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Section AH 1

HEALTH INSURANCE CONCEPTS

Objectives

A California Accident and Health agent is authorized to transact the sale of health, group health, disability, workers' compensation, credit disability and 24-/hour insurance policies. This is a broad group of insurances requiring you to know concepts of accident and health insurance, medical expense, agent responsibilities, insurance codes, ethics and social insurance programs. You will learn all of these concepts in this course to form a solid foundation to prepare you for the challenges and opportunities that lie ahead.

INTRODUCTION

ACCIDENT & HEALTH INSURANCE DEFINED

Insurance Defined-- Insurance by definition is a contract (also known as a policy) in which one party (Insurer) undertakes, for a consideration (Premium), in order to indemnify or guarantee another party (Insured) against loss, damage, or liability by a specified contingency or peril. Accident and Health insurance is a contract

that provides against loss through illness of the insured by covering or partially covering such expenses as surgery and medical.

The term Health Insurance is quite broad, since it can involve three separate elements:

- **Medical expenses resulting form sickness or accident (surgery, hospital, etc.)**
- **Accidental Death or Dismemberment**
- **Disability resulting from sickness or accident**

A Health Insurance policy can provide a single element or any combination of these benefits. Medical Expense is discussed below while other concepts will be covered more thoroughly in later Units.

It is important to define the above terms "**accident"** and "**sickness"**. Some policies may cover them differently, or a policy may cover one and not the other. An **accident** refers to an injury that occurs accidentally. A **sickness** is a disease or illness that is not caused by an accident. These terms are often used interchangeably in Health Insurance (Accident & Health, Accident & Sickness). It is also sometimes generically referred to as simply *medical insurance;* HOWEVER, there is an entirely separate concept known as **Medical Expense Insurance** that will be covered later.

CONTRACTUAL CONCEPTS

In order to be legally binding, this contract requires *the participation of competent parties* toward *a legal purpose*, involving *the offer and acceptance of the payment* of the policy premium for *the*

performance of the insurance company, stated within the specific policy.

Typically, there are five concepts that apply to Health Insurance contracts:

- **Unilateral Contracts** Health Insurance contracts are unilateral (affecting one side only) because only the insurance company is legally required to fulfillment its obligations within the contract. The insured may choose to cancel the policy or stop paying the premiums. But as long as the insured continues to pay the premiums, the insurance company must adhere to the policy contract.
- **Personal Contract** A Health Insurance contract is *personal* because it is a person–not property or a car–who is being insured.
- **Aleatory Contract** Health Insurance contracts do not contain equal value, in that the insurance company may pay out benefits far in excess of total premiums received from the insured.
- **Contract of Adhesion** Health Insurance contracts are 'one-sided', in that only the insurance company prepares the provisions and benefits stated within the contract. The insured does not participate in the preparation of the contract, although they may request special provisions, benefits, or coverage. But it is the insurance company that ultimately prepares and issues the contract.
- **Conditional Contract** The insurance company's obligation to pay out benefits toward any claims is contingent on the actions of the insured, such as the payment of premiums and providing adequate proof of such claims.

POLICY TYPES

There are as many types of health policies as there are companies. Some limit their products to major medical, group, disability, long term care and more. Others serve limited, special lines such as travel and accident, dread disease, hospital income (so much paid every day you are in the hospital in additional to medical expenses), hospital confinement/hospital only (pays for or indemnifies for expenses that occur IN THE HOSPITAL) , ***accident only*** (benefits paid direct to you if you had an accident), credit disability (loan or premiums are paid if you get sick) and more.

Note: As an agent, it is your job to determine if there are other sources of coverage that should be considered to adequately meet a family's health / disability insurance needs. This can include workers compensation, social security, Medicare, work related benefits, statutory plans and more.

MEDICAL EXPENSE

Objectives
This type of this type of policy provides the insured with protection for medical expenses that result from accidents and illnesses.
Medical Expense Insurance typically refers to essential medical, hospital, and surgical benefits.

This unit includes:
- Basic Expense Insurance
- Other Medical Expense Benefits
- Major Medical Coverage

1. Basic Expense Insurance

The **3** major components of Medical Expense Insurance policies are

1) Regular Medical Expense Benefits
2) Hospital Expense Benefits
3) Surgical Expense Benefits

Here's a closer look at those **3** components:

A. Regular Medical Expense Benefits

Regular Medical Expense Benefits vary from state to state, and concerns coverage for non-surgical services provided by physicians. Some of these policies only cover physician visits while the insured is hospitalized; others cover these services at all times. This coverage is a basic medical expense. The coverage usually includes a MAXIMUM:

- Number of visits per day
- Dollar amount per visit
- Number of days that coverage applies

B. Hospital Expense Benefits

Hospital Expense Benefits provides coverage and benefits for any expenses the insured incurs while hospitalized.

