourse would be in such a case.

Additional coverage

Under some arrangements an employee may have additional coverage over those in the basic group policy by making a contribution to the premium. The additional amount is not usually considered a part of the master policy but is offered as a part of the employee "perk" package. Even in this case the cost of the premiums to the employee is much less than it would be if the employee had an individual policy.

Conversion Options

Group life conversion options after employment termination: Naturally there is a turnover in employees in any company. The group life insurance plan has taken this turn-over factor into consideration when designing group coverage. Group life insurance plans have special provisions affecting individuals who are terminated from a company with a group plan in force. Group contracts allow a terminated employee to convert all or part of the group life insurance coverage into an individual life contract. The group term insurance is usually convertible into whole life insurance.

Group life insurance can be converted into an individual life policy by the employee who is terminated by the sponsoring company. A former group plan participant that converts into an individual policy does not have to provide evidence of insurability. This option is a definite advantage to some former participants. The individual's age will determine the rate of premiums required on the former participant's individual policy. The premiums can be costly for the individual, but at least the individual can buy an individual life policy.

A former plan participant usually has 31 days to convert the group term life insurance coverage into an individual policy without submitting evidence of insurability to the insurance company. The terminated employee must submit an insurance application and the premiums due during the 31-day period.

If the former participant dies within the first 31 days of severance from the group plan, the death benefit is still payable under the group life insurance plan of the former employer. The 31-day extension of benefits affords the former participant protection. During the 31-day extension of benefits, he or she will have time to decide whether to exercise the group conversion option, or whether to purchase an individual life insurance policy. The benefit extension time also allows the former participant time to be covered under the new employer's group plan.

Group Life Conversion Options for the Retiree: Under most small group contracts, the coverage of an employee is terminated when he retires. Larger company group life insurance plans allow the former participant to convert into an individual policy. The retiree covered by a convertible option will normally receive the thirty-one days of extended benefits after discharging from the group plan. If the retiree dies within the first thirty-one days of severance from the group plan, his or her beneficiary will receive death benefits from the former group life insurance plan of the employer.

The conversion option for the retiree is very important financial consideration. In most cases the converted policy face amount is reduced substantially after retirement, but at least the retiree will have some death benefits in place.

Group Life Conversion Options for Surviving Dependents: Some group life insurance plans give conversion rights to a surviving spouse. Example: the group life insurance plan provides for coverage of a dependent spouse. The employee-participant elects to cover the dependent spouse through the group life insurance plan. The employee dies during the time he or she is employed. The deceased employee's conversion rights are transferred to the surviving spouse. The surviving spouse can elect to convert his or her group plan coverage into an individual life insurance policy. If the employee had extended benefit rights those too will be

transferred to the surviving spouse. The surviving spouse will have a predetermined amount of time in which he or she is covered by the former employer's group life insurance plan. If the surviving spouse dies within the predetermined time, the employer's group plan will pay death benefits to the beneficiary named by the deceased surviving spouse. The surviving spouse will also have a predetermined amount of time to convert the group coverage to an individual policy.

Some group life insurance plans give conversion right to a surviving child. Example: The deceased was a participant of a group life insurance plan. The plan provides for coverage of a dependent child, and the former participant enrolls the dependent child into the group plan. The participant dies during the time he or she is employed. The deceased employee's conversion rights are transferred to the surviving child. Some surviving children may or may not have conversion rights. When the surviving child's conversion rights transfer, the right of extended benefits will also transfer to the child, as will all other similar rights. Normally, if the child does have the right of conversion, he or she will be eligible for a lesser face amount of life insurance coverage in the individual life insurance policy.

Waiver of Premiums

Group coverage for the employee disabled while employed: Another factor usually included in group life policy provisions is a "waiver of premium" for group plan members who becomes totally and continuously disabled before a specified age. If the participant does become disabled, the applicable premium for that insured participant is waived by the insurer. The disabled participant retains full coverage for a time period stipulated by the group life plan.

AD&D

Group AD&D Benefits: An accidental death benefit is an additional death benefit. Normally it is equal to the participant's group life insurance benefit. The benefit will be paid if death is due to a policy defined accident. Accordingly, if the participant in the group life plan dies of a policy defined accident, the participant's beneficiary will receive the death benefit and an amount equal to the death benefit due to the nature of the death. Most group life insurance plans include accidental death clauses.

An accidental dismemberment benefit is an additional benefit commonly equal to the face amount of the participant's group life death benefit. The benefits will be paid if the group plan participant loses his or her arms, fingers, legs, eyes or vision. The accidental dismemberment clause is written in conjunction with the accidental death clause and is a benefit found in most group life insurance plans.

Financing Group Life Plans

In not so many years past, 100% employer funded plans were the norm in the United States. Currently, 100% employer funded plans are becoming more and more uncommon. **A group life insurance plan can be financed exclusively by the employer, or can be split between the employer and employee in a predetermined ratio.** For employers, group term insurance provides a means of solving the problem of taking care of survivors if an employee dies, but due to rising cost the employer cannot afford this. The employee must bear some of the cost of coverage.

OTHER GROUP LIFE PLANS

There are other group life plans that are secondary, in most cases, to the major group life plan offered by employers. The plans may be elected by the employer and employees to be an element of the general life plan. In the case of credit life the plan is for a third party, excluding the employer-employee relationship.

Paid Up Insurance

Group paid-up life coverage is designed to ensure that when an employee reaches retirement age, that employee will have life insurance coverage and the cost of that protection will be affordable. Take for example a case where an employee is only covered by a group life insurance plan with conversion rights. At retirement age the participant can let the insurance benefit lapse or convert the coverage into an individual whole life insurance policy. The premium on the individual policy will be calculated using the employees age at retirement. The retiree finds that the premium on the individual whole life policy at age 50-65 is prohibitively expensive. In a different situation it may be that the face value of the participant's coverage is decreased when conversion takes place. This could leave the retiree with insufficient life insurance coverage.

Paid-up life insurance has been designed as a better alternative to the ones mentioned. Group paid-up insurance includes a portion of permanent insurance such as whole life, and a portion of term insurance. The two together equal the total coverage on the participant. The premiums for the paid-up portion of the insurance are normally paid by the participant. The term portion of the insurance coverage is paid by the employer. The participant's premiums are usually deducted from his or her paycheck. In order for the employee to afford the premiums, the amount of the permanent protection will be small at first. As the amount of paid-up life insurance increases over time, the amount of term insurance decreases since the total coverage cannot exceed the employer's scheduled amounts of insurance.

Group paid-up life insurance is not popular with most participants of group life insurance plans. Most employees do not like to have to pay the additional premiums for the paid-up life protection. It is often rejected by the employer or the employees. However, paid-up insurance is a good solution for the employee that has not obtained life insurance other than the term coverage provided through the group life insurance plan. Over time the face value of the paid-up life protection will, at least, provide for final death expenses. Accordingly the emotional and financial burden of the survivors will be lessened.

Credit Life

Another form of group life insurance is group credit life insurance. Large creditors install group credit life insurance policies to protect against the death of their debtors. The creditor has an insurable interest in the debtor throughout the life of the indebtedness. Group credit life insurance plans use decreasing term insurance as opposed to level term life. Decreasing term best fits the need of the creditor and the debtor. The creditor is the owner of the life policy, but the debtor pays the premiums on the life policy and receives the certificate of insurance as a stipulation of the loan requirements. The creditor is the beneficiary of the group credit life insurance death benefits.

The debtor normally will purchase insurance with a face value of the indebtedness. If the debtor dies and the amount of the indebtedness at the point of death is less than the face value of the life insurance, the excess benefit will be paid to the debtor's beneficiary or estate.

A creditor cannot force a potential debtor to purchase group credit life insurance. State law commonly prohibits the creditor from pressuring the debtor in any way. One concern of an insurance company offering group credit life is adverse selection. Since credit life is voluntary, the debtor with poor health may be more likely to purchase the insurance than a healthy debtor. The insurance company offering group credit life will require the creditor to have a specific number of new debtors enter the group annually. With new debtors coming into the program the insurance company's risk of adverse selection is lessened.

Creditors that most frequently install group credit life plans are finance companies, mortgage companies, commercial banks and trust companies. Universities, credit unions and credit card companies may also find a current need for the group credit life insurance plan.

By providing group credit life, universities protect student loans, credit unions protect loans made by their members, and credit card companies protect outstanding credit card balances. Other types of indebtedness that are protected through group credit life are car purchases, secured and unsecured loans made to individuals and proprietors or partnerships, loans on farm equipment made to farmers, loans made for large appliances, and real estate loans.

TAX ISSUES

It is the responsibility of the insurance licensee to understand the tax ramification of group life insurance plans. The employer, as well as the employees, will be most interested in the tax benefits and assessments that will apply to the group.
Group life insurance is offered by employers due to the tax benefits the company will receive by offering the plan. Without the tax incentive, many employers offering group plans would not offer the plan. Without the tax incentive, in most cases, the employer would not be able to afford the group life insurance plan for the employees. Accordingly, tax ramifications are of primary importance to any employer considering installation of a group life plan. Once the plan is installed the employees will want to know if their benefits are taxable, if the premiums paid by the employer are taxable, etc.

The Employer and Federal Tax

If a group life insurance plan is structured properly, the premiums paid for the coverage by the employer on behalf of the employee should be tax deductible to the employer. The tax rules and regulations covering group life insurance have become stricter so as to insure that group life plans take care of the group for which it is intended.

Let's see why some of the restrictions have been mandated. For example: Employers implementing group life insurance plan cannot be named as a participant's beneficiary, and retain tax favor on the group plan.

Why?: Group life policies in most cases give the employee who joins the plan the right to name and change a beneficiary as he or she wishes. A limitation is that the employer may not be named as a beneficiary without affecting the tax status of the plan.

If an employer was allowed to be the named beneficiary, the initial group life plan to assist the employees could be maneuvered into a key employee plan designed to assist the business owners. The group life plan is not taxable to the employer due to the help it gives the employees. The key man plan is taxable to the employer since it has nothing to do with helping the employees, but helps the employer.

In a key employee plan the employer insures the life of key employees to ensure the financial status of the business if a key person were to die. By being the named beneficiary of an employee on a group life insurance policy, the employer would receive the death benefit to assist the business while a new key person was found and trained.

The death benefit of a key man plan would go to the employer. Accordingly, the survivors of the deceased would not receive any of the death benefit. The purpose of the group life coverage would be defeated. Therefore, if the employer company is the named beneficiary the plan loses its tax favor in the eyes of the law, and the premiums paid would not be deductible to the employer.

Deductibility

Group term premiums paid by an employer are deductible if the insured employee's compensation level is reasonable and, as stated previously, the company is not the named beneficiary. The premiums paid by the employer are not counted as taxable income to the employee if the insurance coverage is $50,000 or less. Any coverage over $50,000 provided by the employer is taxable income to the employee.

The 10-employee rule

Generally, life insurance isn't group-term life insurance unless you provide it to at least 10 full-time employees at some time during the year (see IRS Publication 15-B). For this rule, count employees who choose not to receive the insurance unless, to receive it, they must contribute to the cost of benefits other than the group-term life insurance. For example, count an employee who could receive insurance by paying part of the cost, even if that employee chooses not to receive it. However, don't count an employee who must pay part or all of the cost of permanent benefits to get insurance, unless that employee chooses to receive it. A permanent benefit is an economic value extending beyond one policy year (for example, a paid-up or cash-surrender value) that is provided under a life insurance policy.

If an employer implements a qualified group life insurance plan, all qualified full-time employees must be provided insurance. An employee of a small company may be required to obtain evidence of insurability, and this cannot deny the employee the right of participation in the plan.

As discussed previously, the size of the group to be covered is regulated by most states.

A minimum of ten individuals was often the size of a statutory stipulated group. **However, a group plan for employers with fewer than 10 employees can receive the qualified status from the IRS.** Group size is not one of the criteria for qualified status. The insurance company offering the group life plan decides what sort of evidence of insurability is required for the group. The underwriting rules are set up by the insurer. When the underwriting parameters are established, determination of applicability is limited to a medical questionnaire completed by the employee. The employee of a company with a group plan is not required to have a physical examination for proof of insurability.

For example, the minimum size required in California to qualify for Small Business coverage is to show 2 eligible employees. Both eligible employees do not usually have to enroll in the plan if one is able to waive the plan offer due to alternate group coverage through spouse or employment. Companies with size 2-5 employee will see rates assigned typically at the highest allowable rate adjustment factor of 1.1 which includes the 10% additional cost above standard rate book price.

Starting in 2014, groups no longer have a rate adjustment factor (RAF). With the elimination of health status rating and other rating factors, all groups will move to the equivalent of a 1.0 RAF. If a group had an RAF greater than 1.0, this will benefit their rates. If a company had an RAF lower then 1.0, then it will no longer receive the discount on rates.

A small employer can also have a probationary period in the group plan that will exclude an employee from the plan until the required service time with the company has been fulfilled. When the employee has completed the required service time, he or she will then be eligible for enrollment into the group life plan. The probationary period for a small company is the same as with a larger employer, normally 30 days. A longer period can be stipulated by the small employer. Part-time employees of the company can be excluded from the qualified group life insurance plan.

To qualify for the tax benefit the group life plan is required to determine employee benefits using one of the following methods;

1. The employer can use the "uniform percentage employee compensation" method to determine employee benefits. For example, the employer can determine that the employee benefit will equal 15% of the employees' annual compensation. Mary's annual salary is $50,000. Accordingly Mary's group life benefit is established at $7,500. Annie's annual salary is $100,000. Her group life benefit will be $15,000.
2. If the employer does not want to use the "uniform percentage employee compensation" method to determine employee benefits, the "coverage bracket" method can be chosen. For example, the employer establishes the brackets of employees, and then determines the group life coverage each bracket will receive. The employer determines that there will be fours brackets of employees. First will be company officers, then department heads, third will be salesmen and supervisors, and all other employees will fall into the fourth bracket.

The employer determines that the company officers will receive $50,000 of life insurance coverage, department heads will receive $35,000 of coverage, salesmen and supervisors will receive $25,000 of coverage, and all other employees $10,000. The general rule when using

the bracket method is that no bracket may be more than two and a half times the next lower bracket, and the lowest bracket must be at least 10 per cent of the highest bracket.

All employees must be participants in the plan for the plan to be qualified. However, if the insurance company decides that proof of insurability is required by the employees, and an employee does not provide satisfactory evidence, his or her life benefit computed, may be reduced without the plan being disqualified by the IRS. Accordingly, employees over 65 years old may have a separate schedule of coverage established under similar guidelines, and the plan will remain qualified.

Other examples of qualified group life plans for small employers:
An insurance company may decide that a small group is not required to submit proof of insurability. The coverage offered by the insurance company cannot be affected by the proof of insurability decision. If the coverage is affected the plan will not be qualified by the IRS.

A common group life insurance plan for small groups can be established for employees of two or more related employers. Example: XYZ Company is the parent company for ABC Company. XYZ Company has 3 employees and sells widgets. ABC Company has 5 employees and makes widgets exclusively for XYZ Company. A common group life insurance plan for the 8 employees can be established between XYZ Company and ABC Company since the two companies are related. The common plan can be qualified by the IRS if all criteria are met for the tax favored status.

A group life insurance plan for small groups can be established by an organization such as a union. The union members, in this case, would not be participants of the plan. The employees that work directly for the union would be the participants of the plan. The plan can be qualified by the IRS if all criteria are met for the tax favored status.

The Employee and Federal Tax

Group Life Tax Ramifications for Employees: As stated, coverage of $50,000 or less provided by the employer does not create a tax liability for the employee participant. The coverage is not considered additional income by the IRS. The premiums paid by the employer for the employee coverage are not considered additional income by the IRS.

Under Internal Revenue Code Section 79, employees must include in their taxable income the cost of group term life insurance benefits provided by their employers for all amounts in excess of $50,000, assuming the plan is nondiscriminatory. In order to simplify the method of calculating the cost of this benefit, the IRS created a table with standard factors to use uniformly, titled Table I.

If the employer's total coverage for the employees is over $50,000 there will be a tax liability for the employees. The tax liability to the employee will not normally be substantial in most cases. The amount subject to federal income tax will be the determined on the excess of the premiums paid by the employer to establish the coverage over $50,000.

Monthly cost

The monthly cost of group term life insurance is determined by multiplying the number of thousands of dollars of insurance coverage (figured to the nearest 10th) by the appropriate cost per thousand per month. Age is determined on the last day of the tax year. The monthly cost of each $1,000 of group term life insurance protection is as follows;

Age	Cost
Under 25	$0.05
25 through 29	.06
30 through 34	.08
35 through 39	.09
40 through 44	.10
45 through 49	.15
50 through 54	.23
55 through 59	.43
60 through 64	.66
65 through 69	1.27
70 and over	2.06

Example: Assume the employer premium for $50,000 coverage is $1,000. The employer's premium for $60,000 is not relevant to the employee's tax situation. **The amount of the premium subject to tax is computed per the table above. The tax is on the $10,000 coverage exceeding $50,000.** If the employee is 30 years of age, the annual cost of the premium is $9.60 (.08 x 10 x 12). For a 60-year old employee, the cost is $79.20 (.66 x 10 x 12). This is the amount shown as wages for the employee.

The small employer may have a group life insurance plan that allows the employee to buy and pay for additional life insurance. Premiums paid by the employee for the additional life coverage cannot be taken as a deduction on the employee's Federal Income Tax Return.

A small group life insurance plan may require the employee to contribute a portion of the plan's premiums. Although the portion of the premiums paid by the employer are tax deductible to the employer, the portion of the premiums paid by the employee is not tax deductible to the employee. The employer receives a federal tax deduction as an incentive to create a group plan to cover employees. The individual, whether he or she purchases life insurance through a group plan or through an individual policy, does not receive a deduction. The federal government at this time does not believe individuals need an incentive to purchase life insurance. Accordingly, the individual's premiums are not tax favored and are not deductible from taxable income.

Group Insurance, Estates & Federal Tax

Group Life Tax Ramifications for the Estate: There are two kinds of federal taxes that must be addressed when a person dies. **The two kinds are "Federal Income Tax," and "Federal Estate Tax."** The death proceeds received by a beneficiary, named in a group life insurance

plan, are not subject to Federal Income Tax. The beneficiary receives the proceeds tax free. The death proceeds are not automatically tax free when dealing with Federal Estate Tax Law. The beneficiary would not be subject to the estate tax. The deceased's estate would be responsible for the estate tax.

When an employee or retiree of a group life plan dies, the death benefit from the group life policy may be subject to federal estate taxes. If there are any "incidents of ownership," the death benefit could be included in the estate of the deceased. If this occurs the death benefit is subject to federal estate taxes. If the estate of the employee is relatively small, the federal estate tax would not apply due to IRS limitation. Currently, only estate amounts over $600,000 are taxable to the estate.

As stated, if there are any "incidents of ownership," the death benefit could be included in the estate of the employee that died for federal estate tax purposes. Incidents of ownership include the following:

1. Right to name or change the beneficiary
2. Right to assign the policy
3. Right to convert the policy

Example: The employee can assign his or her rights to the group policy. If the rights are assigned, and the employee dies within three years of the assignment date, the death benefit are included in the deceased employee's estate and become subject to federal estate taxes. Under current federal tax laws, only very large ($600,000 and up) estates are affected by estate taxes, but in this day of "more tax," the State in which the employee resides remains a consideration.

Group Beneficiaries and Federal Tax

Group Life Tax Ramifications to the Beneficiary: When an employee dies, the employee's beneficiary will receive a lump-sum death benefit payment from a group term life insurance plan. The death benefits paid to the employee's beneficiary is exempt from federal income taxes. The death benefit may be paid on a periodic basis instead of in one lump-sum.

Methods used to calculate the monthly payment include the annuity method and the installment method. If the beneficiary receives the death benefit payment in annuity type payments or in installment type payments, the portion of the each periodic payment that represents interest earned on the principle death benefit amount may be taxable under federal income tax law.

A supplement to the group term life insurance lump-sum benefit is a group survivor income insurance benefit. The coverage is a supplemental benefit to a group term life insurance plan. Under the supplemental benefit the beneficiary will receive monthly income as long as the beneficiary is an eligible survivor. The beneficiary, in this case, would receive the participant’s death benefit and in addition would receive a monthly benefit payment. The lump-sum death benefit is not taxable to the beneficiary, but the survivor income benefit could be taxable to the beneficiary. The taxable amount would be the total amount that represents interest earned on the benefit principle.

Interest earned will be considered taxable income to the surviving spouse. The portion of the payments that represents the death benefit amount and the portion of the payments that represents interest earned on the death benefit is calculated using percentages. The portion of the payments that can be subject to federal income tax is the amount of interest earned on the benefit principle. The IRS deals with this as an annuity. The starting date determines the method to use on the tax-free and the taxable parts of an annuity payment. Either the General Rule or the Simplified Method will be used to determine the taxability of the payments.

Determining Cost

To figure how much of an annuity or survivor payment is taxable, one must determine the cost (investment in the contract). **One of two methods can be used to determine cost:**

1.) Simplified Method- This method relies on the annuitant's age at his or her annuity starting date. This date is either the first day of the first period for which one receives payment under the contract or the date on which the obligation under the contract becomes fixed, whichever comes later. With the Simplified Method, an IRS provided factor and formula is used to determine cost in the plan.

The Simplified Method must be used if the annuity starting date is after November 18, 1996, and if the person receives their pension or annuity payments from the following qualified plans:

a.) A qualified employee plan.
b.) A qualified employee annuity
c.) a tax-sheltered annuity (TSA) plan or contract

-Or-

At the time the annuity payments began, the recipient was at least 75 years old and was entitled to annuity payments from a qualified plan that are guaranteed for less than five years.

2.) The General Rule- This method is used to determine the tax treatment of pension and annuity income from:

- a.) A nonqualified plan such as a private annuity, a purchased commercial annuity, or a non-qualified employee plan.
- b.) A qualified plan if the following applies:
  - i.) The annuity starting date if before November 19, 1996 (and after July 1, 1986) and the annuitant does not qualify to use, or chooses not to use, the Simplified Method.
  - ii.) The recipient is 75 or over and the annuity payments are guaranteed for at least five years.

-Or-

c.) An Individual Retirement Account (IRA)

The IRS provides life expectancy tables to assist the taxpayer in computing the minimum required distribution amount. In general one can recover the net cost of the annuity tax-free over the period that he or she is to receive the payments. The amount of each payment that is more than the part that represents the net cost is taxable. Under the General Rule, the part of each annuity payment that represents net cost is in the same proportion that the investment in the contract is to the annuitant's expected return.

Expected return is the total amount the eligible annuitants (remember, there can be more than one with joint and survivor annuities) can expect to receive under the contract. The IRS provides actuarial tables and formulas to determine the cost and income portion of annuities.

If the expected return is $300,000 and the annuitant is paid $180,000 on the contract and that amount represents 60 per cent of the return. Once set, this percentage figure is used yearly to specify what part of the annuity payments should be considered return of capital and how much is subject to income taxes. In the example, 40 per cent of each payment would be taxable income.

In summary tax is important to each individual that will be involved in a group life insurance plan. The employer will be interested in personal benefits as well as tax favor for the company. The employee will be interested in the personal benefits and the tax that may have to be paid for the benefit. The beneficiary will be interested in the benefit and the personal responsibility as well as the tax responsibility that will flow to the deceased's estate. The insurance licensee must be able to knowledgeably answer questions on tax and the group life plan.

CHAPTER 3 GROUP HEALTH INSURANCE

The days of the kindly old general practitioner who made house calls when somebody was sick and took chickens, eggs, or nothing for payment are so long gone that most people today find it hard to believe they ever existed. Space-age medicine offers marvels. It has a price tag that sends the average person into orbit at the thought of showing up in a doctor's office or at a hospital admissions desk without an insurance card in hand.

Today, a prospective employee's interest in the insurance protection being offered by the employer is only secondary to the salary that is being offered. The most pleasant words a highly paid corporate officer or a minimum wage worker are likely to hear, are those telling him or her that medical and dental expenses are provided for under a comprehensive corporate health plan.

Group health insurance is somewhat more complicated than group life insurance. A Group health insurance plan involves not only the employer and the insurance carrier, but a third element, the medical care provider. In the early 1900's many insurance companies were not sure about the insurability of medical expenses. Insurance companies began moving into the medical field and group medical coverage only after the Great Depression.

Blue Cross and Blue Shield pioneered the group health insurance plan. Blue Cross and Blue Shield began as a medical service organization. Initially, medical service organizations covered expenses for physician and surgeon fees only. There were also hospital service associations. Hospital service associations were organized to help collect hospital bills in order to protect the solvency of the hospitals.

ACA

The Affordable Care Act (ACA) or Obamacare includes numerous provisions that become effective between 2010 and 2020. If and when the ACA will be modified or repealed is beyond the scope of this text. Policies issued before 2010 are exempted by a grandfather clause from many of the changes to insurance standards, but they were affected by other provisions. Beginning in 2014, significant reforms were implemented including:

- Guaranteed Issue- prohibits insurers from denying coverage to individuals due to pre-existing conditions, and a partial community rating requires insurers to offer the same premium price to all applicants of the same age and geographical location without regard to gender or most pre-existing conditions (excluding tobacco use).
- Minimum standards for health insurance policies are established.
- An individual mandate requires all individuals not covered by an employer sponsored health plan, Medicare, Medicaid, or other public insurance programs (such as Tricare) to secure an approved private-insurance policy or pay a penalty, unless the applicable individual has a financial hardship or is a member of a recognized religious sect exempted by the Internal Revenue Service. The law includes subsidies to help people with low incomes comply with the mandate.
- Health Insurance Exchanges operate as a new avenue by which individuals and small businesses in every state can compare policies and buy insurance (with a government subsidy if eligible).
- Low-income individuals and families whose incomes are between 100% and 400% of the federal poverty level will receive federal subsidies on a sliding scale if they purchase insurance via an exchange. Section 1401(36B) of PPACA explains that each subsidy will be provided as an advanceable, refundable tax credit and gives a formula for its calculation. Consumers can choose to receive their tax credits in advance, and the exchange will send the money directly to the insurer every month. Small businesses will be eligible for subsidies.

- Medicaid eligibility expanded to include individuals and families with incomes up to 133% of the federal poverty level, including adults without disabilities and without dependent children. The law also provides for a 5% "income disregard", making the effective income eligibility limit for Medicaid 138% of the poverty level. Furthermore, the State Children's Health Insurance Program (CHIP) enrollment process is simplified. However, in National Federation of Independent Business v. Sebelius, the Supreme Court ruled that states may opt out of the Medicaid expansion, and several have.
- Reforms to the Medicare payment system are meant to promote greater efficiency in the healthcare delivery system by restructuring Medicare reimbursements from fee-for-service to bundled payments. Under the new payment system, a single payment is paid to a hospital and a physician group for a defined episode of care (such as a hip replacement) rather than individual payments to individual service providers. In addition, the Medicare Part D coverage gap (commonly called the "donut hole") will shrink incrementally, closing completely by January 1, 2020.
- Businesses which employ 50 or more people but do not offer health insurance to their full-time employees will pay a tax penalty if the government has subsidized a full-time employee's healthcare through tax deductions or other means. This is commonly known as the employer mandate.

Federal & State Health Care Reform

State legislatures have recently passed laws to enhance the portability and availability of health coverage and to bring into compliance with federal requirements and pre-existing condition restrictions of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). This legislation affects small employers, large employers and licensed Multiple Employer Welfare Arrangements.

Small Employer Plans

Legislative changes have reduced the minimum number of employees required for classification as a small employer from three to two. This number included the owner or owners of the business. Obtaining health coverage as a small employer offers several advantages. Insurance companies and HMOs cannot refuse to sell a small employer plan because one or more employees have a history of poor health.

Large Employer

A “large employer” is defined as one with 50 (in some states 51) or more eligible employees. Large employers are permitted to determine which employees (if any) are offered a benefit plan.

For all health plans, an eligible employee is one who works at least 30 hours a week, is not classified as temporary or seasonal and is not already covered by another health benefit plan. The number of “eligible employees” determines whether an employer is a small or large employer. Any small employer providing health insurance must offer

coverage to all eligible employees. A large employer providing health insurance is permitted to determine which employees are offered participation in a health insurance plan (however, participation criteria cannot be based on health status.

HIPAA and most state legislation have reinforced the prohibition against discrimination. Employer group health insurance plans cannot treat pregnancy or genetic information as preexisting conditions. **A preexisting condition is one for which the insured received medical advice, care or treatment during the six months before the effective date of health insurance coverage. Companies can exclude benefit payments for these conditions until coverage for a plan participant has been in effect for 12 months.** Additionally, small employers cannot use "health status related factors" (such as claims experience) to determine whether a group will receive coverage. Large employer carriers, once they accept a group for coverage, may not exclude an employee because of these factors.

Guaranteed Renewable

Guaranteed renewal laws prohibit insurers from refusing to renew individual or group coverage based on health status or use of medical services in the previous year. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) prohibits insurers from refusing to renew health plans because of the health status of an individual or group; however, it does allow insurers to opt not to renew a policy for other reasons, including:

- If the insurer stops offering a type of plan altogether, but the insurer must provide all customers under the canceled plan a chance to buy another
- If premiums are not paid at all, or if they are not paid on time
- In case of fraud by the covered individual or group
- If the consumer moves out of the insurer's geographic service area
- If not enough of a small employers' workers agree to participate in the plan
- If a small employer does not pay a minimum share of its workers' premiums
- An insurer may discontinue offering all of its coverage in the individual, small group, or large group markets. If so, they must notify state officials and enrollees at least 180 days in advance. The insurer must discontinue and not renew all coverage in one or more markets and may not re-enter that market for five years.

The Patient Protection and Affordable Care Act (ACA) affirms HIPAA with respect to guaranteed renewal. The ACA also does not change existing federal law with respect to the exceptions listed above.

Portability

Most Americans have access to health insurance through an employer-sponsored health plan, a fact that has made changing or losing a job a complex issue for the purposes of maintaining health insurance. Moving to a new job can be hard if the employer does not offer health insurance, or if the new employer's health plan is not as generous as the previous employer's plan. And with limited protections for people with

pre-existing conditions, many people stay in jobs to keep their insurance rather than risk losing coverage. Portability, in the context of health insurance, describes the ability of an employee to maintain access to health insurance coverage and comprehensive benefits after leaving a job. It also applies to the ability of those purchasing insurance on their own to drop one insurance policy and buy another.

Beginning January 1, 2014, the ACA required individual and fully insured small group market health insurers to guarantee issue coverage and eliminate pre-existing condition exclusions, regardless of a person's health status. In addition, insurers can no longer impose premium surcharges because of a person's health status or claims history. Through these measures, the ACA will allow people to change jobs or insurers without danger of losing access to coverage or having benefits excluded because of a pre-existing condition. These provisions greatly increase protections for consumers losing employer-sponsored coverage or wishing to change jobs. By guaranteeing access to health coverage and eliminating insurers' ability to exclude pre-existing conditions, the ACA is touted as making it easier for individuals to maintain coverage when switching jobs. However, people seeking coverage in the individual market may only be allowed to sign up for coverage during an annual open enrollment period.

Taxability of Group Health Plans

This section provides basic tax information for businesses about group health plans.

Deducting the cost

A business can generally deduct the cost of a group health plan on the "employee benefit programs" line of the business income tax return.

Group health plan defined

For income tax purposes, this is a plan that provides medical care to employees, former employees, or their families. The plan can provide care directly or through insurance, reimbursement, or otherwise. The cost of providing group health insurance to an employee is excluded from his or her wages.

Excise tax on certain plans

Employers are subject to an excise tax if the plan does not cover the working aged, active disabled, or those with end-stage renal disease. **The tax deductibility feature of group insurance is the carrot, while the excise tax is the stick used to prod group plan providers into complying with federal guidelines.** Also, the employer (or the plan, if a multi-employer plan) may be subject to an excise tax if the plan does not meet the continuation-of-coverage requirement. The excise tax generally is $100 per day during the *non compliance period* for each beneficiary. For beneficiaries in the same family, the maximum tax is $200 per day. There are certain exceptions. The excise tax for failing to meet this requirement does not apply to any plan maintained only by employers who normally employed fewer than 20 employees on a typical business day

in the preceding calendar year. In addition certain plans, such as a governmental plan or a church plan, are not subject to these requirements and the excise tax.

Continuation of Coverage

A plan must provide qualified beneficiaries the choice of continuing to be covered if any of the following occurs;

1) Death of covered employee.
2) Termination of covered employee (other than for gross misconduct) or reduction in hours of employment.
3) Divorce or legal separation from a spouse by covered employee.
4) Entitlement to Medicare benefits for covered employee.
5) A dependent child ceases to be a dependent, which ends the child's coverage under the plan.
6) A bankruptcy proceeding (which began after June 30, 1986) under title 11, United States Code, of the employer of a retired covered employee.

If any of these events occur, the plan must provide an election period of at least 60 days to qualified beneficiaries to choose to continue coverage under the plan. In general, this coverage must be identical to that received by beneficiaries who have not experienced any of these events.

Qualified beneficiaries

An employee's spouse and dependent children, if covered under the plan, are qualified beneficiaries. A child who is born to or placed for adoption with the covered employee during the period of continuation coverage is also a qualified beneficiary. The covered employee is a qualified beneficiary if the event is a termination or reduction of hours or a bankruptcy proceeding.

Period of coverage

Coverage generally must extend for at least 36 months from the day the event occurs. If there is a termination or reduction of hours, the coverage period must be at least 18 months. Certain situations may shorten the period of coverage. For example, the coverage period can end earlier if all group health plans offered by the employer are cancelled, if the beneficiary does not pay the premiums on time, or if the beneficiary becomes entitled to Medicare. Employees and their spouses must be given written notice of their rights to continuation of coverage when their coverage under a plan begins.

The plan participant must generally notify the plan administrator within 30 days of the death, termination, or reduction in hours, or Medicare entitlement of any covered employee, or of his or her Title 11 bankruptcy proceeding. Employees or their qualified beneficiaries are responsible for notifying the plan administrator if there is a divorce or legal separation, or if a child's eligibility under the plan ends. They must generally do this within 60 days after the date of the event. Also, within 14 days of their notification, plan administrators generally must inform qualified beneficiaries of their right to choose continuation of coverage.

The plan provider (or the plan, if a multi-employer plan) may be subject to an excise tax if the plan does not meet certain requirements. These requirements generally:

- Limit the circumstances under which plans can deny coverage for preexisting conditions
- Bar group health plans from using an individual's health status to exclude him or her from coverage
- Guarantee continued health coverage to an employer under a multi-employer plan
- Obligate plans to pay for a minimum hospital stay following birth for mothers and newborns if the plan otherwise provides maternity benefits
- Prevent certain special limits from being placed on mental health benefits.

Collective bargaining agreement- If the plan stems from a collective bargaining agreement, the accessibility, portability, and renewability requirements will first apply to the plan for plan years that begin after the collective bargaining agreement expires.

Excise Tax

The excise tax generally is $100 per day during the non compliance period for each beneficiary. This period begins on the first day the plan does not meet these requirements and ends on the first day the plan meets these requirements and the past failures have been corrected.

Exceptions. The tax does not apply:

1) For any period during which:
   a) The employer did not know that the plan failed to meet these requirements, and
   b) By exercising reasonable diligence the employer would not have known that the plan failed to meet these requirements

   -or-

2.) If the plan failed to meet these requirements due to reasonable cause (not willful neglect) and the plan's failure is corrected within a 30-day period beginning when the discrepancy was known to the employer, or would have known if reasonable diligence were used, that these requirements were not met.

However, even if one of these exceptions applies, a minimum tax still may be due.

Minimum tax. Even if one of the preceding exceptions to the excise tax is met, the employer (plan provider) may still owe a minimum tax. To avoid all tax, the employer must correct the failure to meet these requirements before the IRS sends a notice of an income tax examination for a period during which the plan failed to meet these requirements. More information on this excise tax can be found in section 4980D of the Internal Revenue Code.

Plans exempt from the excise tax- The excise tax for failing to meet these requirements does not apply to any plan maintained by a small employer whose coverage is from a contract with an insurance company. In addition, certain plans, such as a governmental plan or a plan that on the first day of the plan year had fewer than two participants who are current employees, are not subject to these requirements and the excise tax.

Small employer defined- A business is a small employer if it employed an average of at least two but not more than 50 employees on business days during the preceding calendar year.

Benefits exempt from these requirements- These requirements do not apply to certain benefits provided under a separate policy, certificate, or contract of insurance or that are not otherwise an integral part of the plan.

Accessibility- Generally effective for plan years beginning after June 30, 1997, a plan must not base eligibility rules for employees or their dependents on any of the following factors;

1) Health status,
2) Medical condition (physical or mental),
3) Claims experience,
4) Receipt of health care,
5) Medical history,
6) Genetic information,
7) Evidence of insurability, or
8) Disability.

Also, the plan cannot use these factors to charge a higher premium for certain individuals.

Penalties Under ACA

There can be problems if an employer-sponsored group health plan is not compliant with healthcare reform. The ACA (or PPACA) made a number of amendments to the Public Health Services Act (PHSA) that were incorporated by reference into ERISA and the IRC, making the mandates applicable to group health plans subject to the Code, ERISA, and the PHSA.

Subject to certain exceptions, failure to comply with ACA mandates will potentially trigger an excise tax of $100 per day "with respect to each individual to whom such failure relates." That means $100 per day per enrollee in the plan. The minimum excise tax for a compliance failure is $2,500. The maximum excise tax for "unintentional failures" is the lesser of 10% of the amount paid during the preceding tax year by the employer for group health plans, or $500,000.

For single employer plans, this excise tax is imposed on the employer as the plan sponsor. For multi-employer plans, or MEWAs, the excise tax is imposed on "the plan." Just where does the liability fall? Entities liable for the Code §4980D excise tax must self-report on Form 8928. Multi-employer plans must file the return by the last day of the seventh month following the end of the plan's plan year (just like Form M-1 and Form 5500 required by ERISA of plans with 100 or more members). Employers must file the form on or before the due date of the employer's income tax return. But how does an employer know if the Form 8928 should be completed at the MEWA level or the employer-member level? If the ERISA Form 5500 regulations are any guide, the answer is not always at the MEWA level.

Portability

Generally effective for plan years beginning after June 30, 1997, the plan must limit exclusions based on preexisting conditions and give credit for certain periods of previous coverage.

Preexisting conditions

- While HIPAA previously provided for limits with respect to preexisting condition exclusions, new protections under the Affordable Care Act now prohibit preexisting

condition exclusions for plan years beginning on or after January 1, 2014. For plan years beginning on or after January 1, 2014, plans are no longer required to issue the general notice of preexisting condition exclusion and individual notice of period of preexisting condition exclusion. Plans are also no longer required to issue certificates of creditable coverage after December 31, 2014. These amendments were made because plans are prohibited from imposing preexisting condition exclusions for plan years beginning on or after January 1, 2014.

The plan cannot exclude certain newborns and adopted children. Also, pregnancy cannot be treated as a preexisting condition.

Creditable coverage- Creditable coverage is coverage that the employee had before he or she enrolled in the plan. Do not count coverage an individual had before any 63-day or longer period during which the individual was not covered under any creditable coverage.
Creditable coverage is coverage under any of the following:

1) A group health plan
2) Health insurance
3) Certain other health plans

Renewability

Generally effective for plan years beginning after June 30, 1997, a multi-employer plan or a multiple employer welfare arrangement (MEWA) cannot deny an employer continued access to the same or different coverage under the plan other than:

1) For nonpayment of contributions
2) For fraud or other intentional misrepresentation of material fact
3) For noncompliance with material plan provisions
4) Because the plan is ceasing to offer any coverage in the employer's geographic area
5) For certain actions related to:
   a) Network plans, or
   b) Collective bargaining agreements.

Group Health Service Benefit Coverage

Service Benefit Coverage: Since the depression, two methods of benefit payments have evolved. Blue Cross and Blue shield pioneered the first method. It is called the service benefit method. Using this method the participating health care provider has a contractual relationship with the service organization. The benefits are measured in terms of days instead of dollar amounts. The claims paid by the service organization are paid, in full, directly to the health care provider. The costs of benefits covered are predetermined and agreed to by the health care provider. The health care provider understands that the amount received from the service organization represents the total billed amount.

As more and more medical carriers entered the group health insurance field, they paid claims but had little control over rising medical costs. Medical costs shot upward in the past two decades. Claims for more than $100,000 are not uncommon. More and more claims are now approaching the million-dollar mark. Consequently carriers have put a greater emphasis on monitoring services. Services are now monitored to insure that they are necessary and priced within reason.

Accordingly, the service organizations have begun to modify the service benefit method. Blue Shield and Blue Cross pays the health care providers bills in total if the expense is considered "usual, customary and reasonable. If the medical charge is not usual, customary, or reasonable, an amount less than the total will be paid to the health care provider. The health care provider accepts the amount as full payment, or bills the patient for the difference.

Some employers have tried to save money by taking on some of the responsibilities of the carrier. Some employers have adopted non-insured programs. Another approach that has evolved out of necessity is for the carrier and the provider to consolidate functions, as in a health maintenance organization.

Group Health Indemnity Benefit Coverage

The second benefit payment method is the indemnity or reimbursement payment method. Under a medical plan underwritten by an insurance company, a contract is entered into between the insurance company and insured. Accordingly, any covered loss will be indemnified by the insurance company. Using this method, the insured pays his or her medical expenses and is then reimbursed by the insurance company. This method has been modified by many companies. The modified method allows for direct payment to the health care provider. The insured executes an assignment form with the health care provider authorizing the medical payment to go directly to the provider. When direct payments are allowed from the insurance company, the insured goes for medical treatment. At that time, the patient fills out a claim form. The claim form may assign benefits to the doctor or hospital. The doctor or hospital then sends the claim to the insurance company and collect the outstanding amount directly from the insurance company. Some health care providers still require the patient to pay the bill and seek reimbursement from the insurance company. This method is most common with charges for small medical procedures or for prescription drugs.

A participant, under the benefit payment method, goes to any doctor he or she chooses, since the insurers contractual agreement is with the insured. There is no limitation on the choice of hospital except for the doctor's preference. The insurance company has no connection with the health care providers.

Benefit amounts are usually determined in exact dollar amounts using the indemnity method of benefit payments. The health care provider could charge an amount that is not fully covered by the health policy. The insurance company is under no contractual obligation to pay an amount in excess of the predetermined amount of coverage.

Insurance companies are using many different methods to try to contain costs today. The insurance company may use the "usual customary, and reasonable," method for determining medical payments. Insurance companies are requiring second opinions when surgery appears to be necessary. Insurance companies are also requiring preadmission authorization before the insured enters the hospital on a non-emergency basis.

ELEMENTS OF THE PLAN

There are three general classifications of group health insurance plans. There are basic medical, major medical, and comprehensive medical plans.

The three general classifications of group health insurance plans all contain standard group medical benefits, exclusions, and optional benefits. The standard group medical benefits, exclusions, and optional benefits will be discussed before we discuss, in detail, the three general classifications of group health insurance plans. These benefits include inpatient medical expense benefits, hospice care benefits, home health care benefits, outpatient benefits, mental health benefits, and emergency accident benefits.

Inpatient Medical Expense

The inpatient medical expense benefits are the most encompassing of all the benefits. Inpatient benefits include room and board, x-ray and other diagnostic services, lab test, radiation therapy and treatment, operating and recovery room benefits, intensive care, anesthetics, in hospital physician and surgeons treatment, physical therapists treatment, ambulance services inpatient prescription drugs, maternity expenses, well baby care, and medical supplies. Medical supplies include blood products, prosthesis, surgical dressings, casts, splints, braces, dialysis equipment and wheelchairs. Medical supplies do not include personal items provided by the hospital. Personal items include facial tissue, water pitchers, tooth brushes, combs, televisions, or telephones.

Hospice Care

Hospice care is for the terminally ill patient and related social services for the family of the patient. The patients care basically encompasses pain control. The hospice does not treat conditions or symptoms. Hospice care creates an environment in which the terminally ill can die in dignity with a minimum of pain and suffering.

Hospice care expenses that are normally covered under group medical plans are home health care paid for a care giver to come into the home to administer care. Family counseling charges for counseling the family members of the terminally ill as well as the patient. In-hospice room and board charges as well as the associated medical services are covered expenses. In-hospice care is covered when used in order to provide rest and relief for the family member caring for the patient. Respite care at home that provides rest and relief for the family care giver, is also a covered expense.

Home Health Care

Home health care is medical care provided to an individual that is under a doctor's care, is totally disabled and who would be confined to a hospital if the home health care was not available. Services that are covered under home health care include nursing care, health aid care, physical therapist, meal services, and social work.

Outpatient Benefits

Outpatient benefits include visits to the doctor, prescription drugs, and rental of hospital equipment. If an individual is required by a physician to obtain lab work, x-ray services, physical therapy or radiation therapy, the charges will be covered under outpatient coverage.

Mental Health Care

Mental health care benefits are provided when the patient is under the care of a psychiatrist, psychologist, or a psychiatric social worker. Benefits are provided for expenses incurred on an

outpatient basis in an approved psychiatric facility. If the patient is hospitalized with mental illness, the expenses are covered under in-patient medical expenses.

Emergency Accident Benefits

The emergency accident benefit may be a standard or optional benefit. The employer of the group plan will make the determination. Emergency accidental benefits are paid when the insured receives emergency medical attention after they have been involved in an accident. Covered charges may include emergency room charges, medical supplies, and x-ray charges. The emergency accident benefit is commonly a predetermined maximum dollar amount benefit. If John falls down his stairs and is injured the total emergency bill could be $700. John's emergency accident benefit is $600. John must pay the difference in the benefit amount and the actual charge.

Group Health Exclusions

Many medical expenses incurred by an insured individual will not be covered expenses under his or her group medical insurance plan. The medical expenses excluded by the group medical plan will be the responsibility of the individual. Theses exclusions include excess medical expenses not covered under medical insurance, hearing aid expenses, nursing home expenses, cosmetic surgery unless medically required, routine physical examinations and immunizations, vitamins and food supplement, contraceptives and weight loss expenses unless medically required. Also excluded are work related sickness and accidents covered by workers compensation, war related accidents or illnesses, dental expense not covered by an accident or optional benefit plan, and eye glass expense not covered by an optional benefit plan.

Optional Benefits

A group health insurance plan may offer the employee optional medical benefits. The optional benefits will increase the premium payments, but may be worth the added cost by increasing employee morale and by helping the employer to retain quality employees. The optional benefits include dental benefits, eye glass benefits, prescription drug benefits, long-term care benefits, and disability income protection. The most frequently chosen optional benefits are disability income protection, prescription drug benefits, and dental benefits.

Dependent care coverage is commonly provided for in group health plans. The dependent coverage may be included with the employee's coverage. The coverage would be paid for by the employer. This type of coverage, due to high employer premiums, is not as popular as it was a decade ago. Today the dependent coverage may be available through a group plan, but the employee would be responsible for all or part of the additional premium paid for the coverage.

Coordination of Benefits

This is extremely important when there is coverage from more than one source. When there is coverage by multiple groups the "coordination of benefits" clause will apply. The liability of each insurance carrier is generally applied in a specified order. The primary insurer pays its full benefits. Then the secondary insurer follows with payment on the balance up to the limits of its policy. Then the tertiary follows, and so on.

Unnecessary duplication of benefit payments and the possibility of over-insurance are prevented by the coordination of benefits provision. The total of all insurance benefits paid from group plans is limited to total allowable expenses.

In 1979 U.S. Public Law 95-555 was passed by the federal government. U.S. Among other things, Public Law 95-555 prohibits discrimination against women on the basis of their sex. The very limited maternity coverage in group health plans previous to 1979 was determined to be discriminating and illegal. The maternity benefit was much lower than other covered benefits. The law required that health-care benefits provided by the employer must be the same for maternity care as it is for covered illnesses. Now, in group health insurance plans, pregnancy is treated routinely like a covered illness or disability.

State laws require group health plans to include conversion privileges for participants. A plan participant that is terminated or resigns can convert his or her group coverage into an individual health insurance policy. The employee has 31 days after termination to submit evidence of insurability. The employee also has extended coverage for the 31 days. If he or she requires covered medical care, the former employer's plan will pay for the medical care. The law also requires that dependents of the terminated employee have the coverage conversion privileges.

TYPES OF MEDICAL PLANS

Three general classifications of group health insurance plans will be discussed next. Each contains the standard group medical benefits, exclusions, and optional benefits that have previously been mentioned. When an employer implements a group health insurance plan the benefits will be included in the plan as a basic benefit or can be included in the plan, at an additional premium, as optional benefits. Each group health insurance plan is also subject to the same rules and regulations.

Basic Medical Coverage

The most common group health insurance plan is written to cover qualified expenses incurred while the insured is a patient in a hospital. The two basic expenses covered are hospital expenses and surgical expenses. The actual charge for the hospital room and board may be included in a group basic medical plan. However, more commonly, the actual room charge payable by the insurance company is limited to a maximum amount set by the company. Some group basic medical plans pay a flat dollar amount per day for hospital room and board. Commonly, the basic medical plan limits the hospital room and board benefit to the daily charge for a semi-private room at the hospital where the individual is staying. The group basic medical plan will specify the number of days that room and board benefits are to be paid under the policy. The number may be 31, 90, or higher.

Additional hospital expenses are subject to maximum benefit amounts. The maximum costs coverage will be calculated as a multiple of the hospital room and board benefit. Additional expenses may be assigned a specific maximum dollar amount. Additional hospital expenses include laboratory fees, X-ray, cost of drugs, physical or radiological therapy. Additional hospital expenses are those incurred in the hospital other than room and board and surgery.

Payments to physicians other than surgeons are determined separately from the cost of the hospital room. Group basic medical plans may pay, within specified limits, for treatment of drug addiction and alcoholism, as well as nervous and mental disorders.

Surgical procedures may be determined by more than one method, depending on the type of coverage the group plan affords. Surgical procedures most often will be considered scheduled benefits. The insurance company lists various surgical procedures and assigns each surgical procedure a maximum benefits dollar amount. This is the amount that will be paid by the insurance company for each procedure received by the insured patient.

Surgical procedure benefits can also be paid on a relative value schedule. This is referred to as the RVS basis. This schedule is not like the schedule of benefits discussed previously. The relative value schedule refers to values of one procedure in relationship to another procedure. The insurance company will list each surgical procedure and determine its relationship to the other procedures on a financial basis. The procedure is then given a relative unit value. For example, by-pass surgery may be determined to be 15 times more expensive than cesarean section surgery. By-pass surgery may then be given a maximum unit value of 100 and the cesarean section surgery unit value will be 15. The insurance company will also assign a general conversion factor to be applied to the procedure's unit values. To calculate a surgical procedure benefit, the insurance company will multiply the unit value of the procedure by the conversion factor. In the previous example, where the conversion factor is 50 and the by-pass unit value is 100, the benefits paid for by-pass surgery would be $5000 (100 X 50). The benefit paid for caesarian surgery would be $750 (15 X 50), with the cesarean surgery having a unit value of 15.

The least complicated method in paying surgical procedure benefits is to pay the expense in full according to prevailing fees in a geographical area. The procedures are paid in full if they comply with the "usual, customary and reasonable," (UCR) charge for that geographical area.

An advantage of the group basic medical plan is that it does not have deductible payments or coinsurance payments. The employee will not have to initially pay any medical cost. The group basic medical plan does however, have disadvantages for the employer and the employee alike. The basic plan is relatively expensive for the premiums charged. The basic medical plan has limited benefits. The employer must determine the impact the limited benefit will have on the company employees. The employees will have some medical coverage, better than no medical coverage at all. The plan commonly does not cover doctor visits, prescription drugs, or catastrophic medical events. The employee will not have full medical coverage under a group basic medical plan.

Major Medical Plans

One of the major shortcomings of basic medical coverage can be rectified with major medical coverage. Major medical coverage can help protect against catastrophic illness. Group major medical plans have become very popular in providing protection against catastrophic medical expenses. **The coverage is very important since it has been shown over and over that one catastrophic illness can bankrupt and financially destroy a family in no time at all.**

Group major medical plans are available as a separate group medical plan or may be added to a basic medical group plan. If major medical is a separate medical coverage from a basic medical plan, after the premiums are paid, the insured pays an initial deductible amount before any medical benefits start. When major medical is added to a basic group plan, there is a provision for an insured to pay a certain deductible, such as $100, after the basic benefits are exhausted.

Some group major medical plans set the maximum total lifetime benefits payable from the major medical plan. For example, lifetime limits may be set at $250,000 or $1,000,000. This means that the plan participant can incur $250,000 or $1,000,000 of medical expenses over his or her lifetime that will be paid by the insurance company. Other group major medical plans may offer lifetime benefits without a set limit.

The major medical plan requires the plan participant to pay a deductible before the benefits begin. There are two kinds of deductibles. The least common of the two is the per cause deductible. A per cause deductible requires the participant to pay a new deductible for each claim filed with the insurance company. The most common deductible is the calendar year deductible. A calendar year deductible is paid once a year no matter how many claims are filed with the insurance company. The participant can plan for total annual medical expenses using a calendar year deductible. The calendar year deductible can be on a per person basis or on a per family basis. The per person basis requires that each member of the insured family must pay a deductible before that family member is subject to medical benefits. The per family deductible is an aggregate amount the insured family must pay before medical benefits begin. In either case, if the deductible is not met in the current year, the amount paid during the last quarter of the year can be carried forward to the next year. In this way the insured has a head start to meet the deductible requirements of the next year.

Group major medical plans also includes a co-insurance provision. The provision requires the plan participant to share certain medical expenses, after meeting the deductible. A frequent arrangement is to require the insured to pay 20% of his or her covered medical expenses and the insurance company pays 80% of the covered medical expenses.

The trend today is for the deductible to be higher than in years past. By setting higher deductibles the insurance company can offer the group major medical plan at affordable premiums. The more medical costs that are absorbed by the plan participants, the lower the premium for the employer. Through high deductibles and co-insurance, group major medical coverage can remain affordable to the employer. High deductibles curtail over utilization. The idea is for the participant to help with the everyday medical expenses, knowing that if he or she has a catastrophic illness the insurance company will cover the expenses and save the participant from financial ruin.

Major medical plans normally contain a stop-loss provision. The stop-loss provision allows the participant to calculate his or her maximum medical expenses for any given year. **The stop-loss provision dictates the participants out of pocket expenses or losses for medical care.** The stop-loss provision is tied to the co-insurance provision. Once a specified out of pocket amount has been paid by the participant through co-insurance payments, the insurance

company will begin paying benefits at 100%. The participant will not be required to make co-insurance payment after the stop-loss point is reached.

Comprehensive Major Medical

As health care costs have continued to increase, the popularity of comprehensive major medical plans has grown. A comprehensive major medical group plan combines basic and major medical coverage into a single contract.

Most group comprehensive major medical plans include outpatient diagnostic X-rays, emergency care, physical therapy, prosthetic and orthopedic appliances, and liberal inpatient hospital benefits. The tendency has been to make coverage broader and to pay benefits on the basis of what is considered reasonable and customary in a given area.

As in other forms of group health insurance, deductible and co-insurance provisions are included. There may also be a stop-loss feature included. This “stop-loss” provision differs from the one previously discussed, and applies to the employers premiums, not the participants medical payment. For instance, a group policy premium might include a specific charge. This extra charge will insure that losses exceeding a certain figure will not be charged against the claim experience of the employer.

Other Types of Plans

In addition to the three general classifications of group plans that have been discussed, there are other optional plans that may be installed in the design of group plans. The additional plans can be used to supplement group health plans or can be purchased as stand-alone products. It is the job of the insurance licensee to determine which product or blend of products best suits the need of the licensee’s client.

Comprehensive Plan

Comprehensive corporate health plans are the small corporate trend. The comprehensive corporate health plan is a form of group coverage proving very popular with corporations. A portion of the corporate health plan benefits are insured and a portion of the benefits are uninsured. The uninsured benefits are paid by the corporation to the plan participants. The corporate health plan can basically include medical expense and sick-pay (disability) protection. A small corporation, for instance one with 15 to 20 full-time employees could offer a group plan providing basic medical coverage, short-term disability income, and group life benefits for all full-time workers.

The corporation could in addition secure major medical and long-term disability coverage for a select group of employees on either a group or individual basis. A class of employees such as executives or supervisors might be named for these benefits. The comprehensive corporate health plan can be designed to include stockholders. Uninsured benefits, paid by the corporation, such as payment of an employee's salary during an initial period not covered by group disability, could be included in the plan.

The cost of the corporation's contribution to benefits under the plan would be tax-deductible. The benefits would normally be tax-free to employees except for sick pay, which would be partially taxed. A proprietorship or partnership could set up such a plan for its

employees, but uninsured benefits paid to the owners would be taxable to the owner in that case. The plan therefore is especially favorable for a corporation.

A small corporation may not be able to provide a comprehensive health plan all at once, but can start with a basic medical expense plan and add other elements as needed. Some benefits may be uninsured, but insured benefits give the advantage of being able to budget costs and avoid the possibility of having to make large payments of cash unexpectedly. A group insurance policy also makes it possible to have documentation for the health plan and to communicate it to the employees, assuring that requirements for tax deductibility will be met.

The insurance agent needs to work with corporate officers in determining what needs are to be met. When a plan is decided upon it must be formally drafted and adopted by corporate resolution, then communicated to employees. Failure to follow these procedures might let the IRS claim that uninsured payments to employees who were also stockholders actually constituted a dividend and thus were not tax-deductible.

Group Dental

Group dental insurance plans are growing in popularity. There are considerable variations from limited benefit plans to all-out comprehensive plans. The group dental plan may be offered as part of a package with other group health insurance or group dental can be issued separate from other plans. Minimum size groups also vary. There is commonly a deductible and co-insurance provision. Benefits include teeth cleaning, X-ray examinations, fillings, extractions, bridgework, inlays, oral surgery, root canal therapy, orthodontics, and dentures. Exclusions to group dental plans include cosmetic services or services made necessary by occupational injuries, sicknesses, or war injuries.

Medicare Supplement Plans

Most group health plans include a supplemental Medicare insurance plan. The supplemental plan is especially important for insured persons or dependents 65 or over. A supplemental plan is also important for participants that are covered by Medicare at an unusually young age because of disability. Under a group Medicare supplemental insurance plan, benefits are paid first by the Medicare system, and the remainder is paid by the insurance company that is privately insuring the group supplemental benefits.

Accidental D & D Coverage

Accidental Death and Dismemberment Insurance is required by all group insurance plans. For example, $25,000 of accidental death and dismemberment can be the benefit for each plan participant. Group AD&D is often combined with group life insurance plans. When group accidental death and dismemberment insurance is combined with a group life insurance plans, the face amount of the AD&D is usually the same amount as group term life coverage issued to the plan participant. Group accidental death and dismemberment plans normally do not include conversion or assignment privilege. The coverage usually terminates at termination of employment or retirement. In some cases the coverage can be continued for employees who take a temporary leave of absence.

The face amount of the coverage is normally payable in a lump sum payment for accidental loss of life or accidental loss of any two body members, such as arms, legs, hands, or feet, or the

sight of both eyes. One half of the principal sum is payable for the loss of one arm, leg, hand, or foot, or the sight of one eye, through accidents. Accidental death and dismemberment exclusions include suicidal deaths, losses from disease, ptomaine, or any infection other than one resulting from an accidental cut or wound. Also excluded are injuries or death resulting from flying in an aircraft as a pilot or crew member, and injuries or death resulting from an act of war, declared or not.

Voluntary group accidental death and dismemberment coverage is available in separate non-cooperation policies at amounts that can be elected by employees. Some plans cover dependents. Accidents occurring while traveling on company business can be covered for pertinent employees.