These indemnities are usually classified into **2** groups:

1) **Room and Board**, including nursing care and dietary needs. Room and Board Benefits pays either on:
    - **An indemnity basis**, in which the insured pays a pre-established amount for services per day, for a maximum number of days. The specific policy will illustrate this payment schedule.
    - **A reimbursement basis**, in which the policy would pay for the actual charges for a semi-private room, or a percentage of these charges with no specific dollar limit. However, a maximum number of days are specified. The policy will pay the actual room and board charges without regard to the specific dollar amount. A special provision may exist for intensive care facilities. Usually, policies will pay out **2** or **3** times the amount for normal room and board. There may also be a limit on the length of this benefit.
2) **Miscellaneous Medical Expenses**, to include X-rays, medications, lab and testing fees, and operating and treatment rooms.

Putting it into Context:
Wayne is diagnosed with an illness and requires a stay in the hospital. Wayne stays in the hospital for 5 days, with the hospital charging $1000 dollars a day for room and board for up to ninety days. The total charge amounts to $5000. Wayne's Room and Board benefits, as stated in his policy, will pay the full $5000 for Wayne's Room and Board expenses.

Note: **Miscellaneous Medical Expenses Benefits** are stated as a limit that is separate from Room and Board Benefits. The limit is usually stated a multiple of the per-day limit for room and board for each period of hospital confinement. A policy may state it will pay up to ten times the room rate at a hospital. If the room rate is $100 dollars a day, then the payout for Miscellaneous Medical Expenses would be $1000 dollars.

C. Surgical Expense Benefits

Surgical Expense Benefits pay surgeon's fees and other related costs for necessary operations. Examples of other related costs might be for the anesthesiologist, the assistants, or even the operating room itself.

Surgical Expense Benefits operate on **2** separate plans:

1) **Scheduled Plans** include benefit amounts in a schedule that itemizes the major commonly performed operations, as well as the benefits payable for each. However, if a particular type of surgery is not included on this list it does not mean it's not covered. (Please excuse our double negative—so, in other words, it could be covered)

2) **Nonscheduled Plans** include surgical benefits not listed by a specific dollar amount in a schedule. When this occurs, the insurance company will pay benefits on what is considered Usual, Customary and Reasonable. UCR is based on the dollar amount physicians in a specific area usually charge for similar procedures. These nonscheduled plans allow for inflation and rising medical costs.

2. Other (Optional) Medical Expense Benefits

In addition to medical, hospital and surgical benefits, other benefits exist that can be added when the policy is created, or at the insured's discretion. Some insurance companies may include these options in comprehensive policy (to be discussed later in this Unit) or written as a separate policy:

- Maternity
- Convalescent/Nursing home
- Emergency first aid/Urgent care
- Home health care
- Mental infirmity
- Hospice care
- Prescription drugs
- Dread disease
- Outpatient treatment
- Dental
- Private nursing
- Vision
- Prescription Drug Cards
- Supplemental Accident

3. Major Medical Coverage

Major medical expense insurance covers a much broader range of the insured's medical expenses. These policies typically have higher benefits and policy maximums, which may be:

- Lifetime
- Annual
- Per cause

They are classified in **2** important ways:

1) Comprehensive
2) Supplemental

Here's a closer look at those **2** ways:

A. Comprehensive

Comprehensive is a single policy that covers all major medical expenses. This is the most popular form of major medical coverage.

There are **2** types of Comprehensive Major Medical plans:

1) **First-dollar coverage** means that as soon as any medical expenses are incurred by the insured, the comprehensive plan begins to pay benefits.
2) A plan **without first-dollar coverage** requires the insured to pay a specified deductible before any benefits are paid out. When the specified deductible is met, then the policy begins reimbursing.

Putting it into Context:

Sheena has a comprehensive **plan without first-dollar coverage**. Before her policy pays benefits, Sheena must pay the first $500 of medical expenses a year–this is Sheena's deductible. On the other hand, Jeff has a policy **with first-dollar coverage**. When he receives any medical treatment, his policy begins to payout towards these expenses. Jeff has no deductible.

B. Coinsurance

Another important element of major medical coverage is **coinsurance.** This means the insurance company and the insured will share any expenses above the specific deductible amount. The insurance company always carries the bulk of the expenses, usually in the familiar 80/20 split with the insured. However, other percentage proportions may be used according to the specific policy.