Group Disability Plans

The group disability insurance plan is an optional group insurance benefit plan. Disability is the worst fear of the wage earner. The wage earner fears disability more than death. When the employee is disabled the employee's family has the problem of caring for the disabled person on top of meeting the ordinary expenses of everyday life. The benefits of a group disability plan are important to the employer as well as the employee. The importance of the benefit to the employee is obvious. The employee, if disabled, will still need income to pay monthly bills and buy food. Disability income will provide some of the income the disabled employee requires. The importance to the employer is not as obvious. The employer feels a moral obligation to help a disabled employee. The employer would like to be able to continue paying the employee his or her salary but, the employer has a problem with paying both his ill worker and the substitute worker hired to fill-in or replace the disabled worker.

A well designed group disability insurance plan can help bring peace of mind to worried employers, employees, and families. Group disability plans replace an unpredictable expense with one that can be budgeted. Group disability plans set reasonable limits, and makes provision for coordinating all sources of disability income in establishing benefits.

Group coverage usually can provide far greater benefits than individual disability policies for less cost. The employer may pay part or all of the disability group premium. On the other hand, the wage earner needs to bear in mind that group disability coverage usually does not continue when the employee resigns or is terminated. Accordingly a wage earner may be left without disability protection unless he or she has an individual policy. The insurance agent needs to keep this fact in mind with regard to his clients.

Short Term Plans

Group disability income plans deal with two kinds of coverage, short-term and long-term disability. Under a short-term disability plan, benefits are provided for a limited period of time. **Short-term plans usually extend benefits for 13 to 26 weeks or less.** Short-term plans can, however, extend benefits up to a full year. Some short-term disability plans extend benefits for two years, but this is rare. The short term provisions may be carried out through an informal or a formal program varying with individual employers. A most successful approach for protecting large numbers of employees has been found to be group disability income insurance.

Benefits paid by short-term disability plans are set as a percentage of regular salary or wages. The benefit will normally range for 50 per cent of the disabled person's wages up to 67 per cent of his or her regular income. Benefits are subject to a maximum amount and sometimes to a minimum. Maximum benefits usually are limited to between $300 and $400 a week. The disabled worker will have to satisfy an elimination or waiting period before any benefits can be paid to him or her. The waiting period is relatively short. It can be as short as 15 or 30 days. If the disability occurs due to a non-job related accident, the disability benefits may be payable from the first day after the accident. If the disability occurs due to an illness, the benefits can be payable from the eighth day after the participant is rendered disabled.

Short-term policies usually have a recurrent disability clause. The recurrent disability clause defines the period of time a former disabled employee must be back on the job before he or she can become eligible for a new benefit period. Some disability clauses require two weeks of active employment before a new benefit period can begin.

Group disability insurance excludes part-time employees from coverage. Short-term disability plans normally will have a probation period clause. The clause requires a specified amount of service before an employee is eligible to join the plan. To be eligible for a short-term disability plan, an employee must work for a minimum period of time, usually 30 to 90 days.

Short-term disability policies generally define disability as the inability of the insured person to perform each and every duty of the customary job. **Total disability must be verified in writing by a physician. The disability normally must be a result of non-occupational illness or accidental injuries.** Disability due to pregnancy is excluded as a covered disability in most group disability programs. Also, if disability occurs while the participant is at work and is job related, the disabled worker is qualified for workmen's compensation coverage.

Workman compensation will provide benefits in the form of income replacement for the occupational disability. Some short-term disability plans do, however, allow for disability benefits to be used as a supplement to workers' compensation payments up to a specified percentage of regular earnings. Other sources should be considered such as the social security system. Social security may provide benefits to offset or supplement the group policy payments in a non-occupational disability. The disabled employee may have an individual policy that will pay benefits on a short term basis. Such sources may provide help on a short term basis but may have longer waiting periods and do not provide supplemental coverage on a short-term basis.

Funding group disability income plans can be an expensive proposition. The employer must determine if the plan will be worth the premium expense**. Premiums for short term disability programs are calculated based on the age, sex, and occupation of the plan participant.** Premiums for a plan with a longer elimination period are less expensive than premiums for a plan with a relatively short elimination period. Premiums for a plan that covers older workers are relatively high. Other factors, contributing to high premiums could be a large number of female employees or a group of employees that perform what would be considered hazardous duties. Employees performing hazardous duties are considered to be in a higher risk group than the average account. Also, actuarial tables support the ideas that women present a higher disability risk than men.

Group short term disability plans are often established by the employer as a plan to cover the disabled worker until the social security system provides income benefits to the worker. The waiting period for Social Security is five months. Employers want to design a plan that will pay the worker during those five months not paid for by the system. In reality however, the disabled worker may not qualify for Social Security, or may have to wait a very long time to realize any benefits from the social security program.

Long-term Plans

Most absences from work because of illness or injury are of short-term duration. The absence does not last for more than a few weeks. The long-term disability lasting more than six months is infrequent, but if it occurs could prove to be far more costly than the disabled employee would believe. Insurers have strict underwriting rules for groups covered under a group long-term plan. If the group is small, the insurance company will usually require evidence of insurability from all individuals to be covered under the long-term plan. There are several insurance companies in the small group market that will not even write long-term disability coverage. For the group that can get long-term coverage, however, it is a valuable income protection plan. Usually it is purchased only for selected categories of employees.

Group long-term disability plans have an initial benefit period. Most insurance companies determine the initial benefit period to be 2 years. During the initial benefit period disability is defined more liberally than it is defined after the initial benefit period is over. During the initial benefit period disability is defined more liberally as an illness or injury that prevents the participant from performing any and every duty pertaining to his or her occupation. Benefits are continued after the initial period only if it is proven that the insured is unable to engage in any gainful employment for which he or she is reasonably suited by training, education, or experience.

Benefits under a long-term policy usually are payable monthly rather than weekly. The long-term benefit is limited to a percentage of regular gross earnings of the disabled employee. The percentage allowed is usually 50 per cent, 60 per cent, or 70 per cent of the disabled employee's net earnings. The insurance company will set a maximum amount that a disabled employee can receive. Benefits may range from around $300 a month to around $1,200, or may go up to $2,000 or $3,000 or even more for upper-bracket employees.

Long-term benefits may not be paid until the worker has been disabled for at least 30 to 90 days. A waiting period may last as long as six months or a year. If the group insurance plan includes a short-term plan or salary continuation plan, the long-term plan will commonly begin when the other benefit payments have been exhausted.

Benefit periods for a long-term policy vary with the insurance companies that establish them. Some benefit periods will run for five years or up to the disabled participant's 65th birthday. There are some companies that offer lifetime benefits in cases of disabilities resulting from accidents. The benefit period will often end when the disabled individual becomes eligible for retirement benefits.

Three limiting factors are added to specific exclusions in long-term disability policies. The first is the two-year limit for the liberal disability definition. After that period an individual is expected to

turn to other employment if he is capable of it. Length of benefit periods is limited by how long a disability lasts or by the policy's benefit period provision, whichever is shorter.

A third limitation on group disability benefits is a coordination of benefits provision. Total benefits from all sources are limited under this provision to a stipulated percentage of the regular earnings of the disabled participant. Other sources that will be coordinated with the group long-term benefits include Social Security and other federal programs, or state disability programs, or continuing salary or retirement benefits, or workers' compensation, or other employers' plans. There are other sources of benefits that could also have to be coordinated. The long-term disability benefits will be offset by the benefits provided by the alternative means previously mentioned. Coordination of benefits helps to assure that the disabled participant is not overinsured. The purpose of the plan is to make the disabled financially whole. The purpose of the plan is not to have the participant make money from the disability. The disabled participant should not be allowed to make more than 100% his or her pre-disability income.

Under long-term disability income plans, exclusions usually include self-inflicted injuries and disabilities resulting from war or participation in the commission of a felony. Group long-term disability plans have begun to pay benefits for disabilities resulting from alcoholism, drug addiction, and nervous or mental disorders under certain conditions.

To summarize, there are basically three categories of group health insurance plans. The three plans are the basic medical plan, the major medical plan, and the comprehensive plan. There are other kinds of group health plans, but they are used to supplement the basic benefits afforded by the primary group plans.

The basic medical plan provides coverage for hospital expenses and surgical expenses. The plan does not contain deductible or coinsurance clauses. The coverage under the basic medical plan is limited. The group major medical plan provides the same coverage as the basic medical plan but also includes coverage for catastrophic illnesses. The major medical plan contains deductible and coinsurance clauses. The group comprehensive plan is a hybrid of the basic medical plan and the major medical plan.

HMOs & PPOs

In general, two types of coverage, traditional insurance plans and managed care plans, may be available to you as an individual or as a member of an employer or association group health plan. Managed care plans include preferred provider organization (PPO) plans and health maintenance organization (HMO) plans.

Managed care plans use "networks" of selected doctors and other providers to provide comprehensive health services. They may require that you use the plan's providers or they may offer incentives to encourage their use.

Preferred provider organization (PPO) plans issued by an insurance company are insurance plans that provide higher reimbursements if you go to PPO network physicians, providers and hospitals that provide services to health plan members for discounted fees. You choose your personal doctor and do not need a referral to see a specialist. Gatekeepers are prohibited in PPOs and other indemnity health plans.

Health maintenance organization (HMO) plans typically require that you use network physician's hospitals and other health care providers. Your personal "gatekeeper" physician also must provide a referral if you want to go to a specialist or outside the HMO's network for treatment. HMOs also eliminate the need to file claims. Members "prepay" for their health care through monthly premiums and co-payments made as services are delivered. HMOs pay providers a set fee, called a capitation fee, for each health plan member, regardless of the amount of services performed.

Point-of-service (POS) plans or "wrap" plans may be available with some HMOs. They give HMO enrollees the option of receiving services outside the HMO's network without prior approval from a network physician. Inside the network, the plan operates like an HMO. Outside the network, it operates like a traditional insurance plan.

Payment & Benefit Comparison

With an insurance plan or PPO plan, you pay:

- ✧ Premiums: the monthly amount you pay for insurance coverage.
- ✧ Deductibles: the amount of covered expenses you pay each year before the policy begins to pay.
- ✧ Co-insurance: your share of each covered expense, usually 20 percent, up to a certain limit, or a higher percentage if using out-of-network providers. Co-insurance applies to each person and starts over each year.
- ✧ Out-of-pocket limit: the maximum you pay in one year when you combine your required deductible and co-insurance.
- ✧ Co-payment: the amount you pay when you receive medical care (usually found in a PPO plan.).

Your insurance company pays:

- ⌑ Lifetime maximums: the maximum amount, such as $1 million, that the insurance company will pay in your lifetime toward your total medical expenses or toward certain benefits.
- ⌑ Co-insurance: the company's share of each covered expense, usually 80 percent of the "usual and customary charge."
- ⌑ 100 percent payment: the amount the company will pay on covered expenses when you reach the annual out-of-pocket limit for your plan: Payments continue until the policy's maximum limits are reached or until the end of the year.
- ⌑ Discount fees for service to providers: Insurance companies often negotiate discounted fees with health providers.

With an HMO you pay:

- ❋ Premiums-the monthly amount you pay for coverage.
- ❋ Co-payment-the amount you pay when you receive medical care or a prescription not fully prepaid. Co-payments usually refer to set fees HMOs charge.
- ❋ Deductibles- the amount of covered expenses some HMO plans may require you to pay each year before the plan begins to pay. (Most HMO plans, however, do not have deductibles.)

❋ Maximum out-of-pocket expense- The maximum amount an individual covered under a health care plan must pay during a certain period for expenses covered by the plan. Until the maximum is reached, the covered individual is required to pay a co-payment.

Your HMO pays:

Capitation to providers: A system where an HMO pays a doctor or hospital a flat monthly fee for the care of each health plan member whether or not any services are delivered. Not all providers receive capitation.

✸ Discount fees for service to providers: HMOs contract with health providers to provide services at discounted rates.

✸ 100 percent of the cost of all covered services in excess of the co-payments.

Source of Health Insurance Coverage for Non-elderly Population;

1996		**2016**	
Employer-	64.0%	Employer-	56%
Individual-	6.8%	Non-Group	7%
Medicaid	12.1%	Medicaid	22%
Other Public	3.9%	Other Public	4%
Uninsured	17.7%	Uninsured	12%

Source: Kaiser Family Foundation website

New Strategies

In 2016 twenty major companies, including American Express, Verizon, Coca-Cola and HCA, joined the Health Transformation Alliance to combine data on the population health of their employees. The initiative focuses on reducing the redundancies and waste in the supply chain that drive up the cost of health care coverage. By coming together to share expertise, the companies seek to make the current multilayered supply chain more efficient. The effort to transform the system is led by a not-for-profit entity known as the Health Transformation Alliance. The Alliance serves as part of each company's health strategy, bringing increased innovation, better analyses of the latest data, and greater leverage into how corporations obtain coverage for their workers. The Alliance seeks to fundamentally transform the corporate health care benefit marketplace by first focusing on the following four areas

Greater Marketplace Efficiencies

Today, employers rely on a broad range of organizations to procure health care services, and often these organizations serve interests not aligned with the interests of employers and the people they employ. The Alliance pools the resources and expertise of its member companies to gain leverage and create an organization whose sole focus will be to ensure the health care needs of employees are being met more effectively and efficiently.

Learning from Data

Employers have become experts in studying data and trends to make wise business decisions in a variety of areas. The health care marketplace lags behind other sectors in using data available to identify best treatments, good outcomes and cost reductions. By

pooling aggregated data that doesn't identify individual patient information and using it to improve the effectiveness of the health care supply chain, the Alliance anticipates delivering better health care while reducing costs.

Educating Employees

Employers have considerable experience working directly with their employees to explain companywide benefits, but the complexities of health care are difficult and costly to explain. By pooling their knowledge and resources, members of the Alliance will be able to develop better and more helpful tools to educate employees about their health care choices. Helping employees to better navigate these choices will result in better outcomes, increased savings and more satisfied employees.

Breaking Bad Habits

Patients, along with the health care system, too often pay for prescription drugs that are not the most cost effective for their care. Doctors, along with patients, aren't always armed with a full range of facts concerning best outcomes and pricing for pharmaceuticals. This happens in part because incentives currently built into the delivery system have made it habitual to pass costs along. The Alliance will seek to change costly and inefficient purchasing and contracting systems that don't deliver better health care results, but do drive up health care costs.

Collectively, the 20 companies are responsible for health care benefits for four million people and spend more than $14 billion annually on health care for employees, their dependents and retirees. Beginning in 2017, pilot projects will be launched to help employees obtain more affordable prescription medications. The rest of the major initiatives are planned to begin in 2018 or later.

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CHAPTER 4 GROUP LONG-TERM HEALTH CARE

More people are getting old. At the beginning of the 20th Century, the average life expectancy in the United States was fewer than 50 years. Life expectancy in the US sits at 78.7 years in 2018 (Center for Disease Control (CDC) National Center for Health Statistics).

Medical advances and improved living conditions have combined to produce this major change. The infectious diseases that used to cut lives short have been brought under control to a large extent by vaccinations, antibiotics and the use of high-tech diagnostic equipment

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The fastest growing population group now recorded by the U. S. census is made up of individuals 80-years old or over. With adequate medical care as well as growing public awareness of the importance of diet, exercise and healthful lifestyles in general, many people stay active 20 years or more beyond normal retirement age. Naturally these developments mean there are more old people than there used to be.

This longer average life span, though, has its down side. Even for the strongest, time will bring a decline in abilities. Chronic conditions like arthritis, diabetes and the two major killers, heart disease and cancer, still lie in wait. Strokes and degenerative brain diseases such as Alzheimer's may erode mental powers and personality. Eventually a person who lives long enough is likely to need help just to stay alive.

Help at home is scarce today. Back in the days of a farm-based economy, when more children meant more help, large families were the norm. Often one or two siblings remained at home, unmarried, and took care of their parents when the time came for them to need it. Divorce was rare and families stayed in the same place, sometimes for several generations.

Family Structures

The social situation is very different now. Single parents raise almost half the children in the United States. If there are two parents on hand, the cost of living often requires both of them to work outside the home. The number of children in an average family is much smaller than in the old days, and few of them spend their whole lives with their parents.

With the fragmentation of the family unit, new ways to care for the old and aging have been designed. There are several types of care available to the older population. There are institutions that have been set up to care for the old and the sick as well as home health care help. Jobs are insecure and moves are frequent. Taking care of disabled elderly patients in the home is in general a far more difficult problem than it used to be. One answer has been found in the development of nursing homes.

TYPES OF LONG-TERM CARE

The nursing home solution: The cost of nursing home care in the United States seems to grow every year. As an example of the increase in cost of care, in California, the average daily nursing home rate in 1996 was $110.78 and in 2016 it was $265.76. The increase from 1996-2016 was $154.98 – an increase of 140%. That 20 year reporting period comes up to a compound increase of about 4.5% yearly.

Nursing Homes- An older person's likelihood of living in a nursing home increases sharply with age. The U.S. nursing home population in 2014 consisted of the following age groupings;

Under 65	15.1%
Age 65-74	16.1%
Age 75-84	27.2%
Age 85+	41.6%

The vast majority (80.8 percent) of those who did not live in a nursing home also had one or more disabilities. Difficulty doing errands alone and performing general mobility-related activities of walking or climbing stairs were the most common types, which indicates that many who live in households may need assistance with everyday activities (CDC Study of Long-Term Care Providers, 2013-2014).

People who have not encountered the problem first-hand are inclined to put off thinking about it. "If you're over 65, Medicare will pay for it," is a common attitude. In fact, however, nursing home care for which Medicare will pay is limited. To qualify, a patient must have been hospitalized at least three consecutive days for the same ailment requiring admission to the nursing home. This admission must be within 30 days of the patient's discharge from the hospital.

The nursing home to qualify for coverage must be a skilled nursing facility (SNF) approved by Medicare. The necessity for daily skilled nursing or rehabilitation services must be certified by a doctor

Medicare does not pay for custodial care, such as help with getting in and out of bed, bathing, dressing, eating, walking, and taking medicine. This kind of care makes up the major part of most nursing home services.

Nursing Home payment periods: If the patient qualifies for SNF care, **Medicare covers the first 20 days. For the next 80 days a copayment is required,** and after the 100th day Medicare pays nothing. If the nursing home is not a skilled nursing facility certified by Medicare, there is no coverage.

Medicaid pays for custodial care, but requires the patient to have an income below the poverty line and very limited or zero assets. A nursing home has to be found that is certified and will accept what Medicaid will pay. Space in such facilities is limited. The only places available may be far from the patient's home and not what would be chosen otherwise.

Home care- is an alternative if nursing home care is beyond a family's resources. For an elderly or entirely disabled patient requiring round-the-clock attention, however, home care also may be more than a family caregiver can cope with. For a 110-pound wife to lift, bathe and dress a 160-pound husband left helpless by a stroke is not an inconvenience, but rather an impossibility.

If one wage earner in a two-income family has to quit work to care for a helpless parent, the financial situation quickly grows worse. If both continue to work, they may find that the cost of

hiring full time professional home care for a long period may add up to more than nursing home expense.

Medicare and Medicaid

Medicare and Medicaid provisions along with the use of such equipment as hospital beds and wheelchairs give some home care support. There are also community-based services including adult day care centers. How much these measures can help depends on how severely the patient is disabled and for how long.

Other alternatives include house sharing arrangements or board and care in private homes. Congregate housing is a relatively new type of care providing individual apartments with central dining and housekeeping services, along with some medical supervision, counseling and social programs. All these arrangements involve financial and sometimes legal problems.

The Medicare program at its beginning in 1965 was designed to cover medical expenses for the elderly and disabled resulting from acute illness or injuries. It was not meant to meet the expenses of chronic conditions requiring long periods of care. It still does not do so to any great extent in spite of changes and expansion over the years.

As for Medicare insurance supplements, generally known as "Medigap" policies, they are designed primarily to meet requirements that otherwise would be the responsibility of the patient, such as co-payments and deductibles required under the Medicare program. In general, custodial care and other areas not covered by Medicare are not covered by Medigap policies either.

To meet the growing need for help with the chronic conditions of old age, as well as for younger disabled people, long-term care insurance has become an important risk coverage method.

Early long-term care insurance policies had qualifying restrictions similar to those of Medicare. A three-day hospital stay was required before a patient could be admitted to a nursing home, and the admission had to be within a certain period of time after the hospitalization. Skilled nursing care had to precede custodial care.

Coverage for patients with Alzheimer's or similar diseases was difficult or impossible to get. Some contracts did not have guaranteed renewability provisions or inflation protection. These and other limitations provoked criticism. Some policies were seen as so full of restrictions as to be almost useless.

High-pressure Medigap policy marketing in the past had brought on negative publicity. Potential customers for long- term care policies tended to confuse the two types.

Competition and improved regulations have helped make it clearer to long-term care insurance prospects that this product is different from Medigap policies and offers protection that Medigap coverage cannot provide. Each long-term care policy sold in California now must carry a statement that this is not Medicare supplement coverage.

NAIC Models**NAIC Model Policies:** The National Association of Insurance Commissioners, made up of the heads of insurance regulatory agencies in all 50 states, designed 10 standard plans for Medigap policies which have now been adopted nation-wide. These plans make it easier for prospective purchasers to compare Medigap policies and decide which they need. The NAIC also has provided a model for long-term care policies.

The California Insurance Code follows the NAIC guidelines, defining long-term care insurance as any coverage providing for maintenance or personal care as well as diagnostic, therapeutic or rehabilitative services administered in a setting that is not an acute care unit in a hospital.

Benefit Types

Products under California long-term care regulations may contain any or all of three types of benefits. These are institutional care coverage, community-based coverage and home care coverage. Institutional coverage includes care in a nursing home, either a skilled nursing facility or one for custodial care. Also included are convalescent and extended care facilities and personal care homes.

Under home care coverage both home health care and personal care are included. A home care policy also covers homemaker services and hospice care or respite care. Today there is also community based coverage that includes adult day care centers as well as hospice or respite care.

Policy Identification

While a long-term care policy may provide for one, two or all of these types of coverage, under California regulations only policies that cover both institutional and home care can be sold as comprehensive long-term care insurance. A policy limiting coverage to institutional care must be identified as a "Nursing Facility Only" policy, and one that offers only home care as a "Home Care Only" policy. The policy itself must define the types of service to be covered and specify the setting and nature of care, the facilities available and the level of skill required for caregivers. Licensing or certification requirements may be specified in the policy.

Benefit Requirements: In a comprehensive policy offering both home care and institutional care, the home care benefit must be at least half the maximum payable for institutional care, and not less than $50 a day. If a time limit is specified for benefits, the maximum for home care must be at least half that for institutional care.

Hospital Stays

No Hospital Stay Necessary: Regulations provide that no long-term care policy can be issued or delivered requiring an insured person to be hospitalized before benefits are available. This is among the state regulations designed to meet objections to early long-term care policies, which used Medicare standards for authorizing benefits. Elimination of the requirement for prior hospitalization recognizes the reality that not all chronic conditions for which long-term care is necessary will require a stay in an acute care facility first.

> The regulation also prohibits requiring institutional stays to establish eligibility for community-based care, home health care or other non-institutional benefits. Benefits

provided in an institutional care setting may not depend for eligibility on the receipt of a higher level of institutional care.

Post Claim Underwriting

Some insurance companies in launching long-term care policy programs tried to simplify and speed up the processing of policy applications by asking only a limited number of medical questions at the time the application was made. Instead of careful investigation by office underwriters of an applicant's medical history, which might take a month or more, a company using post-claim underwriting might issue policies within a week or two. The investigation would come only after a claim was submitted.

At that time, if a serious pre-existing condition was revealed, the issuing company might deny the claim on the basis that if this information had been known; the policy never would have been issued. Instead of benefits, the policy holder would receive a refund of premiums. This practice led to considerable dissatisfaction.

California long-term care insurance regulations require that all medical underwriting on such insurance be done before a policy is issued. Applications must contain clearly written questions, requiring only yes or no answers, to provide information on the applicant's medical history.

An underwriter using this information can make a further background check and accept or reject the application according to the standards set by the insurer. Once a policy is issued, however, it cannot be rescinded and claims cannot be fumed down unless there is clear evidence of misrepresentation or fraud on the part of the applicant. A mistake or accidental omission in filling out an application does not qualify as misrepresentation.

The contestability period in which the insurer may deny benefits or rescind a policy on the basis of fraud or misrepresentation is two years from the issuance of the policy. All long-term care policies written in California must be submitted to the insurer's office for underwriting. None can be field issued.

Pre-existing Conditions

A long-term policy in California **cannot exclude coverage for a pre-existing condition unless a loss or confinement resulting from that condition occurs within 6 months of the date policy coverage began.** This waiting period and any other limitations established by the insurer for pre-existing conditions must be set out in a separate paragraph in the policy under a heading specifying that they are pre-existing condition limitations.

Excluded coverage or reduced benefits for such conditions beyond the six-month limit must be specified in a waiver or rider approved by the insurance commissioner. A pre-existing condition is defined as one for which treatment or advice was received from a health care provider within six months preceding the date of coverage by the long-term care policy.

Alzheimer’s coverage

Benefits may not be limited or denied to long-term care policy holders under California regulations because of a diagnosis of Alzheimer’s or similar organic degenerative conditions of the brain.

Other nervous or mental disorders, however, as well as alcoholism and drug addiction, are among the allowable exclusions for long-term coverage set by California insurance regulations.

Exclusions

Exclusions also are allowed for illness or treatment resulting from service in the armed forces, war, riot, activities as a non-fare paying aviation passenger, suicide, self-inflicted injury, or participation in a felony. Exclusion of coverage is allowable for treatment provided in a government facility.

Services covered by Medicare, workers' compensation, employer's liability or motor vehicle no-fault laws also are included under allowable exclusions. Except for these specified exceptions, coverage under a long-term care policy in California cannot be limited or excluded by any illness, treatment, medical condition or accident.

Non-Allowable Provisions

A long-term care policy issued or sold in California cannot be terminated, canceled or nonrenewed because of the age of the insured or deterioration in the insured's physical or mental health.

Unless the insured voluntarily selects a replacement policy for an increase in benefits, a new or different policy with the same insurer replacing or converting coverage cannot require a new waiting period. Coverage for skilled nursing care only or for significantly more skilled care coverage than that for lower levels of care in a facility is not allowed under California long-term care insurance regulations.

Insurance benefits cannot be reduced because of out-of-pocket expenditures by or on behalf of the insured under a California long-term care policy. Payment of benefits cannot be based on standards described as usual and customary, reasonable and customary, or in similar words.

Benefits Extension

If a long-term care policy is terminated, benefits payable for institutionalization must continue for the duration of the policy period or until maximum benefits allowed under the policy are paid. That is, provided the institutionalization began while the policy was in force and continued without interruption after the termination of the policy. **This extension of benefits is subject to policy waiting periods and other applicable policy provisions.**

Policy Renewals

Either a guaranteed renewable or noncancelable provision must be included in every California long-term policy, meeting another frequent objection to early policies of this type.

A policy carrying a guaranteed renewable provision can be renewed by the insured as long as premiums are paid on time, and the terms of coverage cannot be changed by the insurer.

Premiums can be changed for all policy holders in the same class, but the insurer cannot refuse to renew coverage. Under a policy with a noncancelable provision, the insurer cannot change either the terms of coverage or the premium rate as long as premiums are paid on time.

Renewal provisions must be explained in all California long-term care policies. The explanation must include statements showing the original term of policy coverage, terms and conditions for renewal of the policy, and whether the premium can be changed by the insurer.

Inflation Protection

The lack of inflation protection in early long-term care insurance policies, making it necessary to apply for new policies periodically in order to meet rising costs, was another subject for complaint when long-term care coverage was first introduced.

The California Insurance Code requires that all long-term care applicants must have an option to purchase a policy that provides for an increase in benefit levels. Such an increase must be designed to match anticipated increases in costs of long-term care. A policy may either increase benefit levels annually, set benefits to cover a specific percentage of charges, or guarantee that the insured may increase benefit levels if the option for the previous period has not been declined, without having to show evidence of insurability.

Free look period: Applicants for long-term care insurance in California are entitled to a free look period of 30 days on all policies. After receiving a policy, an applicant can return it for any reason and be entitled to a full premium refund. After the policy return, the insurer must return all premiums paid and policy fees within 30 days. Each long-term care policy must carry a printed statement explaining the free look provision.

Necessary services provision: Insurers may require what evidence they believe suitable about the necessity of services covered by their policies. This evidence may be provided by a written statement from a physician. An independent needs assessment agency or other independent source acceptable to the insurer also may be used.

Home Health Care Coverage: Minimum coverage offered in home health care long-term policies in California must include skilled nursing or other professional care in the insured's residence, as well as personal care and homemaker services. Under a plan developed by a physician, personal care is to include help in activities of daily living, such as moving about, bathing, dressing, eating and taking medications.
This type of help may be given either by a skilled or nonskilled person under a doctor's plan. Cooking, laundry and light housekeeping also can be included. Homemaker services include activities by either a skilled or unskilled person under medical direction to make it possible for the insured to remain at home.

Community Services

Community-based services under home care policies include adult day care in a licensed facility outside the home for patients who need help in activities of daily living, as well as hospice services and respite care.

Hospice care is for terminally ill patients. Its purpose is to provide physical and emotional support for both the patient and the family. Hospice care may be given by either skilled or unskilled persons under medical direction or a plan prepared by a physician.

Respite care is a separate benefit for short-term care either in the home or as a community-based or institutional program designed to provide relief to a primary caregiver.

Benefits Standards

Eligibility of the insured to receive home health care coverage is to be based on minimum standards as set out in California regulations. There must be impairment in two activities of daily living (ADL's). ADL's include bathing, dressing, continence, toileting, transferring, eating, and ambulating.

There are two types of long-term care policies in California;

1.) Long-term care policies (or certificates) intended to qualify for federal and state of California tax benefits.
2.) Long-term care policies (or certificates) that meet California standards and are not intended to qualify for federal or state of California tax benefits but which may make it easier to qualify for home care benefits

In addition to the Activities of Daily Living test, a policyholder can become eligible for benefits because of cognitive impairment.

There are important differences between the two types of policies, for both individual and group insurance. The information in this chapter is introductory in nature. Further training in long-term care insurance products can be obtained through the state of California mandated eight-hour long-term care continuing education course.

Policies may specify fewer requirements than these, but not more stringent ones. Other substitute criteria may be approved on application from the insurer showing that the substitution would be in the client's interest.

Home health care policies cannot require a need for care in a nursing home or that skilled nursing services must be used before or along with unskilled services. Benefits cannot be limited to services from providers or agencies certified by Medicare. An acute condition is not a necessary requirement for home health care. Benefits cannot be based on a standard expressed as "medical necessity."

Licensed or skilled caregivers are not required for approval of home health care benefits, except as required by law, when other providers could give the same service. An eligible provider cannot be defined in a way more restrictive than that required for the provider's license in the state where the service is provided.

Group Coverage Offered

Group policies as well as individual policies may offer long- term care under California regulations. For a group policy the applicant holding member certificates may be an employer, a

professional association, a trade or occupational organization, an employee group, a credit union or a labor organization.

Individual insurance certificates under group policies are required to carry a description of the policy's principal benefits and coverage, as well as of its exclusions and limitations. Terms under which the policy may be continued or discontinued are to be shown in a statement. The insurer's right to change premiums, if one is included in the policy, must be indicated. A statement must explain that the group master policy determines provisions of the contract. The rights of the insured to continuation, conversion and replacement of the policy must be listed. California regulations provide that every certificate of long-term care insurance must offer continuation or conversion coverage for the individual insured in case group coverage ends for any reason other than nonpayment of premium. Continuation coverage means that coverage under an existing group policy may be maintained by continued payment of premiums when nonpayment is the reason for prospective termination. Under conversion coverage, an individual long-term care policy is issued without evidence of insurability to provide benefits for the insured equal to the ones in a group policy that has been discontinued.

In case of coverage under a group policy based on the insured's relationship to another person which is terminated by death or divorce, the insured individual is entitled to continuation coverage. To qualify for conversion coverage, the individual must have been covered by the group policy for at least six months. In such a case, a written application and premium must be submitted to the insurer within what is specified as "a reasonable period" under California regulations, and a conversion policy effective the day following termination of the group coverage will be issued.

If an insured individual applying for a conversion policy under group regulations already has long-term care insurance payable on an expense incurred basis, and this payment combined with the conversion policy would pay more than 100 per cent of incurred expenses, a provision for a benefit reduction may be included in the conversion policy. Such a reduction would require a decreased premium.

Group Markets

The group health insurance market is a major one in California. As an example, the California Public Employees Retirement System has coverage for nearly a million members and dependents.

The advantages of cooperative buying for a group of this size are indicated by reported savings of almost $500 million in negotiating the purchase of its insurance over a three-year period. The group secured a premium rollback in spite of a high concentration of older employees, while other group buyers were facing an average annual increase in premiums of eight per cent.

Coverage under this group's policies continues for members when they retire, paying medical care premiums for life. One 82-year-old member has had heart bypass surgery, hip replacement and prostate cancer, while his wife has had chronic lupus and cataracts.

Marketing regulations

Any insurance policy offered for sale in California as nursing home or long-term care insurance must comply with all provisions of the state insurance code. For long-term care policies the

insurer must submit to the California Department of Insurance a specimen policy form, either individual or group, with an outline of the coverage it offers, along with samples of advertising materials that will be used in the state.

A copy of any advertisement to be used by an insurer offering long-term coverage in California must be provided to the Department of Insurance at least 30 days before use. An advertisement must display the statement that a prospect answering the ad will be contacted by an insurance agent if that is to be done. An agent contacting a prospect as a result of such an ad must explain that fact.

Fair Dealing

Duties of individuals and companies engaged in the insurance business, specifically long-term care insurance, are named in California regulations as honesty, good faith and fair dealing. The conduct of agents or brokers before the sale of a policy is considered in the case of an action alleging that these duties have been breached.

In connection with these duties, it is required that agents or brokers in the course of an offer and sale of a policy make reasonable efforts to determine how that policy would be appropriate in meeting the prospect's needs, and whether some alternative form of coverage might be better suited to the case.

Outline of coverage

With every offer of sale of a long-term care policy the prospect must be given an outline of coverage. This outline is to provide a brief description of the main features of the proposed policy. It must be given to the prospect by the agent before the application or enrollment form is presented.

The outline must state that it is a summary of the coverage offered and is recommended for use in comparing this policy with others for which a summary is received. The outline, besides showing the insurer's name and address and the terms under which the policy may be resumed for a full premium refund, must contain a statement that the policy is not Medicare supplement coverage. A description of long-term care coverage is to be included. The relationship between cost of care and benefits is to be shown, and terms under which the policy may be continued or discontinued are to be specified. The outline is to show that Alzheimer's and other organic brain diseases are to be covered.

Premium payments and other relevant features of the policy must be set out. There is to be a notice of information and counseling services available through the California Department of Insurance and the Health Insurance Counseling and Advocacy Program, with their phone numbers.

Compliance Requirements

Insurers issuing long-term care policies are required by California regulations to develop procedures under which compliance with marketing rules can be audited. The regulations are designed to require marketing procedures assuring that comparison of policies available will be done fairly and give accurate information.

Excessive amounts of insurance are not to be sold. The law states that no insurer or agent may cause the holder of a long-term care policy to replace it unnecessarily. A third policy or more sold to an individual within a 12-month period will be presumed unnecessary under the law, except in a case of consolidating policies with the same insurer.

Insurers' Responsibility

The responsibility of evaluating a policy already held by a prospect and deciding if a new long-term care policy is needed lies with the insurance agent or broker. A replacement is to be recommended only when it is in the best interest of the prospective buyer.

All applications for long-term care must contain a question as to whether the prospective policy is intended to replace any other health or long-term care insurance. If it is a replacement, the applicant must be given a formal notice to be signed before issuance of the new policy.

This notice applies to accident and sickness as well as long- term care coverage. It states that the applicant is aware of factors in the new plan that could affect insurance protection already available. A copy is kept by the applicant and another is to be kept on file by the insurer. The exact wording of the notice is specified in the California insurance code.

Another notice required to be printed on the first page of the policy or group certificate and on the outline of coverage must advise the prospective buyer that the policy may not cover all costs associated with long-term care during the period of coverage. The prospect is advised to review all policy limitations carefully.

Specified Waivers

The insurer must waive any probationary period or requirement affecting pre-existing conditions to the extent that they already have been satisfied under a previous policy. The agent is required to sign a statement that after reviewing the applicant's current coverage the agent has concluded that replacement of the policy will cause material improvement in the position of the applicant.

The sale commission for a replacement policy is to be calculated using the difference between the annual premiums of the replacement and original coverage. An explanation of the compensation plan of every long-term care insurer must be filed with the Department of Insurance.

Group Policy Replacement: If a group long-term care policy is replaced, benefits must be substantially equal to those under the original coverage. The premium is to be calculated on the age of the insured at the time the original policy was issued, unless new or increased benefits are added. In that case, the age of the insured at the time of replacement can be used.

Coverage must be offered to all individuals covered by the original group policy at its termination date. Pre-existing conditions that were covered in the old policy must be covered in the replacement. New waiting or probationary periods for pre-existing conditions may not be required. Any such periods satisfied under the previous policy are to be waived for the new one.

Benefits or premiums are not to be adjusted on the basis of the health, disability status or claims experience of the insured.

UNFAIR MARKETING

Specific prohibitions related to practices in the marketing of long-term care policies are included in the California insurance code. These include twisting, high pressure tactics and deceptive cold lead advertising.

Any incomplete or fraudulent policy comparison or misleading information about policy provisions for the purpose of persuading a prospect to buy a policy or to give up or convert an existing policy is known as twisting.

The law specifically states that no insurer, broker, agent or other person shall cause a policyholder to replace a long-term insurance policy unnecessarily. A replacement policy is to be recommended only when it is in the consumer's best interest.

Undue pressure to buy insurance including the use of force, frightening or threatening a prospect comes under the heading of high pressure tactics. Such tactics are prohibited by the statutes.

Any marketing method that does not make plain that its purpose is to sell insurance and that contact will be made with the prospect by an insurance company or its agent is known as deceptive cold lead advertising and is prohibited. Neither state nor federal governments sponsor the sale of insurance policies, and the use of promotional material designed to look as if it is from a government office such as the Social Security Administration is prohibited.

Letters on official-looking stationery sometimes have been sent out with reply cards enclosed in order to build a list of prospects which is then sold to an agent for follow-up use. **The law requires anyone contacting a possible policy buyer to provide immediate and clear identification as an insurance company representative.**

Violation Penalties

Penalties for violations: Enforcement of state laws on long-term care insurance is provided for with penalties for violations. Penalties can be assessed on agents, brokers, insurers and any other entity in the insurance business.

A fine of $250 can be assessed agents and brokers for each first violation of the statutes. For subsequent or deliberate violations, fines can run from a minimum of $1,000 to a maximum of $25,000 for each violation. The fine for each inappropriate replacement of long-term care coverage can be up to $5,000 for agents and brokers.

For insurers, a fine of no less than $5,000 for each first violation and no less than $10,000 for each subsequent or knowing violation may be assessed. For a violation occurring in a manner that indicates a general business practice, an insurer's fine can be from a minimum of $10,000 to a maximum of $500,000, depending on how serious the violation against the public interest is found to be. All fines are payable to the State Insurance Fund.

Besides these penalties, the license of any agent, broker or producer can be revoked for violation of the statutes. An insurer's certificate of authority for providing disability insurance can be suspended, or permission to market any or all long-term care policies in California can be withdrawn.

Anyone charged with such a violation is entitled to due process, and penalties cannot be imposed without a public hearing if it is requested within 10 days after notice of the violation charge is received. The hearing is to be held within 30 days after the serving of the notice.

Medicare

In general, all persons 65 years of age or older who have been legal residents of the United States for at least 5 years are eligible for Medicare. However, if neither they nor their spouse have paid Medicare taxes for a minimum of 10 years (40 quarters), then they must pay a monthly premium to be enrolled in Medicare. Medicare part 'A' premiums are waived if the following circumstances apply:

- They are 65 years or older **and** U.S. citizens or have been permanent legal residents for 5 continuous years, **and** they or their spouse has paid Medicare taxes for at least 10 years.

or

- They are under 65, disabled, and have been receiving either Social Security benefits or the Railroad Retirement Board disability benefits for at least 24 months from date of entitlement (first disability payment).

or

- They get continuing dialysis for end stage renal disease or need a kidney transplant.

or

- They are eligible for Social Security Disability Insurance and have amyotrophic lateral sclerosis (known as ALS or Lou Gehrig's disease).

The 24 month exclusion means that people who become disabled must wait 2 years before receiving government medical insurance, unless they have one of the listed diseases or they are eligible for Medicaid.

Many beneficiaries are dual-eligible. This means they qualify for both Medicare and Medicaid. In some states for those making below a certain income, Medicaid will pay the beneficiaries' Part B premium for them (most beneficiaries have worked long enough and have no Part A premium), and also pay for any drugs that are not covered by Part D.

In 2016 Medicare provided health care coverage for 57 million Americans, making it the largest single health care payer in the nation. Enrollment is expected to reach 78 million by 2030, when the generation is fully enrolled.

Benefits

Medicare has four parts: Part A is Hospital Insurance. Part B is Medical Insurance. Medicare Part D covers prescription drugs. Medicare Advantage plans, also known as Medicare Part C, are another way for beneficiaries to receive their Part A, B and D benefits. All Medicare benefits are subject to medical necessity. The original program was only Parts A and B. Part D was added in 2006; before that, Parts A and B covered prescription drugs in only a few special cases.

Part A: Hospital Insurance

Part A covers inpatient hospital stays (at least overnight), including semiprivate room, food, tests, and doctor's fees. Part A covers brief stays for convalescence in a skilled nursing facility if certain criteria are met:

1. A preceding hospital stay must be at least three days, three midnights, not counting the discharge date.
2. The nursing home stay must be for something diagnosed during the hospital stay or for the main cause of hospital stay.
3. If the patient is not receiving rehabilitation but has some other ailment that requires skilled nursing supervision then the nursing home stay would be covered.
4. The care being rendered by the nursing home must be skilled. Medicare part A does not pay for custodial, non-skilled, or long-term care activities, including activities of daily living (ADL) such as personal hygiene, cooking, cleaning, etc.

The maximum length of stay that Medicare Part A will cover in a skilled nursing facility per ailment is 100 days. The first 20 days would be paid for in full by Medicare with the remaining 80 days requiring a co-payment (as of 2017, $164.50 per day). Many insurance companies have a provision for skilled nursing care in the policies they sell. If a beneficiary uses some portion of their Part A benefit and then goes at least 60 days without receiving facility-based skilled services, the 100-day clock is reset and the person qualifies for a new 100-day benefit period.

Part B: Medical Insurance

Part B medical insurance helps pay for some services and products not covered by Part A, generally on an outpatient basis. Part B is optional and may be deferred if the beneficiary or their spouse is still working. There is a lifetime penalty (10% per year) imposed for not enrolling in Part B unless actively working. Part B coverage begins once a patient meets his or her deductible, then typically Medicare covers 80% of approved services, which the remaining 20% is paid by the patient.

Part B coverage includes physician and nursing services, x-rays, laboratory and diagnostic tests, influenza and pneumonia vaccinations, blood transfusions, renal dialysis, outpatient hospital procedures, limited ambulance transportation, immunosuppressive drugs for organ transplant recipients, chemotherapy, hormonal treatments, and other outpatient medical treatments administered in a doctor's office.

Medication administration is covered under Part B only if it is administered by the physician during an office visit.

Part B also helps with durable medical equipment (DME), including canes, walkers, wheelchairs, and mobility scooters for those with mobility impairments. Prosthetic devices such as artificial limbs and breast prosthesis following mastectomy, as well as one pair of eyeglasses following cataract surgery, and oxygen for home use are also covered.

Complex rules are used to manage the benefit, and advisories are periodically issued which describe coverage criteria. On the national level these advisories are issued by CMS, and are known as National Coverage Determinations (NCD). Local Coverage Determinations (LCD) only apply within the multi-state area managed by a specific regional Medicare Part B contractor, and Local Medical Review Policies (LMRP) were superseded by LCDs in 2003.

Part C: Medicare Advantage plans

With the passage of the Balanced Budget Act of 1997, Medicare beneficiaries were given the option to receive their Medicare benefits through private health insurance plans, instead of through the original Medicare plan (Parts A and B). These programs were known as “Medicare+Choice” or "Part C" plans. Pursuant to the Medicare Prescription Drug, Improvement and Modernization Act of 2003, "Medicare+Choice" plans were made more attractive to Medicare beneficiaries by the addition of prescription drug coverage and became known as “Medicare Advantage” (MA) plans. Traditional or "fee-for-service" Medicare has a standard benefit package that covers medically necessary care members can receive from nearly any hospital or doctor in the country. For people who choose to enroll in a Medicare Advantage health plan, Medicare pays the private health plan a capitated rate, or a set amount, every month for each member. Members typically also pay a monthly premium in addition to the Medicare Part B premium to cover items not covered by traditional Medicare (Parts A & B), such as prescription drugs, dental care, vision care and gym or health club memberships. In exchange for these extra benefits, enrollees may be limited in the providers they can receive services from without paying extra. Typically, the plans have a "network" of providers that patients can use. Going outside that network may require permission or extra fees.

Medicare Advantage plans are required to offer coverage that meets or exceeds the standards set by the original Medicare program, but they do not have to cover every benefit in the same way. If a plan chooses to pay less than Medicare for some benefits, like skilled nursing facility care, the savings may be passed along to consumers by offering lower copayments for doctor visits. Medicare Advantage plans use a portion of the payments they receive from the government for each enrollee to offer supplemental benefits. Some plans limit their members’ annual out-of-pocket spending on medical

care, providing insurance against catastrophic costs over $5,000, for example. Many plans offer dental coverage, vision coverage and other services not covered by Medicare Parts A or B, which makes them a good value for the health care dollar, if you want to use the provider included in the plan's network or "panel" of providers.

The Medicare payment formulas overpay plans when compared to traditional Medicare (Medicare Payment Advisory Commission Annual Reports to Congress). However, Medicare Advantage members receive additional coverage and medical benefits not enjoyed by traditional Medicare members, and savings generated by Medicare Advantage plans may be passed on to beneficiaries to lower their overall health care costs. Other important distinctions between Medicare Advantage and traditional Medicare are that Medicare Advantage health plans encourage preventive care and wellness and closely coordinate patient care.

Medicare Advantage Plans that also include Part D prescription drug benefits are known as a Medicare Advantage Prescription Drug plan or a MA-PD. Since 2004, the number of beneficiaries enrolled in private plans has more than tripled from 5.3 million to 19 million in 2017. This represents 33% of Medicare beneficiaries. Total enrollment is up from 17.6 million in 2016. A third of beneficiaries with Part D coverage are enrolled in a Medicare Advantage plan. Medicare Advantage enrollment is higher in urban areas; the enrollment rate in urban counties is twice that in rural counties (22% vs. 10%). Almost all Medicare beneficiaries have access to at least two Medicare Advantage plans; most have access to three or more.

Part D: Prescription Drug plans

Medicare Part D went into effect in 2006. Anyone with Part A or B is eligible for Part D. It was made possible by the passage of the Medicare Prescription Drug, Improvement, and Modernization Act. In order to receive this benefit, a person with Medicare must enroll in a stand-alone Prescription Drug Plan (PDP) or Medicare Advantage plan with prescription drug coverage (MA-PD). These plans are approved and regulated by the Medicare program, but are actually designed and administered by private health insurance companies. Unlike Original Medicare (Part A and B), Part D coverage is not standardized. Plans choose which drugs (or even classes of drugs) they wish to cover, at what level (or tier) they wish to cover it, and are free to choose not to cover some drugs at all. The exception to this is drugs that Medicare specifically excludes from coverage, including but not limited to benzodiazepines, cough suppressant and barbiturates. Plans that cover excluded drugs are not allowed to pass those costs on to Medicare, and plans are required to repay CMS if they are found to have billed Medicare in these cases. Note that for beneficiaries who are dual-eligible (Medicare and Medicaid eligible) Medicaid may pay for drugs not covered by part D of Medicare, such as benzodiazepines, and other restricted controlled substances.

Neither Part A nor Part B pays for all of a covered person's medical costs. The program contains premiums, deductibles and coinsurance, which the covered individual must pay out-of-pocket. Some people may qualify to have other governmental programs (such as Medicaid) pay premiums and some or all of the costs associated with Medicare.

Premiums

Most Medicare enrollees do not pay a monthly Part A premium, because they (or a spouse) have had 40 or more 3-month quarters in which they paid Federal Insurance Contributions Act taxes. Medicare-eligible persons who do not have 40 or more quarters of Medicare-covered employment may purchase Part A for a monthly premium of:

- $224.00 per month (2015) for those with 30-39 quarters of Medicare-covered employment, or
- $407.00 per month (in 2015) for those with less than 30 quarters of Medicare-covered employment and who are not otherwise eligible for premium-free Part A coverage.

All Medicare Part B enrollees pay an insurance premium for this coverage; the standard Part B premium for 2018 is $134 per month. A new income-based premium plan has been in effect since 2007, wherein Part B premiums are higher for beneficiaries with incomes exceeding $85,000 for individuals or $170,000 for married couples. Depending on the extent to which beneficiary earnings exceed the base income, these higher Part B premiums are $187.50, $267.90, $348.30, or $428.60 for 2018, with the highest premium paid by individuals earning more than $160,000, or married couples earning more than $320,000. Medicare Part B premiums are commonly deducted automatically from beneficiaries' monthly Social Security checks. Part C and D plans may or may not charge premiums, at the programs' discretion. Part C plans may also choose to rebate a portion of the Part B premium to the member.

Deductible and coinsurance

Part A - For each benefit period, a beneficiary will pay (in 2017):

- A Part A deductible is $1,316.
- A $329 per day co-pay for days 61-90 of a hospital stay.
- A $658 per day co-pay for days 91-150 of a hospital stay, as part of their limited Lifetime Reserve Days.
- All costs for each day beyond 150 days.
- Coinsurance for a Skilled Nursing Facility is $164.50 per day for days 21 through 100 for each benefit period.
- A blood deductible of the first 3 pints of blood needed in a calendar year, unless replaced. There is a 3 pint blood deductible for both Part A and Part B, and these separate deductibles do not overlap.

Part B - After a beneficiary meets the yearly deductible of $183.00 (in 2017), they will be required to pay a co-insurance of 20% of the Medicare-approved amount for all services covered by Part B with the exception of most lab services which are covered at 100%, The copay for outpatient mental health which started at 50% was gradually stepped down over several years until it matched the 20% required for other services. They are also required to pay an excess charge of 15% for services rendered by non-participating Medicare providers. The deductibles and coinsurance charges for Part C and D plans vary from plan to plan.

Payment for services
Medicare contracts with regional insurance companies who process over one billion fee-for-service claims per year. In 2010, Medicare accounted for 13.5% ($452 billion) of the federal budget. In 2016 it accounted for 17% ($565.5 billion) of the total expenditures. For the decade 2013-2023 Medicare is projected to nearly double from $592 billion to $1.1 trillion.[1]

Medicare supplement (Medigap) policies
Some people elect to purchase a type of supplemental coverage, called a Medigap plan, to help fill in the holes in Original Medicare (Part A and B). These Medigap insurance policies are standardized by CMS, but are sold and administered by private companies. Medigap policies sold after the introduction of Medicare Part D in 2006 are prohibited from covering drugs. Medicare regulations prohibit a Medicare beneficiary from having both a Medicare Advantage Plan and a Medigap Policy. Medigap Policies may only be purchased by beneficiaries that are receiving benefits from Original Medicare (Part A & Part B).

Payment for services
Medicare contracts with regional insurance companies who process over one billion fee-for-service claims per year. Medicare spending was 15 percent of total federal spending in 2017, and is projected to rise to 18 percent by 2028. In 2017, Medicare benefit payments totaled $702 billion, up from $425 billion in 2007.

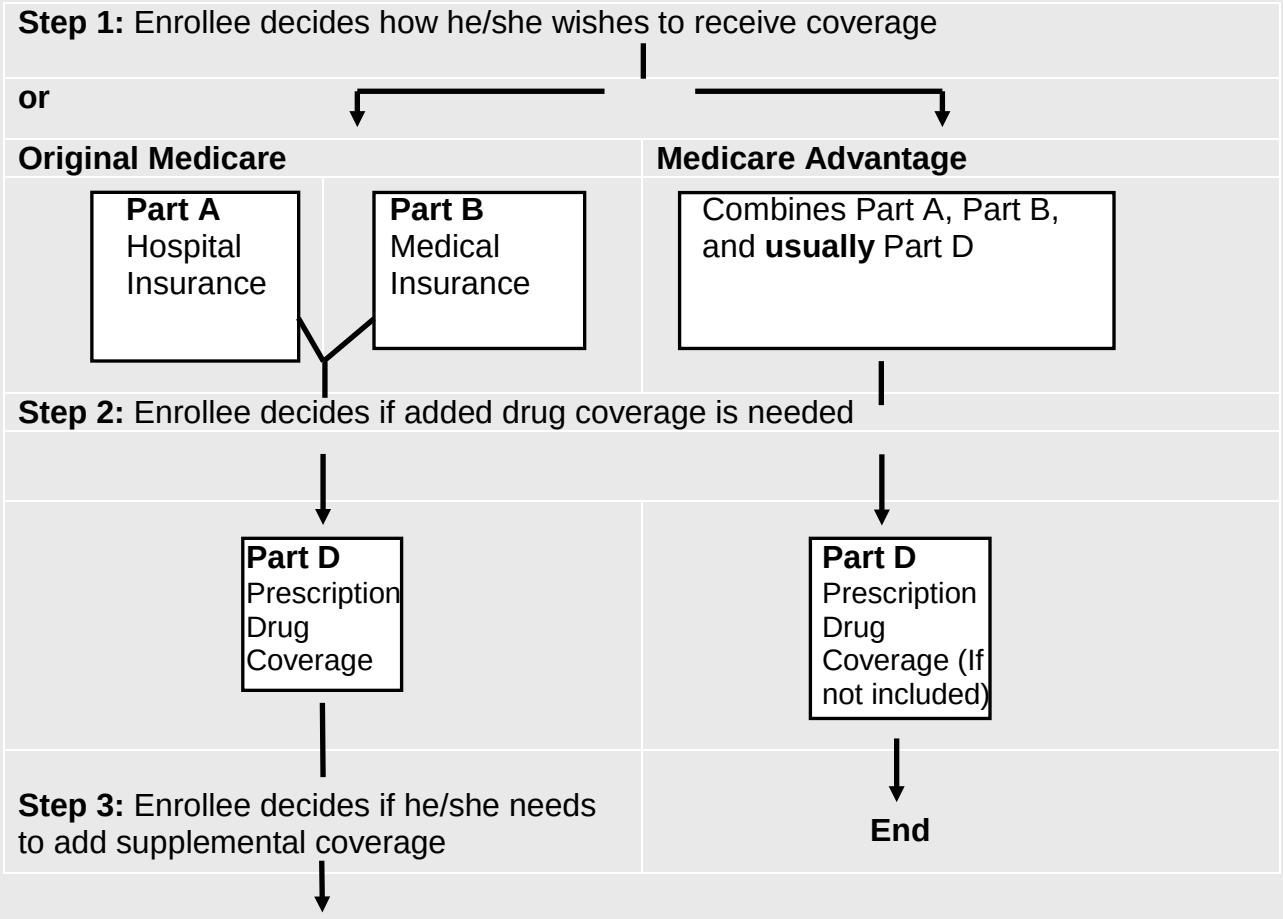
Medicare Summary
Title XVIII of the Social Security Act, designated “Health Insurance for the Aged and Disabled,” is commonly known as Medicare. As part of the Social Security Amendments of 1965, the Medicare legislation established a health insurance program for aged persons to complement the retirement, survivors, and disability insurance benefits under Title II of the Social Security Act. When first implemented in 1966, Medicare covered most persons aged 65 or older. In 1973, the following groups also became eligible for Medicare benefits: persons entitled to Social Security or Railroad Retirement disability cash benefits for at least 24 months, most persons with end-stage renal disease

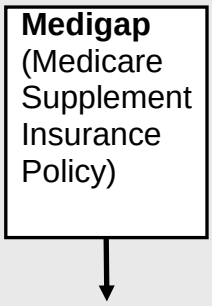
[1] Kaiser Foundation, Medicare Info, http://kff.org/medicare

(ESRD), and certain otherwise noncovered aged persons who elect to pay a premium for Medicare coverage. People with Amyotrophic Lateral Sclerosis (Lou Gehrig's disease) are allowed to waive the 24-month waiting period. This very broad description of Medicare eligibility is expanded in the next section. Medicare originally consisted of two parts:

- **Hospital Insurance (HI), or Part A**: Part A helps pay for inpatient hospital, home health agency, skilled nursing facility, and hospice care. Part A is provided free of premiums to most eligible people; certain otherwise ineligible people may voluntarily pay a monthly premium for coverage.
- **Supplementary Medical Insurance (SMI), or Part B:** Part B helps pay for physician, outpatient hospital, home health agency, and other services. To be covered by Part B, all eligible people must pay a monthly premium.

Chart 1 Medicare Basics



	If enrollee joins a Medicare Advantage Plan, he/she does not need and cannot be sold a Medigap Policy.
End	

Medicare Advantage and Drug Coverage were subsequently added to the mix

- **Medicare Advantage, or Part C:** This was established as the Medicare+Choice program by the Balanced Budget Act of 1997 (Public Law 105-33) and subsequently renamed and modified by the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 (Public Law 108-173). The Medicare Advantage program expands beneficiaries' options for participation in private-sector health care plans.
- **Drug Coverage, Part D:** The MMA also established a fourth part of Medicare, known as Part D, to help pay for prescription drugs not otherwise covered by Part A or Part B. Part D initially provided access to prescription drug discount cards, on a voluntary basis and at limited cost to all enrollees (except those entitled to Medicaid drug coverage) and, for low-income beneficiaries, transitional limited financial assistance for purchasing prescription drugs and a subsidized enrollment fee for the discount cards. This temporary plan began in mid-2004 and phased out during 2006.

Entitlement and Coverage

Part A is generally provided automatically and free of premiums to persons aged 65 or older who are eligible for Social Security or Railroad Retirement benefits, whether they have claimed these monthly cash benefits or not. Also, workers and their spouses with a sufficient period of Medicare-only coverage in federal, state, or local government employment are eligible beginning at age 65. Similarly, individuals who have been entitled to Social Security or Railroad Retirement disability benefits for at least 24 months, and government employees with Medicare-only coverage who have been disabled for more than 29 months, are entitled to Part A benefits. (As noted previously, the waiting period is waived for persons with Lou Gehrig's disease. It should also be noted that, over the years, there have been certain liberalizations made to both the waiting period requirement and the limit on earnings allowed for entitlement to Medicare coverage based on disability.) Part A coverage is also provided to insured workers with ESRD (and to insured workers' spouses and children with ESRD), as well as to some otherwise ineligible aged and disabled beneficiaries who voluntarily pay a monthly

premium for their coverage. In 2016, Medicare provided protection against the costs of hospital and specific other medical care to about 57 million people and Medicare spending totaled $702 billion in 2017.