C. Restoration of Benefits

Most Major Medical policies contain a Restoration of Benefits provision that allows a dollar amount of coverage to be restored each year following a claim.

D. Rating Factors

Health insurance rating is a complex mix of factors that influence rates, such as:

- The Geographical location based on facilities, providers, and local area costs
- Demographics, such as the age, gender, and occupation mix are considered

- Medical history in individual cases such as chronic conditions and pregnancy
- Claims History in Group insurance as well as participating, contribution, coverage, and benefit levels all have a bearing on cost

HEALTH POLICY ISSUES YOU NEED TO KNOW

Note: The California Department of Insurance has jurisdiction over entities that provide coverages designed to pay for health services and expenses UNLESS the health care providers are appropriately licensed or certified by other governmental agencies.

Major Health Insurance Mechanisms

A. Indemnity Types --Insurance companies, Preferred Provider Organization (PPO's), Exclusive Provider Organization (EPO) offering traditional reimbursement of medical expenses. Most health insurance is indemnity in nature.
B. Consumer Directed Plans – Health Reimbursement Accounts (HRA), Health Savings Accounts (HSA) and other compatible plans where health insurance is paid for by the employer or self-employed owner.
C. Self-Funded Plans – Claims are paid for by the employer up to a point (the stop-loss), thereafter, an insurer pays.
D. Other Types – Associations, franchises, trusts, etc. reimburse or pay for member claims under specific terms and limitations

Health Terms You Should Know . . .

Deductible: A specific amount of money the insured must pay before an insurance company starts to pay.

Gatekeeper Concept: A primary care provider or doctor determines the necessity for further treatment by a specialist.

Accident vs sickness: Accident refers to sudden unexpected event which causes bodily injury compared to sickness a physical illness or malady.

Managed care: A variety of techniques are used to reduce the cost of providing health benefits and improve the quality of care.

Master policy owner: A group insurance policy provides coverage to individuals under a single master policy issued to a master policy owner such as an employer, association, labor union, etc

Stop-Loss Provision: Health policies that have coinsurance require that the insured pay a portion of the loss after the deductible . . . called the stop-loss.

Other Health Related Insurance Policies

Within the health industry (both group and individual) there are also many limited lines of insurance where agents can dabble or specialize:

Travel accident – covers travelers, employees, families of employees for anything from trip cancellation, loss of baggage, medical emergencies, accidental death, repatriation and more.

Dread disease and critical illness – coverage for debilitating, but not necessarily deadly diseases like cancer, Alzheimers, Parkinsons, etc

Hospital income and confinement – pays a benefit (income) while the insured is in the hospital

Accident only – pays benefits when the insured and/or family members have accidents

Credit and credit life – pays the balance of a loan when the insured dies or becomes disabled

Blanket – coverage for special groups under an employer or an organization having religious, civic or non-profit status.

Health – covers the high cost of medical expenses (probably the most valuable coverage when you consider one incident, like a heart attach with complications, can run millions).

Dental – typically covers a portion of the bills for dental services . . . many paid for by employers.

Vision – partial or full coverage for eye examinations, glasses, contact lenses . . . with and without copays.

Prescription Drug Card – insurance to pay for all or a portion of the insured's prescription drugs. Or, allows them to purchase them at a discount.

Supplemental Accident – pays for out-of-pocket expenses related to ***accidental injury only*** that an existing health plan does not cover.

It is important to note that limited lines insurance policies, like those above, have the possibility of ***limited benefits***, such as:

Policies that provide for expenses incurred for an accident or disease ***ONLY***.

Policies that pay a ***fixed dollar amounts*** for diseases or impairments

Policies that provide benefits for specified ***limited services***.

Policies that indemnify on a ***fixed dollar amount per day***.

END SECTION

Study Required Minutes before taking the Section Quiz.
Answer all questions correctly on the Quiz to move to the next Study Section. Re-take Quiz if needed.

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Section AH 2

DISABILITY INCOME & GROUP HEALTH INSURANCE

Objectives

The Need For Disability Income provides the insured with a portion of their earnings while disabled. Many people often overlook this type of policy. Statistics show that much of today's working force faces a better than **50%** chance of being disabled for more than three months before reaching retirement age. **Group Health** or Blanket Insurance Policy is probably the most familiar type of insurance to people. It is part of a benefits package offered by employers, and covers a group of people, as opposed to an individual. As part of your agent training, you will come to understand both concepts through material covered in this Section.

DISABILITY INCOME

1. The Different Types of Disability Income Insurance Policies

There are different types of Disability Income Insurance policies:

- Individual
- Group Policies
- Business Overhead Expense Policies
- Business Disability Buy-Sell

Here's a closer look at those different types of Disability Income policies:

A. Individual

Individual policies are typically sold to professionals or the self-employed. The benefit amount is usually related to an individual's earnings and is intended to replace as much after-tax income as possible when a disability prevents the insured from earning a living.

Insurance companies extend a fixed-dollar amount–up to **60%** of the insured's monthly income. Also, a cap exists on such benefits so that no more than a certain amount is paid out over a month. Overpayment might encourage malingering.

Rating is based on:

- Age
- Gender
- Job Classification
- Income
- Health
- Hobbies
- Amount of Benefit
- The chosen Elimination Period

Obviously, the younger the age, the lower the rate. Male rates are lower than female rates, and only earned income is counted. People with more hazardous occupations pay a higher rate, and people who engage in more hazardous sports or hobbies may require an additional rate. Past and current health

is also a rating consideration, and benefit amounts, benefit periods, and elimination periods will impact the premium rate.

Putting it into Context:
Samantha's net monthly earnings are $5,000. She also has an individual Disability Income Insurance policy in place. Samantha's monthly benefit would be $3,000. This is 60% of her net income before disability, however, Samantha's policy may have a monthly cap of no more than $4,000 dollars a month.

B. Group

Group policies are often part of an employees' group benefit package offered by an employer. A contract between the insurance company and the employer would be in place. These policies usually combine group life, health and medical expense coverage. The policy may cover employees, associates, partners and shareholders.

C. Business Overhead Expense Policies

BOE policies are sold to business owners to cover business overhead expenses in case the owner suffers a disability. These policies cover only the usual overhead costs and wages. They do not cover income loss, capital goods costs, or new inventory. A BOE policy would pay benefits to cover rent and utilities, and the purpose of the policy is to keep the business alive until the owner returns to work.

D. Business Disability Buyout

Business Disability Buy-Sell provides funds to purchase the interests of an owner or partial owner of a business if they become disabled. The benefits paid out under this policy would come from the insurance company, allowing the business to remain functional. A disability buy-sell plan has an elimination period of at least a year. When the elimination period concludes, the buy-out must occur.

Putting it into Context:
Samuel is one of a group of owners of a small publishing company. The business has a Disability Buy-Sell policy in place. After suffering a total disability, Samuel decides to dispose of his interest in the publishing company. The policy would provide the funds to purchase Samuel's interest, and the publishing business would remain operational.

E. Key Employee/Partner Disability

A disability policy on a key employee or partner would pay the monthly benefit to the business if the employee or partner became disabled. The funds would allow the business to continue, hire a replacement for the disabled individual on a temporary or permanent basis, and provide the business with time to recover from any economic loss.

2. Basic Disability Income Insurance Provisions

The definition of total disability is important and will always be clearly defined in the policy. Keep in mind, different companies may use different definitions.

They are based on the work activity the insured may be qualified to perform and defined in **4** ways:

1) Own Occupation
2) Any Occupation
3) Presumptive Disability
4) Injury Versus Sickness

Here's a closer look at those **4** definitions:

A. Occupational Coverage

Own Occupation concerns the specific occupation in which the insured is normally engaged and earning money. This is defined as the insured's inability to perform any or all duties involved with their particular occupation.

Also, it refers to the insured's **Own Occupation** at the time of disability.

Putting it into Context:
Jamie is a successful orthopedic surgeon. As the result of an accident, he suffers severe tendon damage to his right hand. Jamie will never be able to perform surgery again. He is entitled to total disability benefits since he is unable to perform the duties of his occupation at the time of disability.

B. Non Occupation

Non Occupation concerns the insured's inability to perform the duties of any occupation for which they are qualified by education, training or experience in relation to their occupation. This is a more restrictive definition of Total Disability.

Putting it into Context:

Jamie is totally disabled under the previous definition: he can't perform his **own occupation**. However, he is more than qualified to become an instructor of orthopedic medicine at a local medical school. So, under this definition he is not totally disabled, since he could work as an instructor (**non occupation)**, a position for which he is more than qualified by his previous training and years of experience.

FEDERAL INCOME TAX & DISABILITY INCOME

The taxability of disability income depends on what type of benefits you receive. If you paid the premiums on an ***individual disability policy*** with after tax dollars, the benefits you receive are tax free, but, you cannot deduct the premiums paid as a medical expense. For a ***group disability*** plan sponsored by an employer, if you paid the premium using after tax money the benefits are tax free. If the employer paid the premiums, benefits are taxable.

Limitations On Disability Income Coverage

Disability income insurers limit the amount of coverage that can be purchased to minimize premiums, disability fraud (you don't want to motivate people to get sick or hurt) and as an incentive for the disabled party to rehabilitate and get back to work (earning less than full salary motivates one to get back to work).