Part A Coverages

The following health care services are covered under Part A:

- Inpatient hospital care. Coverage includes costs of a semiprivate room, meals, regular nursing services, operating and recovery rooms, intensive care, inpatient prescription drugs, laboratory tests, X-rays, psychiatric hospitals, inpatient rehabilitation, and long-term care hospitalization when medically necessary, as well as all other medically necessary services and supplies provided in the hospital. An initial deductible payment is required of beneficiaries who are admitted to a hospital, plus copayments for all hospital days following day 60 within a benefit period (described later).
- Skilled nursing facility (SNF) care. Coverage is provided by Part A only if it follows within 30 days (generally) a hospitalization of 3 days or more and is certified as medically necessary. Covered services are similar to those for inpatient hospital care, and include rehabilitation services and appliances. The number of SNF days provided under Medicare is limited to 100 days per benefit period (described later), with a copayment required for days 21 through 100. Part A does not cover nursing facility care if the patient does not require skilled nursing or skilled rehabilitation services.
- Home health agency (HHA) care (covered by Parts A and B). The Balanced Budget Act transferred from Part A to Part B those home health services furnished on or after January 1, 1998, that are unassociated with a hospital or SNF stay. Part A will continue to cover the first 100 days visits following a 3-day hospital stay or a SNF stay; Part B covers any visits thereafter. Home health care under Parts A and B has no copayment and no deductible. HHA care, including care provided by a home health aide, may be furnished part time by an HHA in the residence of a homebound beneficiary, if intermittent or part-time skilled nursing and/or certain other therapy or rehabilitation care is necessary. Certain medical supplies and durable medical equipment may also be provided, although beneficiaries must pay a 20 percent coinsurance for durable medical equipment, as required under Part B of Medicare. There must be a plan of treatment and periodic review by a physician. Full-time nursing care, food delivered to the home, blood, and drugs are not provided as HHA services.
- Hospice care. Coverage is provided for services to terminally ill persons with life expectancies of 6 months or less who elect to forgo the standard Medicare benefits for treatment of their illness and to receive only hospice care for it. Such care includes pain relief, supportive medical and social services, physical therapy, nursing services, and symptom management. However, if a hospice patient requires treatment for a condition that is not related to the terminal illness, Medicare will pay for all covered services necessary for that condition. The Medicare beneficiary pays no deductible for the hospice program but does pay small coinsurance amounts for drugs and inpatient respite care.

Benefit Period
An important Part A component is the benefit period, which starts when the beneficiary first enters a hospital and ends when there has been a break of at least 60 consecutive days since inpatient hospital or skilled nursing care was provided. There is no limit to the number of benefit periods covered by Part A during a beneficiary's lifetime; however, inpatient hospital care is normally limited to 90 days during a benefit period, and copayment requirements (detailed later) apply for days 61 through 90. If a beneficiary exhausts the 90 days of inpatient hospital care available in a benefit period, the beneficiary can elect to use days of Medicare coverage from a nonrenewable lifetime reserve" of up to 60 (total) additional days of inpatient hospital care. Copayments are also required for such additional days.

Part B Coverages
All citizens (and certain legal aliens) aged 65 or older, and all disabled persons entitled to coverage under Part A, are eligible to enroll in Part B on a voluntary basis by payment of a monthly premium. Almost all persons entitled to Part A choose to enroll in Part B. In 2015, Part B provided protection against the costs of physician and other medical services to about 55 million people (46 million aged and 9 million disabled enrollees). Part B benefits totaled $167.8 billion in 2015.

Part B covers certain medical services and supplies, including the following:
- Physicians' and surgeons' services, including some covered services furnished by chiropractors, podiatrists, dentists, and optometrists;
- Services provided by Medicare-approved practitioners who are not physicians, including certified Registered nurse anesthetists, clinical psychologists, clinical social workers (other than in a hospital or SNF), physician assistants, and nurse practitioners and clinical nurse specialists in collaboration with a physician;
- Services in an emergency room, outpatient clinic, or ambulatory surgical center, including same-day surgery;
- Home health care not covered under Part A;
- Laboratory tests, X-rays, and other diagnostic radiology services;
- Certain preventive care services and screening tests;
- Most physical and occupational therapy and speech pathology services;
- Comprehensive outpatient rehabilitation facility services, and mental health care in a partial hospitalization psychiatric program, if a physician certifies that inpatient treatment would be required without it;
- Radiation therapy; renal (kidney) dialysis and transplants; heart, lung, heart-lung, liver, pancreas, and bone marrow transplants; intestinal transplants;
- Approved durable medical equipment for home use, such as oxygen equipment and wheelchairs, prosthetic devices, and surgical dressings, splints, casts, and braces;

- Drugs and biologicals that are not usually self-administered, such as hepatitis B vaccines and immunosuppressive drugs (certain self-administered anticancer drugs are covered);
- Certain services specific to people with diabetes;
- Ambulance services, when other methods of transportation are contraindicated; and
- Rural health clinic and federally qualified health center services, including some telemedicine services.

To be covered, all services must be either medically necessary rendered by a physician or one of several prescribed preventive benefits. Part B services are generally subject to a deductible and coinsurance (see next section). Certain medical services and related care are subject to special payment rules, including deductibles (for blood), maximum approved amounts (for Medicare-approved physical, speech, or occupational therapy services performed in settings other than hospitals), and higher cost-sharing requirements (such as those for certain outpatient hospital services). The preceding description of Part B-covered services should be used only as a general guide, due to the wide range of services covered under Part B and the quite specific rules and regulations that apply. Medicare Parts A and B, as described above, constitute the original fee-for-service Medicare program.

SMI Components

Since 2006, Part D has provided subsidized access to prescription drug insurance coverage on a voluntary basis for all beneficiaries upon payment of a premium, with premium and cost-sharing subsidies for low-income enrollees. Part D activities are handled within the SMI trust fund but in an account separate from Part B. It should thus be noted that the traditional treatment of “SMI” and “Part B” as synonymous is no longer accurate, since SMI now consists of Parts B and D. The purpose of the two separate accounts within the SMI trust fund is to ensure that funds from one part are not used to finance the other. When Medicare began on July 1, 1966, approximately 19 million people enrolled. In 2016, over 57 million are enrolled in one or both of Parts A and B of the Medicare program, and almost 11 million of them have chosen to participate in a Medicare Advantage plan.

Part C Benefits

Medicare Part C, also known as Medicare Advantage, is an alternative to traditional Medicare. Although all Medicare beneficiaries can receive their benefits through the traditional fee-for-service program, most beneficiaries enrolled in both Part A and Part B can choose to participate in a Medicare Advantage plan instead. Medicare Advantage plans are offered by private companies and organizations and are required to provide at least those services covered by Parts A and B, except hospice services. These plans may (and in certain situations must) provide extra benefits (such as vision or hearing) or reduce cost sharing or premiums.

The primary Medicare Advantage plans are:

- Local coordinated care plans, including health maintenance organizations (HMOs), provider-sponsored organizations, local preferred provider organizations (PPOs), and other certified coordinated care plans and entities that meet the standards set forth in the law. Generally, each plan has a network of participating providers. Enrollees may be required to use these providers or, alternatively, may be allowed to go outside the network but pay higher cost-sharing fees for doing so.
- Regional PPO plans, which began in 2006 and offer coverage to one of 26 defined regions. Like local PPOs, regional PPOs have networks of participating providers, and enrollees must use these providers or pay higher cost-sharing fees. However, regional PPOs are required to provide beneficiary financial protection in the form of limits on out-of-pocket cost sharing, and there are specific provisions to encourage regional PPO plans to participate in Medicare.
- Private fee-for-service plans, which for the most part do not have provider networks. Rather, members of a plan may go to any Medicare provider willing to accept the plan's payment.
- Special Needs Plans (SNPs), which are restricted to beneficiaries who are dually eligible for Medicare and Medicaid, live in long-term care institutions, or have certain severe and disabling conditions.

For individuals entitled to Part A or enrolled in Part B (except those entitled to Medicaid drug coverage), the new Part D initially provided access to prescription drug discount cards, at a cost of no more than $30 annually, on a voluntary basis. For low-income beneficiaries, Part D initially provided transitional financial assistance (of up to $600 per year) for purchasing prescription drugs, plus a subsidized enrollment fee for the discount cards. This temporary plan began in mid-2004 and phased out in 2006.

Part D Benefits

Part D provides subsidized access to prescription drug insurance coverage on a voluntary basis, upon payment of a premium, to individuals entitled to Part A or enrolled in Part B, with premium and cost-sharing subsidies for low-income enrollees. Beneficiaries may enroll in either a stand-alone prescription drug plan (PDP) or an integrated Medicare Advantage plan that offers Part D coverage. Enrollment began in 2005. In 2017, Part D provided protection against the costs of prescription drugs to about 42 million people. Part D benefits totaled $85.2 billion in 2015. Part D coverage includes most FDA-approved prescription drugs and biologicals. (The specific drugs currently covered in Parts A and B remain covered there.)

Plans may set up formularies for their prescription drug coverage, subject to certain statutory standards. At its most basic level, a **formulary** is a list of medicines. Traditionally, a formulary contained a collection of formulas for the compounding and testing of medication (a resource closer to what would be referred to as a pharmacopoeia today). The main function of formularies today is to specify which

medicines are approved to be prescribed under a particular contract. The development of formularies is based on evaluations of efficacy, safety, and cost-effectiveness of drugs.
Part D coverage can consist of either standard coverage (defined later) or an alternative design that provides the same actuarial value. For an additional premium, plans may also offer supplemental coverage exceeding the value of basic coverage.

Not Covered

It should be noted that some health care services are not covered by any portion of Medicare. Noncovered services include long-term care, custodial care, and certain other health care needs, such as dentures and dental care, eyeglasses, and hearing aids. These services are not a part of the Medicare program, unless they are a part of a private health plan under the Medicare Advantage program.

Program Financing, Beneficiary Liabilities, and Payments to Providers

All financial operations for Medicare are handled through two trust funds, one for Hospital Insurance (HI, Part A) and one for Supplementary Medical Insurance (SMI, Parts B and D). These trust funds, which are special accounts in the U.S. Treasury, are credited with all receipts and charged with all expenditures for benefits and administrative costs. The trust funds cannot be used for any other purpose. Assets not needed for the payment of costs are invested in special Treasury securities. The following sections describe Medicare's financing provisions, beneficiary cost-sharing requirements, and the basis for determining Medicare reimbursements to health care providers.

Program Financing

The HI trust fund is financed primarily through a mandatory payroll tax. Almost all employees and self-employed workers in the United States work in employment covered by Part A and pay taxes to support the cost of benefits for aged and disabled beneficiaries. The Part A tax rate is 1.45 percent of earnings, to be paid by each employee and a matching amount by the employer for each employee, and 2.90 percent for self-employed persons. Since 1994, this tax is paid on all covered wages and self-employment income without limit (Prior to 1994, the tax applied only up to a specified maximum amount of earnings). The Part A tax rate is specified in the Social Security Act and cannot be changed without legislation.

Part A also receives income from the following sources:

(1) a portion of the income taxes levied on Social Security benefits paid to high-income beneficiaries,
(2) premiums from certain persons who are not otherwise eligible and choose to enroll voluntarily,
(3) reimbursements from the general fund of the U.S. Treasury for the cost of providing Part A coverage to certain aged persons who retired when Part A

began and thus were unable to earn sufficient quarters of coverage (and those federal retirees similarly unable to earn sufficient quarters of Medicare-qualified federal employment),
(4) interest earnings on its invested assets, and
(5) other small miscellaneous income sources. The taxes paid each year are used mainly to pay benefits for current beneficiaries.

Trust Fund Differences

The SMI trust fund differs fundamentally from the HI trust fund with regard to the nature of its financing. As previously noted, SMI is now composed of two parts, Part B and Part D, each with its own separate account within the SMI trust fund. The nature of the financing for both parts of SMI is similar, in that both parts are primarily financed by contributions from the general fund of the U.S. Treasury and (to a much lesser degree) by beneficiary premiums.

For Part B, the contributions from the general fund of the U.S. Treasury are the largest source of income, since beneficiary premiums are generally set at a level that covers 25 percent of the average expenditures for aged beneficiaries. The standard Part B premium rate was $104.90 per beneficiary per month in 2015. There are, however, three provisions that can alter the premium rate for certain enrollees (and the third reduced the premium for most enrollees in 2015). First, penalties for late enrollment (that is, enrollment after an individual's initial enrollment period) may apply, subject to certain statutory criteria. Second, beneficiaries whose income was above certain thresholds are required to pay an income-related monthly adjustment amount, in addition to their standard monthly premium. The 2015 Part B income-related monthly adjustment amounts and total monthly premium amounts to be paid by beneficiaries, according to income level and filing status, are shown in Table 1. Finally, a "hold-harmless" provision affects premiums. Beneficiaries in Medicare Part D prescription drug coverage plans pay premiums that vary from plan to plan.

Table 1 2018 Part B income-related monthly adjustment amounts

Beneficiaries who file an individual tax return with income	Beneficiaries who file a joint tax return with income	Total monthly Part B premium amount
Less than or equal to $85,000	Less than or equal to $170,000	$134.00
Greater than $85,000 and less than or equal to $107,000	Greater than $170,000 and less than or equal to $214,000	$187.50
Greater than $107,000 and less than or equal to $133,500	Greater than $214,000 and less than or equal to $267,000	$267.90

Greater than $133,500 and less than or equal to $160,000	Greater than $267,000 and less than or equal to $320,000	$348.30
Greater than $160,000	Greater than $320,000	$428.60

The monthly premium rates paid by beneficiaries who are married, but file a separate return from their spouses and who lived with their spouses at some time during the taxable year, are different. Those rates are as follows:

Beneficiaries who are married, but file a separate tax return, with income:	Total monthly Part B premium amount
Less than or equal to $85,000	$134.00
Greater than $85,000	$428.60

Hold-Harmless Provision

The “hold-harmless” provision, which prohibits increases in the standard Part B premium from exceeding the dollar amount of an individual’s Social Security cost-of-living adjustment, lowers the premium rate for most individuals who have their premiums deducted from their Social Security checks. Those not protected include most new enrollees during the year; enrollees with high incomes who are subject to the income-related monthly adjustment amount; and enrollees- such as certain federal, state, and local government retirees- who do not have their Part B premium withheld from a Social Security check. Also not protected are dual Medicare-Medicaid beneficiaries for whom premiums are paid by state Medicaid programs.

General Fund Contributions

For Part D, as with Part B, general fund contributions account for the largest source of income, since Part D beneficiary premiums are to represent, on average, 25.5 percent of the cost of standard coverage. The Part D base beneficiary premium for 2018 is $35.02. The actual Part D premiums paid by individual beneficiaries equal the base beneficiary premium adjusted by a number of factors. In practice, premiums vary significantly from one Part D plan to another and seldom equal the base beneficiary premium. As of this writing, it is estimated that the average monthly premium for basic Part D coverage, which reflects the specific plan-by-plan premiums and the estimated number of beneficiaries in each plan are about $34 in 2018. Penalties for late enrollment may apply. (Late enrollment penalties do not apply to enrollees who have maintained creditable prescription drug coverage.)

Beneficiaries meeting certain low-income and limited-resources requirements pay substantially reduced premiums or no premiums at all (and are not subject to late enrollment penalties) In addition to contributions from the general fund of the U.S. Treasury and beneficiary premiums, Part D also receives payments from the states.

With the availability of prescription drug coverage and low-income subsidies under Part D, Medicaid is no longer the primary payer for prescription drugs for Medicaid beneficiaries who also have Medicare, and states are required to defray a portion of Part D expenditures for those beneficiaries. During the Part D transitional period that began in mid-2004 and phased out during 2006, the general fund of the U.S. Treasury financed the transitional assistance benefit for low-income beneficiaries. Funds were transferred to, and paid from a Transitional Assistance account within the SMI trust fund.

The SMI trust fund also receives income from interest earnings on its invested assets, as well as a small amount of miscellaneous income. It is important to note that beneficiary premiums and general fund payments for Parts B and D are redetermined annually and separately. Payments to Medicare Advantage plans are financed from both the HI trust fund and the Part B account within the SMI trust fund in proportion to the relative weights of Part A and Part B benefits to the total benefits paid by the Medicare program.

Beneficiary Payment Liabilities
Fee-for-service beneficiaries are responsible for charges not covered by the Medicare program and for various cost-sharing aspects of Parts A and B. These liabilities may be paid

(1) by the Medicare beneficiary;
(2) by a third party, such as an employer-sponsored retiree health plan or private Medigap insurance; or
(3) by Medicaid, if the person is eligible.

Medigap

The term “Medigap” is used to mean private health insurance that pays, within limits, most of the health care service charges not covered by Parts A or B of Medicare. This includes deductibles and coinsurance charges not covered by Medicare. These policies, which must meet federally imposed standards, are offered by Blue Cross and Blue Shield and various commercial health insurance companies.

Beneficiary Payment Share
For beneficiaries enrolled in Medicare Advantage plans, the beneficiary’s payment share is based on the cost-sharing structure of the specific plan selected by the beneficiary, since each plan has its own requirements. Most plans have lower deductibles and coinsurance than are required of fee-for-service beneficiaries. Such beneficiaries, in general, pay the monthly Part B premium. However, some Medicare Advantage plans may pay part or all of the Part B premium for their enrollees as an added benefit. Depending on the plan, enrollees may also pay an additional premium for certain extra benefits provided (or, in a small number of cases, for certain Medicare-covered services).

For hospital care covered under Part A, a beneficiary's fee-for-service payment share includes a one-time deductible amount at the beginning of each benefit period ($1,260 in 2015). This deductible covers the beneficiary’s part of the first 60 days of each spell of inpatient hospital care. If continued inpatient care is needed beyond the 60 days, additional coinsurance payments ($315 per day in 2015) are required through the 90th day of a benefit period. Each Part A beneficiary also has a “lifetime reserve” of 60 additional hospital days that may be used when the covered days within a benefit period have been exhausted. Lifetime reserve days may be used only once, and coinsurance payments ($630 per day in 2015) are required. For skilled nursing care covered under Part A, Medicare fully covers the first 20 days of SNF care in a benefit period. But for days 21 through 100, a copayment ($157.50 per day in 2015) is required from the beneficiary.

After 100 days per benefit period, Medicare pays nothing for SNF care. Home health care requires no deductible or coinsurance payment by the beneficiary. In any Part A service, the beneficiary is responsible for fees to cover the first 3 pints or units of nonreplaced blood per calendar year. The beneficiary has the option of paying the fee or of having the blood replaced. There are no premiums for most people covered by Part A. Eligibility is generally earned through the work experience of the beneficiary or of the beneficiary's spouse. However, most aged people who are otherwise ineligible for premium-free Part A coverage can enroll voluntarily by paying a monthly premium, if they also enroll in Part B. For people with fewer than 30 quarters of coverage as defined by the Social Security Administration (SSA), the Part A monthly premium rate will be $407 in 2015; for those with 30 to 39 quarters of coverage, the rate will be reduced to $224. Penalties for late enrollment may apply. Voluntary coverage upon payment of the Part A premium, with or without enrolling in Part B, is also available to disabled individuals for whom coverage has ceased because earnings are in excess of those allowed.

For Part B, the beneficiary’s payment share includes the following:

- One annual deductible ($147 in 2015), the monthly premiums,
- The coinsurance payments for Part B services (usually 20 percent of the remaining allowed charges with certain exceptions noted below),
- A deductible for blood,
- Certain charges above the Medicare-allowed charge (for claims not on assignment), and payment for any services not covered by Medicare.

For outpatient mental health services, the beneficiary is currently liable for 20 percent of the approved charges. For services reimbursed under the outpatient hospital prospective payment system, coinsurance percentages vary by service and currently fall in the range of 20 percent to 50 percent. For certain services, such as clinical lab tests,

HHA services, and some preventive care services, there are no deductibles or coinsurance.

Part D Payments
For the standard Part D benefit design, there is an initial deductible ($360 in 2015). After meeting the deductible, the beneficiary pays 25 percent of the remaining costs, up to an initial coverage limit ($3,310 in 2015). The beneficiary is then responsible for all costs until an out-of-pocket threshold is reached. (The 2015 out-of-pocket threshold is $4,850) For costs thereafter, catastrophic coverage is provided, which requires enrollees to pay the greater of 5 percent coinsurance or a small defined copayment amount ($2.65 in for generic or preferred multisource drugs and $6.60 in 2015 for other drugs). The benefit parameters are indexed annually to the growth in average per capita Part D costs. Beneficiaries meeting certain low-income and limited-resources requirements pay substantially reduced cost-sharing amounts. In determining out-of-pocket costs, only those amounts actually paid by the enrollee or another individual (and not reimbursed through insurance) are counted; the exception to this “true out-of-pocket” provision is cost-sharing assistance from the low-income subsidies provided under Part D and from State Pharmacy Assistance programs. Many Part D plans offer alternative coverage that differs from the standard coverage described above. In fact, the majority of beneficiaries are not enrolled in the standard benefit design but rather in plans with low or no deductibles, flat payments for covered drugs, and, in some cases, partial coverage in the coverage gap. The monthly premiums required for Part D coverage are described in the previous section.

MEDICAID

The joint federal-state program known as Medicaid was established as part of the Social Security act amendments that were passed by Congress in 1965. **The purpose of Medicaid was to provide health care for those without the incomes or resources to meet their needs.**
In California, “Medi-Cal” is the name for the Medicaid program as implemented in California. The federal program sets guidelines for the Medi-Cal program and states establish their own rules within those guidelines. Federal funds provide a little over half of Medicaid expenditures and states pay for the rest. Because the states have different minimum incomes for welfare, Medicaid eligibility as well as other provisions vary from state to state.

As a means-tested program, Medicaid differs from Medicare and Medigap policies. The most notable difference in coverage is that Medicaid, or Medi-Cal, provides for custodial care in nursing homes and the others do not. This is an item of major interest to people worried about who will take care of them if they become helpless.

Agents for long-term care insurance policies report that Medi-Cal is their major competitor. The largest total amount paid for nursing home care now comes from Medi-Cal.

Medicaid Eligibility

An applicant for Medicaid or Medi-Cal must fill out a questionnaire listing all assets and income. Limits for eligibility, besides varying from state to state, can be changed annually. A person may need to "spend down" or get rid of assets in order to qualify.

Revised federal statutes now give some protection to the family of Medicaid recipients to prevent total financial ruin. A spouse living at home can keep half the couple's assets and some monthly income. The state establishes limits within the range of the federal guidelines.

Types of Medicaid assets

Medicaid divides assets into countable, non-countable and inaccessible categories. Countable assets must be reduced to zero to establish eligibility. They include cash, checking and savings accounts, usually over a $2,000 limit, as well as stocks, bonds, CDs, Treasury notes and bills, IRAs or other retirement plans that can be liquidated, life insurance cash values above certain limits, vacation homes, second vehicles and any other items not specified as non-countable.

Assets on the non-countable list can be kept without affecting Medicaid eligibility. They include a primary residence and household furnishings being used there, one car being driven by the spouse, one engagement ring and one wedding ring, cash value of life insurance under a limit, usually $1,500, a cemetery plot, a burial trust fund and real property, up to a set value limit, needed for support.

Inaccessible assets are those made unavailable to Medicaid by various means, including gifts, qualifying trusts or certain types of joint accounts, as well as assets that cannot be reached by an incapacitated nursing home resident.

Various ways of Medicaid estate planning to change countable assets to non-countable or inaccessible ones include transferring assets, changing property titles and wills, setting up Medicaid trusts, or divorcing a spouse. "Spending down" to get rid of cash might involve buying expensive furnishings for a residence or paying family members or other informal caregivers for invalid care.

Property transfers and similar arrangements may cause legal or tax problems and are likely to require the services of a lawyer or other qualified consultant. Also, recent tax law changes have tightened Medicaid eligibility regulations. A person who gives away assets faces a longer waiting period for eligibility than before, depending on the amount of the gift. This waiting period could run up to 50 months for $150,000 given away. Programs for recovering Medicaid payments from estates are now in effect in all states. Requirements for eligibility of trusts have been tightened.

Other Medicaid or Medi-Cal qualifications

In addition to income and asset limitations, there are other eligibility requirements for Medicaid nursing home care. A person to be eligible must be 65 or over, blind or disabled. U. S. citizenship or permanent resident status is required. The person must be certified as needing the type of care that is provided only in a nursing home.

Such care to be eligible for Medicaid must be given in a nursing home certified under the Medicare program and the home must have an available bed for the patient. There may be a waiting period ranging from days to months.

Sometimes a qualified nursing home is not located near the patient's residence or relatives. A state may try to hold down Medicaid expenditures by limiting the number of nursing home beds it will certify or the number of nursing home construction permits issued. Qualified nursing homes may refuse to take Medicaid patients, and some are decertifying their Medicaid beds when a patient leaves.

Nursing home operators point out that states pay less for Medicaid residents than private patients pay for nursing home care. Medicare payments also tend to run behind schedule, sometimes as much as nine months. This situation makes it difficult for nursing homes to provide adequate care for Medicaid patients or to maintain a profitable operation.

Other Medicaid Coverage

Other Medicaid coverage: Nursing home care is only part of the core package set by federal regulations for Medicaid patients. States design their individual Medicaid programs around the federal core package to fit local conditions, and services vary from state to state. In general, those eligible for Medicaid have their bills paid for doctors' services, inpatient and outpatient hospital care, prescription drugs and lab and X-ray services in addition to nursing home care. Some states also provide for home-based care, community services or intermediate facility care.

A recent survey, however, indicated that only a little over half of the private medical providers in this country will accept Medicaid patients. Those who cannot get medical attention otherwise are forced to go to community hospital emergency rooms in case of need. Besides involving long waits, this procedure keeps the indigent from seeking preventive medical care or maintenance treatment until a crisis situation develops.

Large numbers of the working poor who fall below the national poverty line may not meet state welfare eligibility requirements necessary to qualify for Medicaid. The elderly, children and families receiving public assistance under the Aid to Families with Dependent Children program, blind and disabled people receiving Supplemental Security Income account for most Medicaid recipients. Able-bodied people between 21 and 64, childless couples and two-parent families earning wages below the national poverty level often are not eligible for Medicaid.

As more middle-aged, middle-income individuals begin to think about the possibilities of needing long-term care, they are faced with unpleasant prospects regarding the Medicaid program. These include the narrowing of legal limits on Medicaid estate planning for eligibility, as well as the difficulty of finding acceptable nursing home accommodations.

There are also ethical aspects to the practice of using the Medicaid program for those who may qualify technically but are not actually in want, rather than for the truly poor. The alternative solution is realistic planning for private long-term care insurance coverage.

LONG-TERM POLICY STRUCTURE AND MARKETING

Long-term care policies are designed to achieve the classic purpose of insurance: shifting risk. An individual prepares for future threats to security by paying a consideration to an insurer. The insurer seeks to spread similar risks over a group, producing a pool of funds to pay for losses suffered by individual premium-payers.

An insurance company underwriter is responsible for selecting and maintaining a set of policy holders whose risks are similar and predictable enough to keep adequate funds flowing into the pool and not flowing out too fast for profitable operation.

Underwriters identify and evaluate risks, set standards for evaluating applicants, help actuaries price and establish terms for policies, and monitor the accounts. Agents are given guidelines for meeting the company's underwriting standards when selecting prospects and having them fill out application forms. A sound insurance company's standards are set with the aim of providing necessary coverage at a price low enough to be competitive and high enough to meet obligations and maintain required reserves.

Long-Term Policy Features

There are many companies now offering a wide variety of long- term care policies, and an agent needs to be familiar with the main features to look for in comparing policy provisions. Most long-term care policies are indemnity contracts, paying a fixed dollar amount for each day the beneficiary receives specified care. The patient is responsible for the actual cost of the care.

A choice of indemnity amounts is usually offered, in a range which may run from about $100 to $150 a day or more. For nursing home care with an average statewide cost above $90,000 a year[*] , if the indemnity amount in a policy averages $150 a day, the balance must come from outside sources. Home health care indemnity amounts cannot be less than $50 a day in California. Beyond these similarities there will be a number of options complicating the choice of a policy.

Levels of Care

Levels of care: Three levels of care usually are covered in long-term policies;

❶ **Skilled care** is generally defined as care designed to treat a medical condition from which the patient is expected to recover. It must be available 24 hours a day and be given by a qualified nurse under doctor's orders in a licensed skilled care facility.

❷ **Intermediate care** usually calls for occasional nursing and other care needed for rehabilitation under the supervision of qualified medical personnel.

❸ **Custodial care** primarily meets personal needs to assist a patient in the activities of daily living, such as bathing, dressing and eating. It can be given by people who do not have professional medical skills. Usually it is administered in the patient's own home or in a residential care home. Long-term care is generally custodial care.

[*] 2013 Office of Statewide Health Planning and Development data shows the California average at $247.03. For 365 days that is $90,165.

Coverage Outline

Coverage Outline: In order for prospective purchasers to compare what is offered, an outline of coverage is required for long-term care policies sold in California and most other states. Chief features to look at for comparison include benefit triggers, definition of care providers, and design options for benefits.

A benefit trigger is an event or condition required for the payment of benefits. This may be a medical emergency, injury or illness certified by a doctor as making long-term care necessary, whether in the patient's home or in a nursing home. Prior hospitalization is no longer required as it is under Medicare.

Standards of need: To determine whether long-term care is necessary, the standard most commonly used is the functional model. This is based on a measurement of physical function which lists activities of daily living (ADLs) in ascending order of difficulty. Patients who are hampered in such ADLs as mobility, dressing and bathing are judged as needing scheduled care, meaning that they do not have to have constant attendance. Further ADLs, such as eating or management of bowel and bladder functions, are needed on demand and require care that is available full time.

Types of Assessment

Policies tend to judge physical impairment by the number of ADLs affected. A more realistic assessment is based on whether or not on-demand care is needed. Some companies use only physical ADLs as standards, although a person may be physically able to bathe and dress without the mental faculties to know when and why to do so. For this reason “cognitive impairment” is a trigger.

If both physical and mental abilities are being measured, memory tests or interviews may be used. Separate physical and mental assessments give a better indication of the patient's abilities than those that are lumped together. Assessments may be made by physicians, insurance company employees or independent observers. Physicians may not be familiar with the ADL model being used or may delay the assessment. Company employees naturally would tend to favor their employers' interests. The most objective information is likely to come from an independent assessor.

Medical Necessity

The medical model is an older type of benefit trigger which bases coverage on what is determined to be medically necessary care. This may be specifically designated in the policy or left for interpretation when a claim is made. In other cases the determination of whether or not care is medically necessary may be left up to the patient's physician. Confidence that legitimate claims will be paid on the basis of objective assessments assures the agent of the underwriting fairness of the company and makes possible a successful sales presentation.