C. Presumptive Disability

Presumptive Disability automatically qualifies the insured for Total Disability benefits, regardless of their ability to work.

These conditions are:

- The loss of any two limbs
- Total and permanent blindness
- The loss of speech and hearing

D. Injury Versus Sickness

Injury versus Sickness is a definition of Total Disability determined by its cause. Some policies may only cover (or cover differently) disability caused by accidental injury. And some policies may only cover (or cover differently) disability caused by sickness. The terms Total Accident Disability or Total Sickness Disability may be used.

3. The Separate Periods In a Disability Income Insurance Policy

There are **3** separate periods provided within a Disability Income Insurance Policy

1) The Probationary Period
2) The Elimination Period
3) The Benefit Period

Here's a closer look at those **3** periods:

A. Probationary Period

A **probationary period** is usually a part of most Disability Income policies. It is a period of time in which no benefits will be paid to the insured under the policy.

Typically, the **probationary period** is 15 to 30 days. This protects the insurance company from paying benefits to the insured for pre-existing conditions–health problems that existed prior to the inception of the policy. This period will occur only once in the life of the policy.

B. Elimination Period

This is a period of time between the onset of a disability and the actual date benefits begin. The length of the **elimination period** is chosen by the insured based on how long they think they can manage without income benefits after becoming disabled. Generally, choices range from 30 days to a year.

A longer elimination period can benefit the insured in **3** ways:

1) It keeps insurance premiums low. The longer benefits are deferred, the lower the premiums will be.
2) It can be combined with any additional benefits that may be provided by an employer
3) Choosing the proper **elimination period** allows the insured to use premium money to purchase a benefit package that best fits their needs

C. Benefit Periods

Policies may be written to pay benefits to the insured for varying lengths of time.

These **benefit periods** are classified in **2** ways:

1) **Short-term policies** might have benefit periods ranging from three months or perhaps up to two years. These policies, though, typically provide benefits for six months. Benefit amounts range from **50%** to **66 2/3%** of earnings before disability with a cap for maximum payout, and typically have a weekly benefit limit.
2) **Long-term policies** can pay benefits up to age **65** or even for life if disability results from an accident. The

caps for long-term policies vary. Again, just as with the elimination period, the longer the benefit period, the higher the premium. The shorter the benefit period, the lower the premium. However, the importance to the insurance companies is that the insured will return to work as soon as possible or practical

Note: A policy written for more than **2** years is usually considered long-term.

4. Other Disability Concepts

Here are some other Disability concepts you should know:

- Partial Disability
- Residual Disability
- Recurrent Disability
- Delayed Disability

Partial vs Total Disability

Partial Disability means the person can't perform one or more of their regular duties. Usually a partial disability lasts from 3-6 months. The person usually receives 50% of the total disability benefit for a partial disability. ***Total Disability*** means the employee—due to work-related injury or disease—will never be able to return to his/her normal job.

Social Security has the most stringent definition of total disability. That being the "inability to work at any substantial gainful occupation". Others might say "inability to perform duties for which

the insured is reasonably suited", or inability to engage in his own occupation".

Here's a closer look at those concepts:

A. Partial Disability

Partial Disability is when an individual cannot perform every duty of their job, but can perform one or more important duties of their occupation. Partial disability applies to accidental disability; however, some policies will pay benefits for certain illnesses. The partial indemnity is usually 50% of the weekly or monthly indemnity for total disability. It is possible for the insured to receive both Total Disability and Partial Disability benefits for the same accident.

Putting it into Context:

Max works in a factory as a shipping manager. His job duties include driving a lift truck and handling small packages to be shipped out. After severely injuring his back, Max is unable to drive a lift truck for four months. He would receive Total Disability benefits until he is able to return to work. However, after the four months, he is only capable of handling the lightweight packages and ship them. Max would receive Partial Disability benefits for a stated period of time in his policy.

B. Residual Disability

Residual Disability is usually a percentage of the Total Disability benefit for periods of partial disability as defined within the policy. Earnings are an important factor in a Residual Disability policy. During partial disability, earnings must be a stated percentage less than earnings prior to disability. The percentage will be stated in the policy (i.e., 20% of monthly benefits).

Putting it into Context:

The percentage of reduction in earnings would be multiplied by the normal monthly amount to figure the Residual Disability amount. If the usual monthly benefit for disability was $1,000, and the policy stated the Residual Disability amount was 25% of the monthly benefit, than the Residual Disability amount would be $250.

A **residual disability rider** pays benefits based on the loss of income due to a disability rather than the loss of an ability to perform work.

C. Delayed Disability

Delayed Disability occurs when a person is injured but not immediately disabled. The injury causes disability as time passes. The insured may still be eligible for Total Disability benefits later. Most Delayed Disability polices give either 20, 30, 60, or 90 day stipulations for when the disability manifests itself after the initial injury.

Putting it into Context:

Alba gets into a car crash on her way home from work one evening. No injuries are apparent at the time of the accident, so she resumes her life. Three days after the crash, however, her right knee begins to ache. After a week its clear that her right knee was severely injured in the accident, and Alba cannot report to work and she is totally disabled. Her Delayed Disability policy stipulates a period of twenty days. Alba could be entitled to Total Disability benefits.

D. Recurrent Disability

Many disability plans have a recurrent disability provision stating that if an insured goes back on disability within a certain period of time (usually after three to six months) it is

treated as one recurring disability rather than a second disability claim.

Disability Income Eligibility and Rating

Eligibility and ratings affect policy premiums and coverage. All are influenced by the following factors:

Age – A younger person is actually more likely to incur a job-related disability than an older person. On the other hand, older workers are more likely to be in poor health. The length of time a benefit lasts may be reduced for an older employee. Underwriters assess all factors in determination eligibility and rates.
Gender – Men are more likely to be injured on the job, but women have more health issues.
Income and elimination periods – A higher salaried person is more likely to survive a longer elimination period.
Job Classification – Occupation has a direct link to the cost of disability income coverage. Riskier jobs have a higher incidence of disabilities affecting both eligibility and premiums.
History – Medical history BOTH on and off the job are important to know. Someone with a preexisting condition might be more likely to be disabled and therefore likely to pay more or be rejected.
Avocation – A person with a high risk hobby is more likely to end up disabled.
Waiting periods – A longer waiting period before benefits begin means a lower premium. People able to financially survive longer waiting periods will get better deals.
Probationary Periods – The day the policy goes into effect tends to be longer for longer term benefit plans. The benefit of having a choice here is that it allows an insured to purchase a benefit that fits their needs.

IMPORTANT: No agent may alter any of the written application for any disability policy **without** the written consent of the applicant.

Disability Income Policy Provisions and Riders

Maximum and minimum benefits – benefits for an insured are based on a maximum or minimum wage, e.g., a benefit can be no more than 70% of your earned income, or 90% of the weekly average wage, or a minimum of 45% of the weekly average wage.
Notice of claim – a claim must be given to the insurer within a specified number of days from when it occurred, e.g., 20 days.
Automatic increase – benefit payments automatically increase each year based on a set schedule, e.g., 5% per year for the first 5 years.
Beneficiary – who benefits are payable to.
Own occupation -- if the insured's disability keeps them from performing their job, they can collect disability vs ***any occupation*** where the disability is the inability to perform duties of any occupation for which they are qualified.
Cost of living rider – higher benefits will be paid as the cost of living increases. No proof needed that your income is higher.
Benefit period – example: pays benefits up to 50% of earned the insured's wage; payable for a maximum of 5 years
Social insurance benefit rider – additional benefits can be paid if the insured does not qualify for Social Security disability benefits.
Benefit integration – all the insured's sources of income are factored. Coverage can be reduced if other sources exist.
Residual – a person can return to work but a residual condition keeps the person from performing all of their usual duties, which reduces the person's income.
Rehabilitation benefit – Additional benefits, beyond monthly income, are made to cover vocational rehabilitation.
Recurring disability – no additional benefits are paid unless the reoccurring disability is determined to be a new disability.
Transplants – If an insured donates an organ and it results in a disability benefits may be reduced or limited.
Standard exclusions – like most disability income plans, the policy contains certain standard exclusions like waiting periods, reductions, limitations, terms, etc.
Return of premium – requires the insurer to refund a portion of the insured's premiums if no claims are made for a specified period of time state din the policy.

GROUP HEALTH INSURANCE

Objectives

This unit covers Group Insurance.

This unit includes:

- Group Health Insurance
- Characteristics of Group Health
- Eligibility & Underwriting Issues
- Forms of Group Health
- Miscellaneous Group Health Legislation

Group Health Insurance

A Group Health Insurance Policy is probably the most familiar type of insurance to most people. It is part of a benefits package offered by employers, and covers a group of people, as opposed to an individual. Insurance companies usually require a minimum number of employees for coverage. This differs from state to state. Those covered in the group must have a common employer or other connection aside from obtaining insurance.

Characteristics of Group Health Insurance

Reference CIC 10270.5, 10270.505, 10270.55, 10270.57, 10753, 10753.05, 10755.