Providers

Coverage under a long-term care policy also is affected by how it defines providers of care. The Medicare definition was used by early LTC policies, but coverage now has been broadened. Nursing homes, adult day-care centers and home health care agencies usually are included.

In order to be clear, a policy definition of long-term care providers should specify who will provide services, which services qualify for coverage and where the services are to be provided in order to be eligible for benefit payments.

Nursing Homes-

A policy may provide nursing home coverage including skilled, intermediate and custodial care while at the same time it specifies that the custodial care can be given only in a skilled nursing facility in order to qualify. Such nursing homes are required to be certified by Medicare. They also must be state licensed, have medical professionals on call at all times, have a certain number of beds and maintain required medical records.

Home Health Care

A home health care agency may provide both personal care and medical care given by a nurse or other qualified professional. Nutritionist services and physical therapy as well as speech and occupational therapy may be included. A home health aide, personal care worker or family member may take care of the non-medical services. Benefits for these may be restricted. The agent needs to check and compare policy definitions of home health care.

If Medicare certification is required for a home health care agency it may be difficult to find an adequate one. Many such agencies prefer not to deal with Medicare because of payments that do not meet expenses.

Day Care Center

An adult day-care center will take patients during daytime hours if the home caregiver has to be away at work. Such centers do not have overnight accommodations. A long-term care policy usually will require the center to be licensed by the state and to have regular hours of operation. Some policies call for registered nurses, doctors and other licensed therapists to be included on the staff.

Policy Options

Standard options usually are offered in long-term care policies. With the help of the agent, the prospective purchaser can select choices from these to fit individual circumstances. The amount of benefits to be paid, the period to be covered, the elimination period, what providers of care are to be eligible for coverage, and whether benefits are to be level or increasing make up the standard selections that determine the cost of the policy.

Coverage Amounts- The amount to be paid by the policy is the first factor determining the amount of the premium. An indemnity plan provides a specific benefit that lets the policy holder know exactly what to expect. The policy holder pays the cost of care and the insurance company provides a set per diem payment in return. Other arrangements, including a reimbursement plan or a plan covering usual and customary charges, usually offer less coverage.

Benefit Period- As to benefit period lengths, some companies provide lifetime benefits. Options of two, three, four or six years are more common. The longer the period, the higher the premium. A two or three year period can cost 30 to 50 per cent less than a lifetime period. With

the average nursing home stay less than three years, many policy purchasers opt for the shorter periods. A restoration of benefits clause can return the policy to its original benefits level if the patient does not receive additional treatment for six months after being discharged from a nursing home. This provision, which can keep brief stays in a nursing home from using up benefits, makes the shorter benefit periods more attractive.

Waiting Periods- Another option which influences the premium cost of long-term care policies is the elimination period, or waiting time between the start of a benefit period and the time coverage begins. A first dollar policy will pay from the beginning of a nursing home charge, while a catastrophic expense clause means a waiting period before benefits start.

A longer waiting period means lower premiums. Elimination periods ranging from zero to 180 days may be selected, but the policy holder runs the risk of being charged more for services during the waiting period than the difference in premium charges would be.

A policy that allows accumulating days of different types of care, such as home health or adult day care, to satisfy the waiting period is more favorable to the policy holder than one that requires consecutive days. The agent needs to check policy provisions to be sure that home health care and adult day care both are counted as full days of care and that all providers are included in figuring an elimination period.

Inflation Protection- Like other expenses, nursing home costs can be expected to increase with time. Insurance policy riders provide ways to offer increased benefits in order to keep up with inflation. **An automatic increase rider raises the benefit amount to adjust to increases in the cost of living.** The benefit may be raised at a set annual rate, such as 5 per cent. It can be a simple or compound interest increase. A compound benefit increase option could raise the daily benefit once a year by 5 per cent of the benefit level for the previous year. A simple benefit increase option also could provide an annual 5 per cent raise in benefits but would be based on the original daily benefit established in the policy. Neither rider would increase premiums as the cost would be figured into the original premium.

Additional Coverage Option- As an alternative to an automatic rider, a policy might offer an option to purchase additional coverage as needed. In this way the amount of benefits might be more closely matched to actual nursing home cost increases, but there could be a possibility that worsening health might keep a policy holder from qualifying for the additional insurance. The age rate also would change. Additional premiums would be required for the added coverage, and this option could cost more over the life of the policy than an automatic increase rider.

Other Options- Individual companies often add other options to the basic ones to make the policy more attractive. Among these might be ambulance benefits. An option might be included for a nursing home bed reservation in order to have a vacant bed ready in case a patient needed to enter a hospital and then return to the nursing home. A survivorship benefit might cover the spouse of a patient after the couple had paid on a policy for ten years or more. A provision for coordination with Medicare might mean that the insurance company would not pay anything during a patient's stay in a hospital that was covered by Medicare. Days in a

nursing home in this case might not count against the long-term care policy benefit period. Such an option would not be likely to be worthwhile to a Medicare-covered patient.

An option for Alzheimer's disease was sometimes included in the first long-term care policies, but this coverage is now required in California and elsewhere as a standard offering. The policy needs to specify Alzheimer's or similar forms of senility in order to cover organic brain disease. Although these and other options might appeal to a prospect wanting full coverage, it has to be pointed out that the more options there are, the more the policy costs. The benefits need to be analyzed and weighed against premium increases. A base policy that conforms to state regulations and that is issued by a reputable company offers a reliable guide to most needs.

Long-Term Care

Marketing Issues- For successful marketing of long-term care policies, an agent needs the same type of preparation necessary for other successful selling: thorough understanding of the product, its advantages and applicable regulations, plus adequate information about the potential market and confidence in the company being represented.

The agent needs to be familiar with the underwriting requirements and policy provisions of the company in order to be able to explain them satisfactorily to the prospective client. Many people do not fully understand the basic structure, purposes and philosophy of the insurance industry. They tend to be distrustful of an unfamiliar product because of widespread media criticism of unethical insurance practices. Bad news always tends to be emphasized because the unusual rather than the usual attracts attention.

Policy Improvement.

There have been abuses in the health insurance field, but competition and regulation have produced a long-term care product that is much improved over earlier offerings. The same is true of Medigap insurance, which is often confused in the public mind with long-term care policies.

Selling of overlapping and unnecessary supplemental policies to elderly Medicare recipients resulted in reform measures which now restrict Medigap policies to 10 standard offerings. California regulations require a specific statement on each long-term care policy sold in the state that it is not Medicare supplement insurance.

Marketing Segments

Retirees: According to the U.S. Census Bureau website, some 47.8 million Americans are now 65 or older (2015 estimates). That number is growing by 12 per cent a year.

Projections are that almost half of them eventually will need nursing home care. Only a small percentage of them now have long-term care insurance. New retirees who have recently turned 65 are well aware of the fact that long-term care may come to be their major need. Although not all of them can afford private insurance, many can. They may live on fixed incomes but as a group they have a relatively high net worth, with paid-up mortgages and little installment debt. For investments they are mainly interested in security.

By pointing out how Medicare alone or even with Medigap supplements cannot fully cover long-term care needs, an agent can make a successful approach to many in the over-65 group.

Those who have seen friends have to spend down or give up assets in order to qualify for Medicaid may be especially interested in paying their own way.

They probably are accustomed to budgeting in order to live within fixed incomes while having enough left over for secure investments. If they are in good enough health to meet underwriting requirements they are among the best long-term care insurance prospects.

Boomers- The postwar baby boom generation, now in middle age, is well aware of the reality of retirement needs. Saving is difficult and asset protection is a major consideration. Many of those in their mid-40s have encountered the problem of long-term care at first hand as their parent's age, and they have become concerned about what will happen as they themselves grow old.

This 40-plus age group, as the youngest major segment of the prospective market for long-term care, has the advantage of qualifying for the lowest premiums. Even though it may be years before long-term care is needed, coverage can be established at minimum rates that may provide large savings later. Members of this group also may want to buy long-term care insurance for their parents while they are still able to qualify.

The Mature Market- Members of the age group between 50 and 65 provide the best potential market for long-term care insurance. Although of course individuals vary widely, as a group this market segment controls more than 77 per cent of the wealth in this country.

As pre-retirees, most of the over-50s are at the peak of their earning capacity. With their level of income and with their children having left home, the empty nesters as a group have more discretionary spending income than ever before- in fact about half the nation's total of such income, some $160 billion a year. Also they are in general healthier and more active than people their age were in the past.

At the same time they are becoming more aware of long-term care needs. They may have the responsibility of caring for their own parents and have first-hand acquaintance with the costs of such care. In any case they are aware of investment values and can understand that with age, an individual's insurance needs may evolve from protecting dependents against a breadwinner's untimely death to preparing for a longer and better quality life.

Building a prospect list from a selected segment of this age group can offer an agent a cost-effective way of making contact with possible clients who will appreciate a quality product clearly and competently explained.

Qualifying Limits

Qualifying Limits: Many long-term care insurers set age limits for issuing policies at around 50 to 84. Below 50 individuals have other insurance needs that are likely to be more pressing, and after 84 the probability of a chronic health condition that would disqualify a prospect is high. Some companies, however, offer policies to individuals as young as 21 and as old as 99.
In addition to age, a prospect for long-term care insurance needs to be considered for ability to keep functioning. Health needs differ from those of life insurance qualifications. Such a disease as crippling arthritis might not affect life expectancy but would have a bearing on whether or not the person suffering from it would be likely to need long-term care.

The prospect's level of assets also has to be taken into consideration. Not only is it a question of being able to pay insurance premiums, but of whether there are enough assets to justify measures for safeguarding them. A person on Medicaid or Medi-Cal rolls is not a prospect for long-term care insurance.

Proper planning for long-term care can help avoid dependency on others or the necessity of having to get rid of assets in order to qualify for Medicaid. Adequate insurance can preserve pride and independence of choice so that an individual does not have to rely on family members and can select levels of care, including a nursing home if necessary, according to preference.

Product Knowledge and Marketing

Successful marketing of long-term insurance calls for the same basic requirements as any type of salesmanship: understanding of the market, knowledge about the product, and the ability to communicate that knowledge to individuals making up that market. **There are over 100 million people age 50 and over in this country, according to the U.S. Census Bureau website (2015 projected figures).** Only a small percentage has long-term care insurance. Even omitting all those who could not afford or could not qualify for such insurance, this is still a huge untapped potential market.

An agent who understands the structure and purposes of long- term care policies can offer a valuable service to people who have begun to realize they may need such coverage but have not been approached about it or do not know where to get competent advice on the subject.

Participation Fears

Some prospects will have a negative reaction to the idea of long-term care insurance. They may have heard that collecting on claims is difficult. They may think that policies cost too much or that they can handle nursing home care from their own funds. They may say that they count on being covered by Medicare or Medicaid, that their children will take care of them, or that they are too strong and well ever to become helpless.

Consumer Protection

To answer these objections an agent needs to be ready with facts rather than opinions or vague reassurances. In early days of the development of long-term care insurance, there were misunderstandings about benefit triggering requirements in policies, as well as abuses by careless or uninformed agents. Consumer protection regulations by both federal and state governments to make policy provisions clear, fair and enforceable now are in place and can be documented.

Cost of Policies

Long-term care insurance premiums have to be set to meet underwriting requirements, and the probability of claims is unavoidably high for this type of coverage. Such policies are not cheap and there will be those who cannot afford them.

Risks of waiting

Those who plan to wait and see what government health plans may offer in the way of long-term care need to be reminded that they are running the risk of becoming incapacitated in the meantime, as well as growing older every day. To those who think they are too strong ever to become helpless, the statistical probabilities of eventual need for nursing home care or qualified assistance at home can be pointed out.

Cost of Care

A person who feels able to cover long-term care costs from private finds may not know that **the average charge for a nursing home is over $97,000 a year (Genworth). Figures from the California Office of Statewide Health Planning and Development (OSHPD) indicate the statewide average cost per day for nursing home care is about $266 for 2016.** Medicare pays for some nursing home costs, but not for the custodial care which accounts for most nursing home stays. Medicaid will pay, but only if the patient is almost entirely without assets and has a sub-poverty income level. The choice of Medicaid-sanctioned nursing homes is limited. In many cases financial arrangements can be made to cover long-term care policy premium costs. Reverse annuity mortgages or sale and leaseback of property might be considered. An arrangement of this type would make funds available for a private insurance policy, relieving the aging person of worry about care from other sources. It also could free children or other relatives from the possible future burden of having to take care of a helpless patient 24 hours a day, a task that might be entirely beyond both their physical and financial capabilities.

An agent dealing with the age groups that make up the prime long- term care insurance market needs to remember that most of these potential clients have had long experience with products that do not live up to expectations and with people who turn out not to be trustworthy. Establishing confidence in the policy to be provided, in the company issuing it and most of all in the agent personally is essential for closing a sale. The prospect wants to be sure that the policy will provide independence, peace of mind, and dependable service when needed.

People of mature ages do not want to be treated as "old" or patronized, but they do want clear, careful and unhurried explanations of future problems likely to be encountered and how the proposed solutions will meet those problems. They want quality that will justify the expense involved. Security and independence are their prime considerations in making a decision.

Such a prospect does not want to be rushed into an agreement without making sure that it will do what it promises to do. The agent who can identify the prospect's needs and show convincingly how long-term care insurance can fill those needs has the ingredients for success.

CHAPTER 5: Designing, Implementing, Monitoring Group Plans

While it is important for the insurance agent to know as much as possible about group insurance plans, no amount of knowledge is worth anything until it is put into practice. When an agent is going to show a prospect the necessity of a group insurance plan, the agent must have the features of the group plan firmly in mind. It is the agent's job to explain to an employer the need for a group insurance plan. Before talking with the employer, the agent should have the elements of a group plan firmly planted in his or her mind. The agent is then ready to approach the employer interested in implementing a group plan. The initial interview will provide the agent with ideas to implement a plan designed for that particular employer. During the initial interview the agent must know the right questions to ask, and listen closely to the responses in order to determine the employer's primary group plan objectives. After determining the objectives the agent can begin explaining the plan elements in a manner that is easily understandable by the employer. The agent now can explain how the plan can be tailored for the employer to reach the company's plan objectives.

One employer may be most interested in taking advantage of tax deductibility. Another employer may want greater protection for highly paid executives. Another employer may be looking for a way to keep valuable employees on line and attract new ones with competitive fringe benefit packages. The agent should be able to arrange the emphasis in the plan presentation to fit the needs of the prospect. Through a well planned and executed presentation, the agent will begin to build confidence with the employer in the agent's ability to provide the service the sponsoring company needs.

FINANCIAL STATEMENT ANALYSIS

As a professional, the insurance agent should be familiar with financial accounting terms and legal terms used in business. When an employer wants to have the company's accounting and legal staff join the meeting, the insurance agent should be knowledgeable enough to follow and assist in the financial and legal discussions. The employer ready to install a group insurance plan normally has discussed the feasibility of the plan with the financial and legal staff of the company before the agent is invited in. The financial staff is the personnel that knows the in's and the out's of the company. These people are an invaluable source of information. The information, once gathered by the agent, can be used to design the client's group plan. The people that will assist in gathering the required information are initially the financial staff. The legal staff may have company objectives to discuss, but the staff will be more interested in the legal and tax elements of the plan once it is designed and presented. During the proposal phase of the plan, the agent should be able to effectively communicate with the professional staffs as well as the company official in charge of installing a plan.

Group and the Employers financial statements

The accountants use the company's financial statement and back up ledgers and journals to assist in making monetary decisions. **Two of the accounting reports that make up the financial statements are the balance sheet and the income statement.** The other two are the Statement of Owner's Equity and the Cash Flow Statement (what used to be the Statement of Changes in Financial Position). These last two types of financial statements will not be discussed here. They are important and any basic accounting text or a visit to the Internet can provide a quick overview. The income statement is commonly referred to as the profit and loss statement. The two reports primary purpose is to show the company owners, creditors, and potential investors how a business is doing financially. A good agent needs to understand how to read and interpret the financial statements in order to customize a group insurance plan that will fit into the company's budget.

Here is a review of the basics of accounting that the agent should know. Initial financial information is recorded in the company's journal. The primary journal is known as the "general journal." Secondary ledgers may include "payroll journals." When income is received, or expenses paid they will initially be recorded in the journals. **The balances (totals) in the journals are carried to the "general ledger." For example, the amounts paid for insurance are listed in the journals.** The amounts paid are added together at the end of the month to find the total amount paid. The totals only are then listed in the "general ledger." The general ledger will show the monthly totals for each income and each expense account that the company has. The "general ledger," is used to create the financial statements. The balances from the "general ledger" are listed either on the balance sheet or the income statement. Balance sheet items are either assets, liabilities, or owner's equity. Income statement items are receipts and expenses. The three balance sheet categories and the two income statement categories will state the company's financial condition at the time the statements were compiled. They are nominally compiled on a monthly, quarterly, and/or annual basis.

It is important to understand the company's financial position. This understanding comes about through observation, technical inquiry, and financial analysis. After this process has been completed the agent will know if the client is having an average, poor, or good financial year. The agent will know if the client can afford a group plan. If the client can afford the plan the agent will know which elements the plan should include.

The Balance Sheet

Group Insurance and the Balance Sheet: The balance sheet analysis, as well as the income statement analysis, will assist the agent. Through balance sheet analysis the agent will be able to determine liquid asset availability for implementation of the group plan. The agent must be able to determine the stability of the company that wants a group plan. This is part of the feasibility analysis that is performed by the agent.

The agent should know what the client has and what the client needs in order to reach the company's group objectives. The balance sheet is a key to unlocking the previous secrets. The balance sheet contains account balances for the company's assets, liabilities and owner equity.

Figure 5-1
Widget Production Company
Income Statement
December 31, 2015

Revenue:			
Gross sales		$256,800	
Less: Sales discounts		5,120	
Net sales			$251,680
Costs and expenses			
Cost of goods sold:			
Inventory, January 1		$ 98,500	
Purchases	$132,600		
Less: Purchase discounts	2,780	129,820	
		$228,320	
Inventory, December 31		102,300	
Cost of goods sold			126,020
Gross Profit			$125,660
Operating expenses:			
Selling expenses		$ 38,000	
General and administrative expenses			
General expenses	$ 20,000		
Depreciation	8,800		
Bad debt expense	1,080	29,880	
Total Operating Expense			67,880
Income form operations			$ 57,780
Other income:			
Interest Income			$970
Net income before federal income tax			$ 58,750
Less: Federal income taxes			28,720
Net Income			$ 30,030

A balance sheet shows the financial position of a business on a given date, such as the end of the firm's fiscal month, quarter or year. This date may not coincide with the calendar year, depending on the company's start date. The basic idea of the balance sheet is simple and one that individuals use on a regular basis.

Liabilities		Assets		Assets
+ Owner Equity	Or	- Liabilities	Or	-Owner Equity
Assets		Owner Equity		Liabilities

For example, an individual purchases a car (asset) for $10,000 on an installment basis with a down payment of $1000 (owner equity). The individuals still owes creditor financing the car $9,000 (liability). The value of the car represents an asset in the individual's balance sheet. The amount of the down payment will be shown in the owner equity division of the balance. The remaining amount of the car purchase will be shown in the liability section of the balance sheet.

Figure 5-2 **Star Company**
Balance Sheet
December 31, 2015
(in thousands of dollars)

Assets			
Current assets:			
Cash			$ 485
Marketable securities (at cost, market value $220,000)			210
Notes receivable and accrued interest			125
Amounts due from customers	$1,162		
Less: Allowance for doubtful accounts	. 50		1,112
Inventories (at lower of average cost or market)			580
Short-term prepayments			. 60
Total current assets			$ 2,572
Investments			
Stock of affiliated companies, not consolidated (at equity)	$1,250		
Fund for retirement of preferred stock	60		
Land held for future expansion	100		
Cash surrender value of life insurance	50		1,460

Plant and equipment				
Cost	**Accumulated depreciation**	**Carrying value**		
Land	$ 3,060	$ -0-	$ 3,060	
Buildings	10,950	5,992	4,958	
Equipment	8,430	2,720	5,710	
Totals	$22,440	$8,712		13,728

Intangibles		
Goodwill (net of amortization)	$1,105	
Patents (net of amortization)	. 105	. 1, 210
Total Assets		$18,970

Liabilities and Shareholders Equity		
Current liabilities:		
Accounts payable to trade creditors		$ 390
Accrued liabilities		130
Income taxes payable		200
Dividends payable		125
Advances by customers		20
Employees' retirement benefits payable currently		. 40
Total current liabilities		$ 905
Long-term liabilities		
7% bonds payable, due Dec. 31, 2038	$4,000	
Less: Discount on bonds payable	. 20	
Net bonds payable	$3,980	
Employees' retirement benefits payable in future years	250	
Deferred income taxes	. 300	
Total long-term liabilities		4,530
Total liabilities		$ 5,435
Stockholders equity		
6% cumulative preferred stock, $100 par (callable at $105 per share, authorized 10,000 shares, outstanding 9,500 shares)		$ 950
Common stock, no par, stated value $5 (authorized 1,000,000 shares, outstanding 800,000 shares)		4,000
Paid-in capital in excess of par or stated value:		
On preferred stock	$ 95	
On common stock	5,450	5,545
Total paid-in capital		$10,495
Retained earnings		3,040
Total stockholders' equity		$13,535
Total liabilities & stockholders' equity		$18,970

Asset Classification

The company's assets will be listed as current, non-current or fixed. Current assets include liquid assets. Liquid assets are cash on hand or assets that can easily be converted into cash. Examples of liquid assets include policies, prepaid insurance premiums, and cash in bank accounts. Non-current assets, investments and funds, are not as liquid as current assets, although they are more liquid than fixed assets. Non-current assets include cash values from permanent life policies, and accounts or notes receivable within the 12 month statement reporting period. Fixed assets are defined as those having usefulness because of their physical characteristics and are used or consumed in the operation of the business. They are not liquid in nature. Fixed assets include land, buildings machinery, equipment, furniture and fixtures. Fixed assets, with the exception of land, are the assets nominally subject to depreciation.

When the agent determines the asset structure of the client company, he or she will know if the company has enough current assets to create a stable environment to launch the group insurance plan.

There are two main classifications of liabilities. There are current liabilities and long-term liabilities. Current liabilities are those obligations that will be liquidated though use of the current assets. The obligation will normally be liquidated within the 12-month reporting period. Examples of current liabilities include expenses that have been accrued but not paid yet, the portion of a bank loan, or mortgage that is due within the 12-month reporting period, and unpaid dividends for a corporation. Long-term liabilities are the obligations not classified as short term liabilities. The long-term obligation will be discharged in a reporting period other than the current period.

Rational Numbers

The agent, by reviewing the company liabilities, can determine what amount will be required for the company to discharge their current liabilities and what will be left over to create the group life plan. The agent can establish the paying habits of the client. If the liabilities are much larger than the owner equity, the agent will know that the company does not have funds readily available to install a group insurance plan. The agent can review the liability section for any large current contingent liabilities that could throw the company into a tail spin if they become current. The agent can determine the company's working capital ratio to test the solvency of the company. The working capital ratio is found by dividing current assets by current liabilities. This will indicate the company's ability to meet current obligations from current assets as an ongoing concern. Traditionally a working capital ratio of 2 to 1 has been considered to be adequate for a company.

$$\textbf{Current Ratio} = \frac{current\ \ assets}{current\ liabilities}$$

$$\textbf{Three Equity Ratios;}\quad \frac{owners\ equity}{total\ assets} \qquad \frac{creditor's\ equity}{total\ assets} \qquad \frac{owner's\ equity}{total\ liabilities}$$

The third item on the balance sheet is owner's equity or capital section. This section states the owner's total interest in the business. Generally, this section will be broken into "contributed capital." Contributed capital consists of the funds that were contributed to the business at the inception of the business. The other general section is "retained earnings." Retained earnings are the funds that have been generated by the company, and not spent on business expenses,

or asset additions. The section terminology will vary for proprietorships, partnerships, and corporations, but the principles of the equity section remains the same.

A review of the equity section of the balance sheet and determining three equity ratios, 1.) the owners' equity to total assets, 2.) the creditors' equity to total assets and 3.) the owners' equity to total liabilities, can be used to interpret and evaluate the financial condition of the company. The agent can subtract total liabilities from total owner equity to determine possible working capital available for initiating the group insurance plan. The agent will be able to determine if the company has spent more, or less, than it has generated over time and if the company's retained earnings is increasing over time or decreasing.

The Income Statement

The second report or statement that is a part of the financial statements is the income statement. As stated, **the income statement is commonly referred to as the profit and loss statement. The purpose of the income statement is to measure income by matching costs consumed or expired against revenues realized.** It may cover a period of a month, a quarter or a year. Most income statements will give the month's balances as well as a "year to date" amount. The income statement will show the sales generated during the time frame(s) and the expenses paid in generating those sales. The bottom line found on the report is the net income or the net loss after tax.

The types of accounts used on the income statement will vary among businesses and among industries. For example, a manufacturer or retailer would normally have five major sections in their income statement. The five sections include gross sales, cost of goods sold, operating expenses, other income and expenses, and taxes. A service company would have four sections, gross receipts, operating expenses other income and expenses, and taxes. A service company would not have cost of goods sold. The service company does not sell a tangible product, it sells an intangible product, service. Accordingly, the service company would not have a cost of goods sold section in the income statement.

One element of the **income statement analysis is the review of the current and past years' income statement balances to determine the cash flow of the client.** By reviewing past information with the current information, the agent will understand what is an ordinary income statement item and what is an extraordinary item that will not ordinarily occur. The insurance agent can project the company's liquidity, and solvency through income statement analysis as well as balance sheet analysis. Liquidity is important when a group insurance plan is being installed. If the company cannot afford a plan due to lack of liquidity, the agent can determine that he or she is currently wasting time with the client. The agent can tell the client what amount is needed for plan installation and return when the client is in a more liquid position. If the client is on the verge of insolvency the insurance agent will know.

The agent can determine spending habits by reviewing the income statement. The agent should review the amount the client is presently spending on insurance products. The agent can then analyze the kinds of insurance currently in place. The agent can evaluate what the company has, what the company officials have said they want, and what the actual needs appear to be.

The total payroll expense account will be stated on the income statement. The payroll expense can highlight the size of the plan the agent will design. It can be used for further analysis. It may be broken into job classification that will assist in structuring the group life benefit. Salary structure may be found on the statement. If not, the agent can use the journal and ledger to establish the structure.

Review and analysis of the income statement is important in designing a group plan that will stay in place over time. The income statement is comparable to a video of the financial business of the company taken over a period of time. It is continually changing within the accounts, but a pattern can be determined though observation and analysis. In summary, the way a client responds to the agent's group insurance presentation basically will be determined by the figures on the financial statements. The statements consist of the balance sheet and income statement. If the agent understands the importance of the financial statements, and if the agent understands simple financial statement analysis, designing and implementing a group insurance plan will not be too complicated. After the financial statement analysis the agent will be able to fashion a strategic interview with the client. The agent will have pertinent questions for the client concerning the fine points of establishing the group insurance plan. The agent will have good ideas on establishing the plan. If the agent cannot understand the financial statements he or she will be in the dark concerning the client's financial status. The client will know that the agent does not have the knowledge needed to design and implement the group insurance plan.

Group Plan Design

The Plan Proposal: The information presented to the company official sponsoring the group plan should be arranged in a fashion that emphasizes the way the plan will fit the client's particular needs. It should include a plan blue print with a complete description of all benefits and limitations in the plan, and a breakdown of rates and premiums for employees by type of coverage. The breakdown can commonly be found in a sample policy. The information must be presented to the employer in an effective, orderly, clear and concise manner in order to avoid confusion.

To reach the previous objectives, after the plan is designed but before the agent meets with the company official, the plan proposal must be organized. The materials are organized to first state the current position of the client. Next, the presentation states what the plan needs are and what the plan objectives are. The last step is to explain how to implement the group insurance plan to meet the company objectives. The agent will be able to follow through on all counts after observation, interview and analysis.

Plan Implementation

Initially Enrolling Group Plan Members: After receiving consent for the group insurance plan implementation, the exact procedure required by the issuing insurance company must be followed to install the plan and enroll individuals that want to become plan participants. The sponsoring company may have a benefit representative. It is of vital importance to develop a good relationship with him or her. The agent could be working with the person holding this position for the life of the plan.

The agent should be familiar with the insurance company's forms used to implement the insurance products selected by the employer group. **The primary forms needed for group**

plan implementation are commonly the master policy applications, the employee enrollment forms, and an ERISA (Employee Retirement Income Security Act) disclosure statement.

Group Insurance Master Policy Application: The master application becomes a part of the official group contract. The agent must exercise caution when completing the application in order to avoid mistakes. The application will vary with the types of group insurance being offered. After the application is completed, the employer or his authorized official must sign the application to validate the contract. The insurance sales representative must sign the application to complete the validation process.

The application will include the full legal name of the employer's business. It will have a breakdown of the classes of employees that will be insured under the group plan. The application must also include the number of employees eligible to participate in the plan when the contract goes into effect. The type of coverage, waiting periods, and if the plan is contributory or non-contributory will be stated on the form. The master application will also contain the percentage of the premium to be paid by the employer and employee. If the plan is to replace coverage by another carrier, this is shown.

Group Insurance Employee Enrollment Forms: An enrollment form must be completed and signed by each group plan participant. The usual information required is the employee's name, date of birth, occupation, date of employment, hours worked per week, annual wages or salary, and, when applicable, the beneficiary. If applicable the enrollment form may include a payroll deduction clause authorizing payment deduction as will be noted by the employee's signature on the form.

ERISA Disclosure

Under the Employee Retirement Income Security Act (ERISA), **the agent is required to specify all commissions to be paid on group insurance plan, and disclose them fully to the owner of the policy.** The disclosure statement includes both first-year and renewal commissions to be paid to the agent. The insurance company provides a form to be signed by the employer and the agent. The agent keeps one copy of the ERISA disclosure statement and sends one to the home office.