Basic Benefits: Like individual plans, the ACA requires all group health insurance plans to cover the ***10 essential health benefits***: Outpatient services, emergency services, hospitalization, maternity, mental health, prescription drugs, rehabilitation, laboratory services, preventative or wellness management and pediatric services.

Marketplace or Non-Marketplace: Group plans, like individual plans can be purchased in the marketplace (state exchanges) or bought as a non-marketplace plans.

Actuarial Plans: Group plans use the same actuarial values of individual plans, that is, they are identified by metal tiers: Platinum, Gold, Silver and Bronze. All group plans must have a minimum actuarial value of 60%. That means 60% of the cost of medical services must be paid by the insurer, leaving 40% to be paid by the member.

Employer Contributions: California employers must contribute at least 50 percent of the employee's premium

Employee Participation: Most insurance companies require that at least 70 percent of the eligible employees enroll in the group plan. Some Covered California plans require 100 percent participation. The purpose of requiring participation is to prevent "adverse selection" where people more prone to using medical care sign up. Certain employees can be "waivered" from participating where they are able to be covered through a different source, like coverage through a spouse's work, Medicare or Medi-Cal. Employees are likewise waivered if they have an individual plan, either through the exchange or private.

Affordable Coverage / Income Limitations: The ACA limits the amount they expect employees to pay for their portion of an employer sponsored health plan to 9.66% (2016) of household

income. An employer, who may not know an employees "total" household income can apply a ***safe harbor test*** by using the percentage above to the employee's W-2 wage.

Standard Benefits: Health insurance companies must offer identical plans to ALL groups, whether small or large

Standard rates: Premiums may be based on location of the business, age of employees and their dependents. So, a spouse age 56 may cost more than one aged 25.

12-Month Rate Guarantee: Once set-up, however, rates for small group plans are fixed for 12 months.

No Medical Underwriting: No one can charge more for an employee if they are sick.

Guaranteed Renewable: Policies may not be cancelled as long as they are paid.

Shared Responsibility: The ACA requires employers to share the responsibility of providing coverage or pay a penalty.

Tax Considerations: Employers are permitted too fully deduct their portion of premiums paid for an employer-sponsored group health plan. No portion of premiums paid by an employer are taxable to employees either

Discontinuance and Group Policies

Discontinuance is the termination of a policy or termination of coverage between an entire employer unit under a group disability policy. Policies shall include a reasonable extension of benefits upon discontinuance of the policy.

Group policies that replace a previous policy shall immediately cover all employees and dependents who were covered at the

Eligibility & Underwriting Issues

Anyone receiving a W-2 and has payroll taxes deducted is eligible to participate in a group health plan as long as they average 30 hours or more of work per week over a course of a month. 1099 service people or independent contractors are NOT eligible as there is no employer-employee relationship.

Small Groups (1-to 100 Employees)—*This used to be 1-50 employees prior to 1/1/16.*

State and Federal law require group health to be sold on a ***guaranteed issue*** when the small group meets participation and various underwriting requirements. Issuers, for example, may not require an applicant or dependent to fill out a health assessment or questionnaire prior to enrollment in a plan. Issuers may not impose coverage exclusion or limitation because of a pre-existing condition.

Eligible employees are those working an average of 30 hours per week over the course of a month. However, coverage can be denied if eligible employees DON'T live, work or reside in the issuer's service area.

Certain ***tax credits*** can be awarded to employers who offer affordable health insurance with 25 or fewer employees; employees who earn less than $50,000 per year or who purchase plans through the state exchange SHOP program (California Covered).

Employers with fewer than 100 full time employees face no penalty if they don't ***sponsor*** a group health insurance plan or if the coverage is considered unaffordable. Fewer than 100 employers do not report anything to the IRS to stay compliant. The insurer for the employer does that using Forms 1094-B and 1095-B.

Large Groups *(100+ Employees)*

Large group underwriting establishes ***occupational class*** groups. A company, for example, may have a plan for full time salaried employees that is different from full time hourly employees. Benefits and premiums can vary between the two policies. The ***group size and prior claims experience*** are also factors determine benefit and premium packaging.

Penalties WILL BE assessed if a large group ***fails to offer*** "minimum essential coverage" for their full time employees. Large group employers must keep track and report to the IRS the status of their employees regarding group coverage eligibility and enrollment.

Waiting Periods

The ACA prohibits a group health plan from applying a waiting period before an employee's health coverage becomes effective that

exceeds 90 days. All calendar days are counted towards the waiting period. Nothing prohibits an employer from applying different waiting periods for different classes of employees. For example, an employer could apply a 60-day waiting period for hourly employees and a 30-day waiting period for salaried employees.