Group Insurance Plan creation: After the applications and enrollment forms have been completed and the ERISA disclosure is made the forms will be sent to the insurance company's home office. Any additional information that the insurance agent representative is required to file will be submitted in memorandum form or in a forms cover letter. Additional information required can include the names of the client contacts at the employer's business. The contacts will include the client's staff contact person for any policy changes or just when routine questions need to be answered. Supplementary forms may be required to accompany the master policy application. For example, a "replacement" form is required from employers that previously had insurance policy(ies) in place. The form will provide information on the policy(ies) being replaced. The form will include the names of any employees who are disabled and drawing benefits under the previous coverage. The form will included the number of employee participants covered under the previous plan and names of those employees that are not covered as plan participants under the former policy. The reason(s) for policy replacement will

be stated, and a copy of the actual policy being replaced will be furnished with the "replacement" form.

In addition to the master application, the individual enrollment forms, the supplemental forms and the additional information needed, a check for the first premium will be submitted to the home office of the insurance company. If the group plan shares the cost of the group insurance between the employer and the employees, only one check for the first premium is normally submitted with the application. The employer who is sharing the cost of the group insurance with employees advances a check for the premium and then is reimbursed for the employees' portion through payroll deductions.

Group Insurance Plan's master contract: Once the group master application has been approved and processed the group master contract (policy) will be issued to the sponsoring employer. The insurance company's agent representative delivers the master contract in person. At this time the agent will have the opportunity to review the contract with the employer for mutual understanding. The agent, company officials and in-house plan administrator will review the terms and conditions, the benefit provisions and the premium provisions. Any initial questions the employer may have can be addressed at this time. Commonly, the issuing insurance company will provide printed instructions for the administrator of a group plan, giving reference on proper procedures and forms.

The plan administrator will handle the required procedures for new employee enrollments, reinstatements, conversions, claims, changes in amounts of coverage, changes of beneficiary, and other plan provisions that may come up. The agent needs to be familiar with these procedures and go over the instructions with the administrator.

Along with the group master contract (policy,) individual insurance certificates for each plan participant are delivered to the offices of the sponsoring company. **Sometimes these certificates are included in the announcement booklets that will give a summary of benefits, eligibility requirements, cost of any conversion provisions, exclusions and other needed information.** The agent may be asked to attend an employee meeting to discuss the announcement booklet contents with the employee group. Accordingly, the agent should be familiar with the booklet provisions, and possible questions that the employees may ask.

Plan Monitoring

After the group insurance plan is in place, the agent needs to make service calls to see that the plan is running properly and has met expectations of the employer and employees. A good working relationship with the client can offer future opportunities for the agent representative and the issuing insurance company. By periodic review of the account the agent and employer can determine if increasing benefits are needed or if additional coverage is required to be added to the plan. The agent can discuss competitor's proposals that may or may not have been solicited by the employer.

The agent representative may be required to make frequent visits to the client during the first few months after the plan has been established to work out any problems with the plan. After a plan routine has been established, the monitoring of the plan will be on a more infrequent basis. During each visit with the client the agent can inquire about new employees that have been

enrolled or old employees that may have been terminated. Through this process the agent can review the account for name changes, beneficiary changes, and other adjustment that should have been addressed. The agent can review the forms generated by the changes to insure that the forms have been completed and signed in the proper manner. Pending claims, changes in individual employee's insurance benefit amounts, and questions about premium payments may need to be discussed with the plan administrator, along with other details. It is useful for an agent to meet with employees who have resigned or been terminated to discuss conversion options. The former employees should understand the conversion options in order to address them in a timely manner to insure that the group coverage is properly converted into an individual policy.

The need for increased benefits under the existing plan often comes up as salary levels increase and medical care costs rise along with prices in general. In the home office as a policy anniversary date approaches there may be a decision that a premium increase will be necessary. The agent should prepare the client for the initial hike in premiums. The agent representative should assure the client that every effort will be made to keep the premium as low as possible and explain why the premium increase is necessary. In this manner the client will not be shocked one day when the increase has been made. The new actual premium should be discussed with the client by the agent. This will enhance the business relationship. It is helpful to point out that a rate is guaranteed for a specified period and thus costs can be stabilized for that length of time. An agent who has a good working relationship with an employer-sponsor of a group insurance plan will receive referrals from his or her client. Oral or written introductions to other potential clients are valuable and helpful to the agent representative.

In approaching the referral employer, the agent representative should remember the basic advantages of the group insurance plan being offered and thus, the group plan process begins again. If the agent representative is knowledgeable, he or she should be able to design, implement and monitor the new plan with few complications. The concept of the group insurance plan is basic and should be easy to understand. The plan can fill a need that most business owners recognize. A basic understanding, by the agent representative, of group plans and employers' financial statements will enable the agent representative to walk through any door and present a group insurance proposal with little difficulty.

CHAPTER 6 UNDERWRITING PRINCIPLES AND CONTROLS

Background to understanding underwriting principles and controls: The need for group plans began to grow in the early 1900's. As the country moved from an agrarian society to an industrialized society, the way in which the society addressed health and medical needs changed. When the majority of Americans lived on the farm, the extended family was common. Three generations, or more, would live under one roof. The children of the agrarian family were capital. They were the primary source of farm labor. The younger adult members of the family would be the primary providers for the family unit, running the farm business. The old members of the family would do support jobs as long as possible, (i.e. taking care of babies, cooking, etc). When the older could no longer work the family would take care of them until the point of death. The health and welfare of the country was handled by the individual family units.

FRAMEWORK

The agrarian family health and welfare system broke down when the younger adult members of the family moved into the cities to pursue their livelihood. Issues dealing with the care of the young workers family health and welfare as well as the welfare of the old and the sick were of primary concerns. The new groups created by industrialization required a new form of care. The unions, emerging from the new groups of workers, required health and welfare coverage for their members. Group insurance, funded by the employer, began to emerge as a societal requirement for securing the health and welfare of the nation.

Group insurance has become a major part of the underwriting business in this country since the early days. It is a mechanism that fills a need. Through group policies, insurance coverage has become available to millions of people who otherwise might have gone without. The group insurance plan receives tax incentives because it is a socially important plan. The group life plan provides a safety net of coverage maintained by the private sector. The group health plan provides coverage to individuals that otherwise would have to depend on government sources to assist in medical costs. Accordingly, the group insurance plan frees federal funds for other needs which the private sector cannot supply. Inflation, especially in the field of medical costs, along with increased salary and wage levels for health workers, has provided an upward pressure in the group insurance field. During the last three decades the group insurance field has more than tripled in size. **The growth rate of group life insurance currently in force is now substantially greater than that of ordinary life insurance provided through individual policies.** There is no sign that group growth market is slowing down.

Group insurance is an interesting and complicated field providing a challenge for the insurance professional. Knowledge of the group plan is important even if the professional does not decide to join the ranks of the group specialists. Today, in most insurance company home offices, there is a group of specialists that help with technical details of group plans. If the professional prefers to remain in the field, the more familiar he or she is with the general group plan picture and with

the terms used in group insurance, the more at ease and knowledgeable the agent will appear to be to the employers seeking a group plan for the company employees.

Overview of Underwriting System

The law of averages is the basis of the insurance business. Successful underwriting requires a system of risk selection to obtain a group in which loss results will be reasonably predictable by means of the law of averages. To accomplish this goal there must be a balance between obtaining volume and obtaining homogeneous risks. For example, an insurance company issuing individual life policies adopts a strict standard of selection. The only individual that can be selected is the one that has achieved physical perfection, is morally outstanding, and is employed in a risk-free occupation. The pool of individuals that fits the criteria is very small. The group is very homogeneous with all the risk units. In this case, the individual lives are subject to about the same chance of loss. The downside of the group is that the mass, or volume of risk units, is very small. Thus, the predictability of loss might easily be adversely affected. Accordingly, if one individual in the group becomes sick, disabled or dies at an untimely point, the benefits paid to the individual could negatively offset the premiums that are collected during his or her lifetime.

In our example, another factor to consider is the expense associated with finding the nearly perfect group. The selection of such an impractical group would require stringent procedures. The task would be so difficult and complicated that the expense involved in finding this group would more than offset the savings from the mortality rate of the group. In underwriting, selection expense is a factor to be considered. There has to be a balance between the strictness of selection standards and the necessity of having a large volume of risk units to be insured.

CONTROLS

Group Selection

Group life insurance selection standards are set up to achieve a balance between the strictness of selection standards and the necessity of having a large volume of risk units to be insured. Most viable insurance companies issuing group policies adopt selection standards broad enough to permit acceptance of a large majority of insurable risks at standard premium rates. The group that meets the insurance company's selection standards will be considered a standard risk group.

In some cases an insurance company can insure a group employed in hazardous occupations. **The group will have mortality rates consistently higher than standard risks. The group with hazardous occupations will be classified as a substandard risk.** The group insurance plan designed for the participants would have a higher compensating premium rate than the average group. A group representing a higher than average risk may be rejected entirely if the group mortality rate is too great or too unpredictable for the insurance company to accept the risk.

Group Selection Theory

When selling private, individual life insurance, an insurance company is not dealing with a group. The insurance company, therefore, has to take precautions to secure and keep in check individual risks to make up a volume of coverage with an average rate of mortality. Individual

selection methods such as medical exams and other sources of information are used to discover potential risk. When reviewing group insurance applications, however, the underwriter is not as concerned with the health, habits, or morals of any particular individual in the group. The group itself is the unit of review and selection. **One of the main objectives of the group insurance underwriter in choosing acceptable groups to insure is to obtain a group of individual lives that will yield predictable results.** The successful underwriter will, more importantly, select a group of many such groups which will yield predictable results. The necessity in such underwriting is to achieve the proper degree of mass and homogeneity of risk units. When the mass/risk ratio is achieved in selecting groups to insure, each group used as the unit of selection is theoretically sound.

To assure that the group is satisfactorily homogeneous, the underwriter determines that certain essential characteristics are inherent in the nature of the group. If the essential homogeneity characteristics are not present in the group the underwriter can avoid adverse selection by an entire group or by individuals within a group. The underwriter can deny the application for insurance or limit the exposure on certain individuals.

Group Characteristics

The basic characteristics of the group are the first underwriting elements an insurance company writing group insurance will consider. What is the inherent nature of the group? The underwriter will review the potential participants age and sex individually and as a group. The age and sex of the group, as a whole, can be a contributing factor to the groups potential claim ratio. **Older participants and females are shown to file more claims than other participants in a group plan.** The underwriter will review the participant's history of preexisting conditions. A preexisting condition is an illness or condition that has been medically treated or advice received on the illness or condition before the effective date of the group medical coverage. Insurance company policy for preexisting conditions varies from company to company. It is oftentimes determined by the group's size. Preexisting illnesses and conditions cannot be excluded from the group policy. Often, with larger groups, the preexisting condition may not be covered for a named period of time, but will be covered after that period, if the participant is still a member of the plan. The underwriter will review other characteristics of the group such as plan participation and plan discrimination.

The underwriter will determine if the group applying for insurance is based on a natural, pre-existing relationship, representing a group of individuals bound together by some other interest than that of obtaining low cost insurance. If the group meets these criteria, a group selection plan probably will be feasible. If the group appears to be organized primarily to obtain group insurance, the underwriter has to consider that the group is possibility selecting against the insurer. Individuals that are poor risks and possibly uninsurable tend to seek and maintain participation in the group. Healthy individuals are more likely to be indifferent to joining or continuing their participation in the group plan. Thus a workable plan almost always requires insurance to be a secondary or incidental in the formation and existence of the group.

A trustee group established by several employers in order to obtain group insurance for their employees might appear to be seeking adverse selection, but actually such an arrangement produces a group of groups, none of which was formed to secure insurance, and thus the possibility of adverse selection against the insurer by the group of individuals is not large.

Most states' insurance laws will define an eligible group as being an employer-employee group, a trade association, or a creditor-debtor group. The states will have group size requirements in an effort to limit the possibility of adverse selection by groups formed primarily to obtain group insurance.

Group Flow

Flow of Participants through the Group: An element generally considered essential to successful group underwriting is a steady flow of individuals through the group. A stagnant group of participants is no more desirable to the insurance company than is an unpredictable group. A stream of new individuals entering the group represents the addition of young, healthy prospects, and a flow out of the group of older and less healthy individuals keeps the insurability of the group more or less stable. The ideal group has a constant employee turnover ratio.

The chance of loss is never exactly the same for all risks or groups. Even within the classification of insurable risks including standard classes and several substandard classes there is uncertainty. In each class there are individual good risks and individual poor risks relative to the rest of the class.

Experience Rating

The goal of the insurance underwriter to establish rules which will result in securing an average proportion of good risks. If he or she can accomplish this goal, the insurance company's average mortality cost will be lower and the company may be able to offer insurance at a lower net cost. The practice of experience rating helps in selecting groups that will have an average proportion of good risks.

The rules adopted by various companies to secure the desired result will vary. The rules will vary based on the individual insurance company's experience, research, judgment, and at the end, intuition. Though the company rules may vary, the goal each company is trying to achieve is basically the same. For successful operation in the group insurance field, the rules established by any company will help to achieve the proper balance between mass and homogeneity of risks to ultimately achieve predictability of future results. The insurance company's established standards permit the company to accept a large majority of risks that could not be accepted on an individual basis. The insurance company, to accept a large majority of risks, will secure the largest possible proportion of average risks within each classification. To achieve the required average proportion, the insurance company may establish a policy of accepting average risk borderline cases. The borderline cases would not be an asset from the underwriting standpoint but would provide volume to spread and stabilize overhead expense.

Plan Benefits

Defined Benefits: In order to prevent individual or group adverse selection by either the employer or employee, the amount of benefits under a group policy must be determined through a defined formula. The benefits can be determined using factors such as participants' earnings, job classification, or length of service with the sponsoring company.

It would be possible, if the participant could arbitrarily choose benefits, for the participant that is a poor insurance risk to insure heavily through the group plan, while the healthy participant might possibly choose very little coverage at the installation of the plan. It would be possible, if the plan employer could arbitrarily choose benefits, for that employer to select against the insurer for the benefit of certain employees. Such selection by either employer or employee would greatly increase the group insurance plan costs and could possibly lead to the failure of the plan as well as adverse selection.

The group plan must also include a predetermined time when the benefits will become effective under the policy. The employee must apply for participation in the plan within a reasonable period of time or else submit evidence of insurability. The time limits avoid giving the participant the opportunity for selecting against the insurer.

In actuality, the employer does have a degree of choice in selecting the schedule of insurance benefits. In some cases the employer, no doubt, does have particular individuals and their needs in mind in such selection, but in general the benefit control does assist as a sound underwriting control.

Plan Participation

Planned Proportional Participation: All or substantially all eligible persons in a given group covered by insurance must participate in the plan to establish sound underwriting controls and to insure the life of the group plan. Only by covering a large proportion of a given group does an insurer achieve a positive safeguard against an undue proportion of substandard risks.

Noncontributory plan: In a noncontributory plan, in which the employer is responsible solely for premium payment, all of the employees are required to be participants of the group insurance plan. In some plans 100% of the employees in the company are not required to be participants, but 100% of a given classification of employees must be participants.

Contributory plan: When employees contribute to the plan, the requirement is that at least 75 per cent of eligible employees be participants in the group insurance plan. Allowing less than 100 per cent participation, as in a contributory group plan, does introduce some chance of adverse selection. The over-all spread of risk is increased through contributory plans however, because many employers will buy insurance on the contributory plan who would not install a noncontributory plan. Many employers cannot afford a group plan that they would have to fund in total.

Participant-Pay-All plan: Most insurance companies will not write group insurance unless the employer or a third party shares in the cost of the plan. **A member-pay-all plan, where the employer does not share in the premium expense, carries the seeds of its own destruction.** A plan of averaging individual premiums is necessary. If a plan allowed for the participants to pay for all of their coverage, the younger members help pay for the older members. The young would be subsidizing the old.

As the young participant realizes that he or she is subsidizing the older workers premiums, the younger participant would leave the group plan. The younger participant could buy individual insurance with lower premiums. The group plan would then be left with more older workers and

the situation is thus aggravated as average premiums are raised still more. Eventually the older employee and the impaired employee would dominate the group. The result would be high premiums leading to the collapse of the program. In a conventional group plan, participation by the employer in sharing the group cost permits employees to buy insurance at a more affordable rate. The affordable premiums make the plan attractive for all of the participants. The affordable premiums make it possible to get a sufficient number of eligible employees to participate so as to avoid adverse selection. Large plan participation is an important element in successful underwriting. It is so important that plan participation is regulated by each state's insurance department in an effort to assure that the insurance companies avoid adverse selection against them, and will achieve a proper and necessary spread of risk.

Plan Administration

Efficient administration of the group plan is a key element to the longevity of that plan. To be successful, a group insurance plan must require a minimum amount of effort on the part of the employee-participant. If the plan is contributory, the employee-participant will contribute to the premium cost of the plan on a periodic basis. To insure participant compliance there must be a simple, self-operating method for the participant to make his or her contribution into the plan. A payroll deduction plan is an example of a self-operating contribution method. The method must be self-operating in order to secure payment. If a participant has to periodically choose to pay premiums, when he or she gets paid, the insurance premiums will often be spent by the participant elsewhere. The element of continual choice would allow the participant to lose interest in the group plan very quickly, or be unable to keep up with premiums due.

There are many details connected with the operation of a group insurance plan. If the details had to be handled by the employee directly with the insurance company, group participation would dwindle. Participation would dwindle because employees do not have time or forget to file necessary plan forms. The participant may not even be aware of the requirements of the plan. The insurance company cannot easily monitor the group insurance program on a one-to one basis. Administrative operations include initial enrollment of new participants, payroll deduction enrollment, change of beneficiary, name change, increase in amounts of insurance by participants and plan participant termination. Each plan procedure requires the completion of an insurance form. The plan works most efficiently when the employer's insurance administrator handles these details. The employer's administrator is more familiar with the participants and their needs than the insurance carrier, and can carry out the required task with only a minimum of effort required from the actual plan participant. A plan participant would possibly drop out of the group plan if he or she were in charge of the required paper work.

Administrative assistance by the group plan sponsor is imperative to the life of the plan. The sponsoring company's insurance administrator can help insure that the plan will be run efficiently and remain affordable.

Other Controls

There are a number of other miscellaneous controls that may be included in underwriting rules as further safeguards against adverse selection. This includes the participant's initial probationary period. **This is the time an employee must work for the employer before he or she become eligible for participation in the group insurance plan.** The definition of eligible employee will limit the employees that can participate in the plan to full time employees. In

addition the plan participant must comply with the "actively-at-work" rule. If an employee is disabled or ill at the time of group enrollment, the employee will not be allowed to enroll in the plan until the disability or illness ends and the employee is able to return to work. With small group plans the requirement of evidence of insurability for late applicants and for excess amounts of insurance serves as a control over adverse selection as does the insurance amount schedule.

UNDERWRITING FACTORS

General Underwriting Considerations: When underwriting group life insurance an insurance company may use somewhat less stringent rules than employed when underwriting ordinary individual insurance policies. This is related to (because of) the actual underwriting contract and the flexibility in group plans that may not exist in an individual policy. For example, when writing individual life insurance, once an insurance company approves and issues a contract it assumes the risk without any right to cancel, change the contract, or increase the premium rate.

Underwriting principles and controls for group policies still prevail, and each group applying for group insurance must be evaluated for the minimum selection standards established by the insurer, but more flexibility is evident. For example, the group policy premium rate can be changed, usually on the policy anniversary, and with the agreement of the policy holder the schedule of benefits or other provisions can be changed. Also group insurance is subject to experience rating, by which subsequent dividends or premiums can be adjusted. The risk assumed when the policy is initiated can be re-evaluated through renewal underwriting. For good policy holder relations, however, it is desirable to set the initial premium rate with adequate margins so as to avoid rate increases, if possible.

There still must be detailed selection procedures to measure the factors affecting the insurability of individual group risks. Each group must be closely examined both before the contract is issued and before its renewal in order to evaluate the risk and the administrative feasibility involved.

Information Evaluation

How Information Is Obtained: The home office of an insurance company, in judging the insurability of a particular risk, uses three basic sources. The most important source consists of reports submitted by the group representative and underwriter. The reports may be in the form of correspondence about the risk of the group or may be a formal report included on the reverse side of the preliminary application form.

The report would include information about the nature of the employer's business. It would include the number of branches, subsidiaries, and affiliates of the business, as well as their locations. Correspondence would include each segment of the business that is to be covered by the plan. Submitted is the effective date of the coverage and amount of advance premium payment collected. The home office must determine the total number of employees eligible for the plan stated in the report. The home office will want to know if the insurance company representative has any personal knowledge of the business applying for coverage and will usually require an agent's expression of opinion as to whether the case is a good risk.

The application form signed by the employer is the second important information needed by the home office to evaluate the potential client. The group master application contains a limited amount of information compared to an application for an individual life insurance policy. It indicates which classes of employees are to be covered, how insurance is to be allocated, whether the plan is to be contributory or noncontributory, and how premiums are to be paid. Usually the application includes a question as to whether other group insurance has previously been carried and if so the name of the other carrier and the reason for termination.

Sometimes, in small cases the home office will want more information on the business and its officials. The home office may even want to verify the validity of the statements made on the group master application. A private reporting firm may be asked to provide an inspection report in such a case. In some cases where risks are known to be high there may be a report on the physical hazards involved.

Initial Underwriting Factors

New Business Selection: An underwriter, when examining a new client's group application, wants to know first whether the agent and the client's group representative have followed the basic underwriting rules of the company. **They must be in compliance with both the encompassing insurance law and the insurance company policy.** If these rules have been followed, the underwriter then moves to determine whether the client affords a risk factor that the insurance company is interested in from the standpoint of future plan costs and administration expense.

The underwriter must know if the group of participants is subject to exceptional hazards from occupational disease or industrial accident. In such a case the hazards might be reduced or eliminated, or the risk might be classified as substandard and the group charged a higher than standard premium. The worst case scenario is that the risk may be so great that the underwriter might reject the application altogether. In the early days of group insurance, when industrial working conditions and general living conditions were much worse than they are now, exceptional hazards from occupational disease or industrial accidents were of great importance to the underwriter. With stringent government and industry regulation these considerations are less important today than they use to be.

The way a plan is set up to allocate benefits has a bearing on underwriting. For example, there is a large spread between the amounts of insurance available to adjacent classes of employees. **Accordingly, the plan is likely to suffer from declining participation.** Participants will not be happy with the plan, even if it is based on legal discrimination. Schedules of benefits that pay disproportionate amounts of insurance to top executives also must be checked closely under current tax rules in order to establish that the discrimination is in fact legal. Another example of the importance of benefit allocation is shown when an employee receives a small salary increase or promotion to another company rank. Accordingly, the employee becomes eligible for higher insurance coverage under the group contributory plan. He or she may drop out of the plan rather than pay the increase in premium contribution.

Past experience on a risk is an important factor for an underwriter. If the group was previously insured with another carrier and the employer terminated the policy to avoid a rate increase caused by poor experience, the underwriter needs to know. Other factors which need to be

examined are high turnover of employees and seasonal employment. High turnover probably means excessive administration expense and often poor administration by the employer. The number of persons eligible to convert their group certificates to individual policies is greater with a resulting increase in adverse selection. A probationary period longer than usual can in many cases solve the high turnover problem. The seasonal employment problem may be solved by limiting coverage to permanent employees and to groups operating for a minimum period, such as eight months a year.

Having employees in scattered locations also poses a problem. Separate branches, plants, or stores, particularly those with only a few employees in each location, may cause considerable problems in administering the plan. A plan on a contributory basis will tend to have decreasing participation in the smaller outlying units. Risks with widely scattered locations frequently are acceptable only on a noncontributory basis and then only if there is good administration through a centralized responsible authority. Even after a check-off of these and other factors considered by the group home office underwriter, there remains a subjective factor in underwriting-an intuition or "sixth sense" which an experienced underwriter is generally conceded to have.

Rules for Small Groups: Companies writing wholesale or franchise insurance have in the past adopted stringent underwriting rules for groups of 25 or fewer. These small risks, sometimes called "baby group" cases, in the beginning were accepted only at premium rates higher than standard in the hope of covering the extra expense and extra risks involved.

Competition, however, forced the rates down, and as a result additional underwriting safeguards for this class of business were developed. Evidence of insurability may be required through a short health form, either from all employees or from those in the highest insurance class or over a certain age, such as 50. Employees who do not have satisfactory health questionnaires may be excluded or limited to the lowest amount of insurance in the schedule.

The two-and-one-half-times rule may be applied in the schedule of insurance offered, with the top amount not more than two and a half times the smallest amount offered. The percentage of participation required in the case of contributory plans may be higher than the standard 75 per cent. A preliminary application with a census of employees and possibly an inspection report and other data may be required.

Administration cost of small group cases was a factor in more restrictive underwriting, but the development of electronic data-processing equipment has made it possible to reduce such costs.

Renewal Underwriting

Most group insurance is written on a term basis with a one- year guarantee of premium rates, so the renewal underwriting must be done annually. **An underwriting department in a group insurance company has two basic functions: to underwrite new business and to underwrite contract renewals.**

In the consideration of renewals, the underwriter is concerned with risk experience and participation level on contributory plans. The experience with risks is examined both for the

current year and for the accumulated years the risk has been carried, to determine absolute loss results and the appearance of any trends.

The underwriter may go into the claim history if poor experience is shown in order to learn if preventive measures can be taken. It may be that improved participation, a revised insurance schedule, a longer probationary period or other means of exclusion of a class of employees can help the experience. Sometimes a group company will audit the employer's administration of the case to be sure there has been a full reporting of the volume of insurance in force and the full premium has been paid.

In case of poor experience consistently over several years, the company usually will raise the premium rates at the time of renewal. The company may not specifically have the privilege of refusing to renew the group contract, but since premium rates usually are guaranteed only for one year, the company can raise the rates so much as to result in cancellation. The extent of participation in the case of contributory plans is considered by the underwriter along with the risk experience. Frequently there is a direct connection between loss experience and participation. Where participation is low, there tends to be a poor loss experience. If participation is below 75 per cent of all eligible employees on the renewal date, the company may refuse to renew the policy. This right is always reserved in the master contract.

The company usually will try other measures before terminating the contract, however, such as agreeing to renew on condition that participation is raised to 75 per cent, conducting a campaign to increase participation, or agreeing to renew the risk without limitation.

Reinsurance Factors

Use of Reinsurance: Insurance companies generally set limits on the amount for which they will insure any risk. Life insurance companies have a limit beyond which they will not assume the risk on a single life. Fire insurance companies set limits of risk on individual buildings and on fire areas, and casualty insurance companies set limits to their liability exposure on any one risk.

Life underwriters set benefit limits primarily to avoid accidental fluctuations in the mortality rate among the heavily insured. Some insurance companies, however, may assume a large risk on an individual life because they can pass on the excess liability to another company or to a combination of companies by means of reinsurance.

Reinsurance in the past has not been in general use for group insurance because the size of individual certificates usually is not large and because the risk is spread over so many individuals. It was considered that there was such a dispersion of the insured individuals, both on and off the job, that the chance of catastrophic loss was slight. The Texas City explosions and fires in 1947 produced some change in this thinking. One company that had written group insurance in the area paid more than a million dollars in group insurance death claims from one insured risk. This was a tremendous sum of money. This incident, along with the possibilities opened up by new developments in nuclear and chemical technologies, led insurance companies to increased consideration of reinsuring excess hazards for group operations.

There are also instances in which reinsurance is used for sharing business rather than sharing hazards. A large company might want to favor more than one insurer by dividing its group program between several carriers. Sometimes in the consolidation of several plans which have been carried with two or more insurers the policy holder may wish to keep all the companies in the plan and thus places the combined plan with one insurer and gives instructions to have the others participate.

If a buyer has negotiated with several insurers and has business, financial, or personal relationships with more than one of them, he may wish to share the business among them. He may also want to get independent advice from competing sources and thus may have two or more group companies furnishing his coverage.

Business can be split among companies in several ways. It may be divided by means of reinsurance, coinsurance, distribution by geographical location, or distribution by type of coverage.

Reinsurance Method: The most used method of sharing a large risk and generally the most satisfactory is reinsurance. Under this arrangement one company is the insurer and issues a master contract to the employer to cover the entire risk. This company is responsible for the entire administration of the program, including all transactions with the employer and the certificate holders. The employer has told the company at the time of establishing the contract that he wants certain percentages of the risk reinsured with a second and third company. These reinsuring companies agree to let the insurer follow its own practices. The reinsurance nominally represents a percentage of the insurance on each certificate holder, rather than all the insurance on a percentage of the covered group. The primary insurer remits an amount to the reinsuring companies representing their share of the premiums less their share of the claim payments, less a charge for administrative expense and any taxes or commissions paid by the original insurer on the reinsuring companies' share of the business.

The final determination of premium rates and experience rating adjustments usually is left to each reinsuring company on its own share of the business, although usually the results are quite uniform. This arrangement, called a "New York style" reinsurance treaty, is necessary when the reinsuring company is a mutual company and must follow its own dividend formula.

If the reinsurer is a stock company, the arrangement more likely would be of the "Hartford style" under which the direct writing company sets the premium and experience ratings and passes on a share of the net result to each reinsuring company.

An advantage of the reinsurance method of sharing business is that there is little additional expense under this arrangement over a plan involving only one company. The extra expenses are only those in connection with the original reinsurance agreements between the companies and the monthly wholesale accounting statements of premiums and claims.

Commissions on the risk are usually started from the top of the graded commission scale only once instead of once for each company involved. The employee deals with only one insurance company in administrative matters such as claims and conversions. Group reinsurance does

carry some additional cost to the policy holder, but for the large risks in which it is usually concerned, this cost is a relatively insignificant part of the premium.

Coinsurance Factors

Coinsurance Sharing: In the coinsurance method of sharing a group risk, a separate policy is issued by each company to cover a part of the insurance on each individual. Each company handles its share of the risk more or less autonomously. This plan generally results in greater over-all retention of premiums for expenses and is unsatisfactory from the employee's point of view because in the event of conversion he would have to take out a separate small policy with each of the companies involved. The coinsurance arrangement is hardly ever seen any more and such policies already in place are often administered in a similar manner to reinsurance.

Geographic Factors

Geographical Location: A group risk may be shared among several companies through distribution by geographical location. One company might provide all the group insurance at one location, another company at a second location, and a third at still another. This method of sharing may be useful in cases where separate plants are located in different communities with different employment markets, wage levels, and health care costs. There are administrative difficulties involved, however, which may raise expenses. **Unless all the companies adopt uniform procedures, the transfer of employees from one location to another may cause handling difficulties, overlapping coverage, or gaps in coverage for transferring employees.** Also the employee may be entitled to convert his group insurance every time he transfers.

Distribution Factors

Distribution by Type: An employer may distribute his group insurance business among various companies by type of coverage. He might place his group life coverage with one company, group health with another, and group annuities with a third. This arrangement may lead to additional expense in enrolling employees if the plans are contributory, and there will not be uniform administrative procedures for the various group coverages. Also, since the premium base is not as broad, the experience rating may not give as great an opportunity for premium savings. Otherwise this type of coverage distribution has been found to operate about as satisfactorily as reinsurance.

CHAPTER 7 PLAN OFFERINGS AND MANAGEMENT SPECIFICATIONS

As we have found through this discussion of group insurance, the make-up of the group is the most important element of group underwriting. The make-up of the group should represent a random selection factor. For example, if an insurer could stand on a busy street corner, and select the first 1,000 people who walk past, the insurer would have a genuinely random group. That random group would represent a population to which the standard risk tables could be applied. In actuality, most group policies cover a much smaller number of employees than the population in the example group.

In order to remain solvent, the insurance company is required to have some means of pooling risk to guard against anti-selection. For example, an employer puts his terminally ill brother-in-law on the payroll. The employer's brother in law is too sick to work and the employer has full knowledge of this fact. When the employer seeks an insurance company to provide a group insurance plan that will cover all of the company employees, including the sick brother in law, the employer is "selecting" against the insurance carrier. This is an example of anti-selection, or adverse selection. To lessen the likelihood of adverse selection, the insurers must have underwriting rules and limitations for their own protection against this and similar practices.

The insurance company is also required to comply with the various federal and state regulations, and it still must offer group policies that are competitive in premiums and benefits.

There is a need for the underwriting rules for small groups to be more detailed and restrictive than for large groups. Accordingly, group coverage varies due to industry need as well as state and federal government mandates. Plans will vary from management requirements, to benefit structure and plan design due to the many variables that must be considered when offering group coverage.

Employment Groups

As discussed previously, a group cannot be established and bound together for the sole purpose of acquiring group insurance coverage. The plan must be incidental to the group. Most states' law recognizes employer-employee relationships, associations, unions, and creditor-debtor relationships as eligible groups that can purchase group insurance on an incidental basis to the group. Management systems for the first three types of groups will be discussed in this chapter.

Direct Insurance

Most employer-employee benefit programs today are sold through direct insurance company contracts. Direct coverage, either through a self insurance plan set up by the employer or, most frequently, through an insurance contract between the employer and an insurer covering a group of employees, with no outside organization involved. Instead of an association or MET holding the master contract, it is held by the employer.

Costs

Determining Costs: In determining the cost of group insurance to the employer, there are three important steps:

1. Establishing the initial premium
2. Setting renewal premiums
3. Determining dividends

Premiums

The insurance company underwriter establishes the initial premium for the group in all cases by basing it on the expected claims experience of the group.

For large groups, with around 200 or more employees to be included in health or life coverage, the premium will be set by the underwriter on the basis of standard tabular rates for the risk, plus consideration of anticipated changes and the employer's actual prior experience. For small groups, with around 50 or fewer employees to be eligible for health or life coverage, the underwriter will pool the coverage. This means that he will combine this with other small cases to determine the premium. All the premiums from all the pooled employers are considered together and the premiums are based on the overall expected experience. They are then apportioned to each group according to its share of the pool.

If an insurance company, for example, took on a group policy for a firm with 20 male employees, all in their mid-forties and covered with $30,000 life insurance policies, there would be a probability according to actuarial tables that one man in 200 would die at that age. Suppose the annual premium on the policy to be $3,100 and suppose that one of those 20 men should die, it would take the insurance company almost 10 years to recover the loss. But if the insurance company pooled the premiums of 10 such companies, and one man of the 200 covered were to die during the year, there would be enough premiums collected during that year to cover the loss with a little left over for expenses.

Of course in actual life the cases would not be so simple, since the covered groups would have a variety of ages represented and there would be other factors to consider, but this is the underlying principle on which pooling of risks operates.

Credibility

Credibility Factor: In a case having too many covered employees to be fully pooled but too few to be fully experience-rated, an underwriter will apply a credibility factor. He takes the employer's experience as providing some predictability and partially pools the case. The extent to which the experience is meaningful, the type of risk involved, and other elements will enter into determining the figure for the credibility factor.

If an underwriter considers the prior experience of the employer to be of significant help in predicting what the future results of the case may be, he may assign a 40% credibility factor to the case. Then the premium will be based 40% on the employer's actual experience and 60% on the experience of the pool. If a case generated $200,000 in annual premium and a 40% credibility factor was applied, 60% of claims paid would be charged to the pool.

Then if claims paid totaled $170,000, the charge for pooled claims would be $120,000 (60% of $200,000), leaving a credit balance of $50,000 for the experience-rated claims. If on the other hand, claims totaled $230,000, the charge for pooled claims would still be $120,000 (60% of $200,000), the charge for experience-rated claims would be $80,000 (40% of $200,000) and the balance of the charge would be $30,000. Of this 60% or $18,000 would be charged to the pool and 40% or $12,000 would be the excess charge to the experience-rated group. Thus the pool actually would end up with $138,000 in claims and the experience- rated portion of the case would be charged with $92,000.

The underwriter will consider whether such good or bad experiences are likely to continue when he adjusts renewal premiums. If an employer has a better than average experience over a period of years, it will be to the advantage of the insurer to give him a good experience rating in order to keep him and help the overall experience of the pool. The pool experience will be different from that of any one employer. The way in which cases are pooled can influence the amount of premiums paid by the employer. How a credibility factor is applied will depend on the nature of the risk and the historical experience of the group. Some coverage such as long-term disability or accidental death and dismemberment have a greater risk potential and may be pooled on a different basis from health and life coverage.

Renewals

Setting Renewal Premiums: The underwriter at the end of the first year and usually each year thereafter evaluates the experience of the group and, if applicable, the pool. He assembles all the information he can in order to predict as accurately as possible what the experience of the group in the coming year will be. Trends and other factors will be considered in setting the premium for the year. If the experience of the group has not been as favorable as predicted, the underwriter must decide whether this trend is likely to continue.

It might be found in checking on causes of unfavorable experience that eligibility requirements were not strict enough and a disproportionate number of bad risks in the pool resulted. In this case it probably would be too late to change the eligibility requirements for existing groups, although they might be raised for new groups, and in order to allow for continued poor experience it would be necessary to raise premiums.

Dividends

Dividend Payment: If a group insurance contract calls for payment of dividends, the underwriter determines whether one will be paid and if so, the amount. His calculations are based on the formula of the insurer and the experience of the group.

Payment of the dividend is based on actual experience rather than on anticipated experience as is the case in setting premiums, so the formula is different. An insurer might fully pool coverage for a small company with 25 employees and in that case the

employer's premium would not be directly affected by his claims experience. But for paying dividends the insurer might pool only part of the experience of the same employer.

TRADE ASSOCIATIONS

Trade associations or professional associations comprise another kind of eligible group for an insurance plan. The association would be the owner of the group insurance contract. The association members would be eligible for the group coverage. The members that apply for the insurance would be the plan participants. The platform for the association's charter would be to further the profession or the trade. For example, NAPHCC, the National Association of plumbing-heating-cooling Contractors, is an association chartered because there was a need for a unified group of mechanical contractors and the potential for advancement of the industry under combined efforts, the association. The professional or trade association is not chartered exclusively to procure insurance for its members, but to promote its members in other ways i.e. education, legislative lobbying, interfacing with the community. If the association offers a group insurance plan it is only incidental to the association's goals.

Association Group Insurance for members and their employees: Trade associations and professional associations, are the primary groups that required group coverage. Today other groups such as franchise holders or dealers can provide the make-up of a group that requires group insurance coverage. The relationship between the employer and the sponsor, whether the sponsor be a trade association or a franchisor, is what makes possible the coverage through association group insurance

Premiums must be established at an adequate level to maintain suitable reserves and pay claims properly. Usually the employer who participates has a choice of several levels of benefits under a master plan with variations available to give the flexibility needed by small employers. For example, Lillian Lightfoot has a dance exercise studio. She has had her studio for five years and has eight employees. Lillian Lightfoot belongs to the NDEA, (the national dance exercise association). Through the NDEA Lillian receives a number of benefits from her membership. She can keep up with the latest trends in aerobics through the association magazine. She can buy supplies at a discount through various dance vendors. To Lillian, one of the most important reasons for belonging to the association is that it offers a group insurance program. She and her employees are covered for health care, group life insurance, and disability income. Lillian Lightfoot pays a lower rate for the insurance than she could obtain elsewhere for her small group of nine.

Effective marketing and administration are essential for the success of a trade association group insurance plan that includes member employee coverage. There are three basic methods of marketing and administration for the associations. Some large trade associations have their own staff of specialists. The specialist staff handles the initial marketing of the program, the administration of the program and the solicitation of new memberships. A second method of marketing and administering an association's plan requires the insurance company to handle most administrative duties such as collecting premiums, maintain employee eligibility records and handle other administrative matters. Insurance company representatives may also handle solicitation of new members, but this is more often done by the trade association itself. The third and most common approach for marketing and administering a plan is for an independent broker to handle the entire administrative program and also solicit new

memberships. The broker will have the endorsement of the association or insurance company. Association group insurance is a highly specialized field, but it can be a large-scale and successful program if properly administered.

METS

Multiple Employer Trusts for Employer-Employees: All employers are not members of a trade or professional association. For employers who are not members of an association, a "Multiple Employer Trust," (MET) can provide association group coverage. **The MET sponsor creates an association especially for the purpose of providing group plan coverage to a number of small employers joining together to secure advantages otherwise available only to large firms.** A MET may be established to accommodate groups that would otherwise be hard to write. The group is eligible even though it is created to provide insurance, because the insurer(s) understand the reason for the grouping of employers. It is not a hidden fact used for adverse selection. Some groups that would use a MET are very small groups with only two to five individuals or a group that has a hazardous occupation, such as demolition contractors. Medical insurance is not underwritten in Multiple Employer Trusts normally.

A legal trust is established under the MET plan to hold the master contract. The trust is the entity through which all financial transactions related to the plan occur. The plans trustee is responsible for management and supervision of the members of the trust. The sponsor of the plan, either a broker-administrator or an insurance company, sets up the underwriting criteria and administers the plan. There is no association or corporation involved as there is with an association group plan. Accordingly, most MET coverage is placed through insurance agents and brokers just as direct insurance is. The insurance company is responsible in most cases in the marketing of a MET.

For example, Lillian Lightfoot's DEA (dance exercise association) does not offer a group insurance plan for the association members. With only eight full-time employees, Lillian and her employees will probably be a good prospect for MET coverage. She or her benefits advisor can consider MET’s being offered by several broker-administrators and by several insurance companies specializing in the field. Some of the insurance companies will offer more than one MET. One insurance company has a dozen MET’s. Each of the MET’s the company offers covers a specific related industry. Other MET’s may be for all employers regardless of industry, provided certain underwriting rules are observed. No matter which MET Lillian chooses, the MET is the owner of the group contract.

MET sponsors choose to offer this type of insurance because they can provide a better package of benefits for small employers at lower cost and thus meet the competition. Usually the MET plan is more flexible than an association group plan.

For example, Lillian Lightfoot selects a MET that offers 10 different benefit schedules for employees. Accordingly, Lillian can provide the level of benefits she wants to offer her employees. Lillian has flexibility that she would not have if she were purchasing a policy directly from an insurance company offering group plans. When she has made her selection, the case will be submitted just as a directly written group case would be, except that her check is made out to the MET trust, not to the insurer.

MET and association group plan premiums are normally based on the aggregate of all employer groups in the plan. If there are excessive claims from some of the employer groups, the rates for all the employer groups will be driven up. This may result in a loss of the groups with good experience rates. The groups with good experience ratings will go looking for lower premium rates elsewhere, leaving the MET with a higher proportion of groups that have experienced heavy losses.

Premium rate setting can be a complicated and delicate process when creating a MET. **The rate must be at a level that is market competitive and still be high enough to provide sound plan reserves and be able to pay participants claims.** If a MET is declared insolvent, the employers and employees that are participants in the plan are left without coverage. The MET could be a self-insured plan, and may not have been thoroughly examined by regulatory agencies for financial stability or capital.

When a Multiple Employer Trust grows in size and membership, an insurance company may be reluctant to act as the MET's sole insurer. The insurance company may feel that it has very little control over the underwriting and administration of the larger MET. When this happens a MET can turn to self-insurance or spread the insurance purchased among several carriers. The insurance carrier also may not want the MET to represent too large a proportion of its total business. Nevertheless, depending on the soundness of the sponsor, there can be and are excellent MET's. Some are sponsored by insurance companies and some by broker-administrators. Multiple Employer Trusts have operated effectively and have provided coverage at reasonable cost for a number of years.

Summarizing direct and association insurance programs: A firm with several hundred employees will pay a group insurance premium reflecting the experience of those employees and their dependents, and nobody else. A small firm, on the other hand, whether it secures coverage through an association group plan, a multiple employer trust, or direct insurance, will have its risks pooled. When a group includes 35 to 50 participants or more, only part of the risk will commonly be pooled. If the insurer is not maintaining a sound pool, the small employer can be at a definite disadvantage. If the employer is in a pool with a number of bad risks, even though his or her own experience rate is good, that employer can suffer negative occurrences along with the groups creating the situation. For this reason the selection of the right insurance carrier and the right group plan is important. The group package needs to be well designed, underwritten to minimize risks and abuses, and administered effectively. These three requirements are important to both large and small employers.

MEWA's

Multiple Employer Welfare Arrangement (MEWA)- This is a plan which is established by an employer or employee organization for the purpose of providing for its participants, by insurance or otherwise, medical, surgical, or hospital care benefits. Other types of benefits may also be provided. It does not have to be a trust as with the METs, other "entities" may also qualify as defined under § 3(40) of the Employee Retirement Income Security Act (ERISA) of 1974, that is established or maintained for the purpose of offering or providing benefits. The end task is to provide the same service as a Multiple Employer Trust, health insurance for employees of several companies or organizations at (hopefully) a lower cost. MEWAs must meet state mandated standards to avoid being classified as an unauthorized insurer.

Some perceive a problem with MEWA legislation from the federal government is that it preempts or weakens state enacted insurance laws designed to protect consumer choices. Federal legislation that overrides state insurance law represents a dilution of state power and a form of dual regulation that will only lead to confusion. The heart of the problem can be summed up this way; Is the multi-employer plan fully insured or otherwise adequately regulated?

It is prudent that when choosing an employee leasing company, employers should ask the following questions:

- Is the employee leasing company registered with the insurance department?
- Is the employee leasing company offering workers' compensation coverage to the leased employees?
    - If so, is the insurer who is being used to supply coverage *licensed* to sell workers' compensation coverage?

Employers should know that specific issues regarding workers' compensation rates and contract coverage can only be discussed by the employee leasing company if they are a licensed insurance agency. Otherwise, the employee leasing company must either have a licensed insurance producer or an insurer that is a direct writer of workers' compensation to discuss these issues with the employer. The responsibility to ensure that all employees have workers' compensation coverage rests with the employer. Therefore, if only a portion of your employees are leased, make sure that both the leased and regular employees have workers' compensation coverage.

- If the employee leasing company is offering health insurance coverage through an insurer, is the insurer licensed to do business in Maine with an approved health product? Is the product being sold by a licensed producer?
- If the employee leasing company is offering health coverage by self-insuring its health risks, is the leasing company registered as a MEWA (Multiple Employer Welfare Arrangement) with the Bureau of Insurance?

Registrations and licenses with the Bureau of Insurance ensure that specific financial criteria are met to enable companies to pay claims when the time comes. These licensed and registered entities must also comply with all aspects of Maine law for coverage requirements. If entities are unlicensed or unregistered, an employer has very little recourse if the leasing company does not pay health insurance or workers' compensation claims. To check an employee leasing company's Maine registration or license, contact the Bureau of Insurance.

Sometimes self-funded plans are assumed to be fully insured plans because employers or employee groups hire an insurance company, HMO or third party administrator to coordinate providers and handle claims and paperwork. With self-funded plans, the plan (or employer) assumes the risk (financial responsibility) of providing benefits and paying the claims. States are not permitted to regulate most valid self-funded ERISA plans authorized by Congress under terms of ERISA. This means in most cases:

The insurance departments of the various states have no authority to investigate complaints that involve valid single -employer or union-sponsored self-funded ERISA plans. State laws

requiring specific benefits in health care plans seldom apply to valid self-funded ERISA plans. Certain other group health plans provided by governments, churches, some school districts and out-of-state Blue Cross organizations also are exempt from most state regulations.

UNIONS

Unions will use "Jointly Managed Funds" for its members. The Taft-Hartley Act provides for a collective bargaining agreement that can create a jointly managed health and welfare find. Such a fund will normally require that the employer pay a contribution to the fund for each employee covered by the fund. The contributed amount is fixed by the agreement and may be a certain sum per week or per month, or a set amount per hour worked.

A jointly managed fund requires that a board of trustees be appointed. **The board of trustees will include an equal number of representatives from the employer's management division and from the labor force.** The board controls the fund, and determines how the contributions are to be used in providing coverage. An administrator handles the actual day-to-day operations of the fund. The administrator will account for the eligibility of members, the collection of contributions, and paying of operating expenses and claims. As with other plans, the fund may have its own salaried administrator, or may use a contract administrator who works for several funds.

A labor union can provide group insurance for its members under a policy issued to the union. The union is the policyholder, just as the trust is the policyholder under a MET. A union may purchase a group policy for a large number of members who are employed by the same company, or for union members working for different companies. Group insurance purchased through a union is particularly advantageous in industries such as construction, where union members may work for many employers during a year. Despite the opportunity for labor unions to purchase group insurance, few group contracts are issued to unions today. Organized labor more often obtains insurance benefits for its members through collective bargaining with employers. As a result, union members are usually covered under group insurance plans sponsored by one or more employers.

CHAPTER 8 FINANCING GROUP INSURANCE PLANS

In recent years there have been considerable changes in the financing of group insurance plans. During the 1960s, most employers offered benefits that were fully covered by insurance companies or Blue Cross-Blue Shield plans. With the increased expense of health benefits during the 1970s, alternate methods of financing them began to be explored.

Large companies became interested in new financing mechanisms for employee benefits, and non-insured coverage and minimum premium plans began to come to the fore. From health plan financing this trend extended to disability and life coverage, and from large companies it filtered down to small ones. Some companies with a few employees changed their methods of financing health care benefits, sometimes from fully insured plans to substantially non-insured plans with some type of stop-loss arrangement in case of an unusual claim.

This trend can lead to complications in financing smaller plans because they may be part of a multiple employee trust, and in that case the trust, not the employer, is the policy holder. An employer could thus be participating in a trust that was self-insured without knowing it.

The fully insured plan is the most familiar arrangement in the operation of group insurance. There are others, however, and sometimes more than one approach may be used for the same plan. Alternatives were developed primarily to reduce the impact of premium taxes and reserves held by the insurance companies and thus to improve the employer's cash flow.

Fully Insured Plans

Plan Operation: Under a fully insured plan, the insurance company may assist in designing the operation. After the plan is in place, the insurance company collects premiums and assumes the risk. The coverage may be pooled or experience rated, or offered through a combination of the two. Administrative services are provided and claims paid by the carrier.

Small employers who cannot absorb the risk of claim fluctuations find the fully insured plan the most suitable. It also appeals to employers who do not wish to have to become involved with administration and claims or to be forced to make a judgment on the validity of claims. Small businesses in such cases rely on the insurance carrier to keep them from having to complete eligibility information on claims forms.

Fully Non-Insured Plans

Plan Operation: In contrast, under a fully non-insured or self-insured plan, the insurance company or service plan does not collect premiums or assume risk. The employer in effect is acting as an insurance company. He or she pays claims with the money that would be paying for premiums under a fully insured plan. **Insurance companies and independent administrators can be employed on a contractual basis to handle these functions.** Their activities must be monitored carefully as they are handling and disbursing money belonging to the employer.

An employer not able to absorb fluctuations in claims should not adopt a fully non-insured plan. Employers with fewer than 1,000 employees generally will not have the financial or personnel resources for administering a fully non-insured plan and paying claims, and therefore will not find such a plan suitable for their needs. Severe financial loss can be suffered with a plan covering several hundred individuals if just one expensive claim has to be paid, unless a stop-loss arrangement is in effect.

Minimum Premium

Some of the advantages of an insured plan can be obtained by the employer under a minimum premium plan. **In this approach, there is an agreement between the employer and the insurance company that the employer will pay all claims until a certain aggregate level is reached,** The carrier will be responsible for claims above that amount. The aggregate level usually is based on experience of claims paid within the past two or three years, adjusted by a factor allowing for inflation and greater utilization under the policy.

The usual figure is 90% of monthly expected claims to be paid by the employer and the rest by the insurer. The claims are ordinarily paid by the insurance company using employer drafts up to the agreed level, and the insurer's funds after that point. If a company, for instance, had claims averaging $500,000 a month over the past two years and a 20% trend factor was applied under the agreement with the insurance company, expected claims for the next year would total $600,000 a month. The insurer would pay claims up to 90% of that total ($540,000), with drafts on the employer. Claims over that amount would be paid with insurance company funds.

The insurer under the minimum premium plan usually provides all administrative services. It must establish reserves for the entire amount at risk, not just the amount for which it has agreed to pay claims, because it is ultimately responsible for the entire risk if the employer should go out of business. Usually there is some form of reserve reduction arrangement in such a case. Most insurance companies will not offer a minimum premium plan except to corporations with several thousand employees. Advantages of the minimum premium plan to the employer are that it reduces the actual premium and the premium tax, provides protection against claim fluctuations, and lets the employer take advantage of the insurance carrier's claims expertise and other administrative services.

Stop-Loss Insurance

Unless a group has several thousand covered lives, it can be seriously affected by claim fluctuations. Stop-loss coverage is designed to take care of this problem. **It reduces the group premium and premium tax, minimizes the need for the insurer to establish reserves, and provides protection against claim fluctuations and large unforeseen claims.** Such coverage is expensive

Stop-loss coverage usually is set up in terms of aggregate claims. The stop-loss carrier will pay the policy holder for claims after the aggregate amount agreed on of total claims by all employees and their dependents has been reached. Another type of coverage known as specific stop-loss will pay on a per-case basis. This arrangement is similar to an insurance policy with a large deductible. Once the deductible is satisfied, the insurer is responsible for the balance of the claim. Depending on the nature of the contract, either the employer or the

employee may be paid by the insurer in such a case. In spite of its advantages, the stop-loss plan is not in widespread use among self-insured employers. It is expensive and often is offered only in conjunction with other arrangements such as the agreement to purchase group term life insurance.

Deductibles

Big Deductibles: Another way of easing an employer's cash flow problem that is similar to the stop-loss arrangement is the "big deductible" health plan. A number of small and medium-sized employers have adopted it. Such a health plan uses a $500 or $1,000 deductible rather than the traditional $50 to $100. Usually the employer agrees to pay a portion of the deductible in order to keep his employees satisfied with the arrangement.

If the previous health plan had a $100 deductible with 80% coinsurance, for example, under a new "big deductible" plan the employer might continue to let the employee pay the first $100 while the employer would pay 80% of the next $900. The big deductible plan differs from the stop-loss arrangement in that the deductible is always assessed on a per-person basis, not on the aggregate claims the company has. Also the big deductible is an arrangement under a comprehensive major medical plan. A stop-loss approach is an addition to a self-insured comprehensive plan.

As with the stop-loss arrangement, under a big deductible plan someone will have to pay claims. The employer probably will not want to handle these details. Many insurance companies which sell big deductible plans will do so only to employers who use the claims services of an insurer or independent administrator. The employer considering a big deductible plan needs to consider the cost of these services to be sure that the cost of paying claims does not exceed the cost savings on the policy. To allow for inflation, the insurance company will have to increase its deductible by a percentage per year equal to the inflation rate plus an allowance for greater utilization of the plan. Unless the increased deductible is passed on to employees, the employer will not benefit from the change to a big deductible plan. Such a plan does, however, temporarily ease an employer's cash flow problem and it also has the advantage of involving the employer directly in the cost of health care coverage. The insurance company pool absorbs comparatively less of the employer's bad claims experience.

Reserve Reductions

Larger employers have found it possible to enter into agreements with insurers to reduce the amount credited on reserves held if the use of the money will give the employer an advantage because of the rate of interest available.

Insurance companies are required to have adequate reserves, but through agreement the amount can be minimized on large group contracts. Such arrangements usually are used in connection with minimum premium plans. On an insured health plan reserves may be as much as 20% to 30% of the annual premium, and on life insurance plans about 20%.

Under a reserve reduction agreement the most common procedure is to delay paying the premium for several months. The carrier might charge the employer interest for premiums paid later than the 30-day grace period, but this amount probably would be less than the value of the money withheld to the employer. Some employers use letters of credit, securities, or

compensating balance arrangements, but laws and regulations in some states do not allow such procedures. A retrospective rating agreement might be used by an insurer with a large employer. The insurance company and the employer would agree on a premium rate at the beginning of the contract year under this arrangement, and then if this rate proved to be too low the employer would make up the difference to the insurer. In this way the employer would have the use of the money until he repaid the insurer for the deficit. The employer would be obligated to make up the deficit under such a "retro" agreement, whereas under a usual group contract if the rate set at the beginning of the year resulted in a large deficit for the insurer, the employer would have no obligation to make up the loss. The "retro" arrangement is not practical for long-term disability plans, under which insurance companies may set aside as much as 90% of annual premiums for reserves.

Limited Liability Plans

The typical reserve for a fully insured long-term disability (LTD) plan is five times the annual benefit. This can make the impact of reserves on policy cost quite substantial. Some insurance companies are now underwriting LTD plans under a limited liability arrangement. The employer under this approach purchases one-year annual renewable LTD coverage.

Reserves are only established for the duration of the contract, although claims are processed just as they would be under a fully insured LTD plan. At the end of the year or whatever the contract period is, the employer usually renews the contract and the insurer agrees to continue paying current claims and process new ones.

Under the limited liability arrangement, the initial reserve established by the carrier is substantially lower than for a fully insured LTD plan, and the liability for payment of the claim falls with the employer. The liability is not reduced, but the employer has the use of the money which he otherwise would have paid the insurance company for reserves under the fully insured plan. In some states this arrangement may not conform to insurance laws and regulations.

Premium Waiver

In the case of an employee who becomes totally and permanently disabled, under group term life coverage the insurer usually establishes a reserve against the eventual claim to be paid under the waiver of premium provision. Usually this reserve is equal to 75% of the death benefits. It is held as long as the insurance company is responsible for the death benefit, which may be many years. Sometimes larger companies in order to avoid losing earnings on these reserves will eliminate the waiver of premium provision from the life insurance coverage. The employer then in most cases continues to pay the premiums for the disabled individual as if he were an active employee.

This practice is suitable for medium-sized and large employers who are not seriously affected by paying premiums for an individual who is not a productive employee. There may be a problem in this area with some state laws.

Retired Life Reserves

Most employers either continue to provide a portion of the active coverage on an employee when he retires, or terminate the entire group term life coverage. The employee may be covered for permanent insurance accumulated under a paid-up life or group-ordinary plan.

The employer who continues to provide life insurance for retired employees has a fixed liability. In that eventually the retiree will die and the death benefit will be paid. The liability for the death benefit is established at the time the employee retires, and it is therefore logical for the employer rather than the insurance company to assume responsibility for this liability. The death benefit could be paid from company funds, but some employers prefer to pre-fund their retired death benefit plans, especially in the case of a sizeable benefit. This is usually done through a trust or a paid-up life policy. Tax consequences in such cases need to be carefully reviewed.

Options for the Agent

Group insurance offers a significant potential for new business for the life insurance agent. Although many agents have avoided going into the group field because they thought it was too complicated, there are now simplified plans and procedures available for small groups, and selling these involves the same kinds of insurance coverage most agents are familiar with in individual policies.

In most companies, group specialists are available to help with technical details when questions arise with these policies. Group policies are sold with the same basic techniques as individual policies. Group insurance is a fast-growing field, too important to be overlooked.

The Door-Opener: An agent new to the business field will find it easier to talk to a business prospect about group insurance than about individual life insurance. In fact group insurance has been called the universal entree, or door-opener, into the business insurance field. The business owner knows that employee benefit plans are important in hiring and keeping productive and satisfied employees.

He or she also knows that such plans represent a major expense and the business owner probably will be interested in hearing how to get the greatest possible value for the company's group insurance dollars. Productivity is the most important factor in a successful business, and nothing hurts productivity more than disruption from lost workdays, lost employees, and inefficiency. Especially in small and medium-size companies, health problems of employees can have a disastrous effect on productivity. Most business owners recognize the importance of group insurance in providing adequate life coverage and protecting owners and their employees against rising costs of medical care and the loss of income through disability. Successful handling of a group insurance policy will open the door for the agent to other business insurance opportunities.

Daytime Business: The agent probably calls on many individual insurance prospects during evening hours. Group insurance selling is a daytime activity. Business operators expect daytime interviews. Entering the group insurance field can utilize daytime hours the agent may not have been employing profitably.