Waiting period **–**
A waiting period is a period of time that must pass before coverage under a company's group health plan becomes effective for an eligible employee.

Benefit provisions allow companies to select certain groups within their organizations to receive different benefits under a group plan. One example involves salaried versus hourly employees. The insurance company and the employer must agree upon these special benefit provisions.

A Contributory Plan requires that employees pay part of the premium for their insurance benefits. This is the familiar payroll deduction for insurance, something we are all familiar with. It is important to note that at least **75%** of eligible employees must participate in this plan.

A Noncontributory Plan is one where the employer pays all premiums. The employee pays no part of the premium. It is important to note that **100%** of all eligible employees must participate in such a plan.

Putting it into Context:

Robert works as a customer service rep for an electronics company. His company has a Contributory Plan. Every week, a certain amount is withheld from his paycheck to cover his portion of the insurance policy premium. Garrett, however, works as a welder for a company that has a Noncontributory Plan. His employer pays the entire premium for him and the entire company, and nothing is withheld from his paycheck.

Forms of Group Health

Like any other insurance, group health insurance takes on many forms:

- Health Maintenance Organizations (HMO)
- Preferred Provider Organizations (PPO)
- Point of Service (POS) plans
- Exclusive Provider Organization (EPO)
- Self-Funded Plans

These organizations and forms are generally classified as ***managed care systems***. There are also ***consumer-driven plans*** which we will discuss later. Back to the managed care forms, there are important distinctions, such as:

(HMO) Health Maintenance Organizations control medical costs and encourage preventative health and early treatment. It is a combined network of medical professionals who have contracted an agreed price for providing medical and health services. An important

distinction between HMO's and other health care policies is the insured receives both the Health Care coverage and the Health Care service from the HMO.

Members of HMO's have a copayment that is due at the time of service. These plans usually operate under the gatekeeper system, the member must choose a Primary Care Physician, who is then responsible for managing all healthcare. Pre-authorization and prior approval is part of the managed care concept.

HMO's are required to provide:

- Doctor's services
- Hospital inpatient care
- Hospital outpatient care
- Diagnostic/X-Ray Services
- ER Services
- Preventive Care Services
- Diagnostic lab testing and services

Services HMO's provide under most group policies include:

- Prescription drug plans
- Vision coverage
- Dental services
- Home health coverage
- Nursing care/Long-term care
- Mental health resources
- Substance abuse coverage

Putting it into Context:

Drew is a member of an HMO. After hurting his knee during a weekend tennis game, he schedules a visit with his primary care physician (PCP). Drew's PCP approves a referral for Drew to visit a physical therapist to help heal his knee. Drew's HMO policy would cover all medical expenses, besides Drew's monthly premium and $20 copayment each time he receives medical service.

(PPOs)Preferred Provider Organizations are another type of health care organization designed to control costs. It is an agreement between independent medical practitioners and hospitals within a certain region or state. There is a contract to provide medical services at a discounted rate.

Members choose from a list of approved physicians provided by the **PPO**. Generally, members have more choices in a PPO than a HMO. Health care providers receive a guaranteed amount for each time they provide service: known as a fee-for-service basis. This attracts participating providers because of the potential increase in the number of patients they service.

The **PPO** will only pay out full benefits when a member uses the Preferred Provider. When a non-preferred provider is used, it may require a higher deductible or co-payment.

(POS) Point of Service plans. These major medical plans are a hybrid of the PPO and HMO models. They are more flexible than HMOs, but do require you to select a primary care physician (PCP). Like a PPO, you can go to an out-of-network provider and pay more

of the cost. However, if the PCP refers you to an out-of-network doctor, the health plan will pay the cost.

(EPO) Exclusive Provider Organization. These forms are a lot like HMOs. They generally don't cover care outside the plan's provider network. But, members typically do not need a referral to see a specialist. EPO plans may also have lower negotiated rates than do HMOs or PPO plans.

Consumer-Driven Health Plans (CDHP). Insurance carriers, employers, and individuals are showing increasing interest in consumer-directed health plans (CDHP). CDHP's combine a high-deductible health plan with a health reimbursement arrangement (HRA) or health savings account (HSA) or Flexible Spending Accounts (FSA). All are tax-advantaged accounts used to pay health care expenses, and unused balances may accrue for future use, potentially giving enrollees an incentive to purchase health care more prudently. The plans are a form of self-funding and also provide decision-support tools to help enrollees become more actively involved in making health care purchasing decisions.

High Deductible Health Plan (HDHP) is a health insurance policy that requires the enrollee to pay for most medical expenses up to a certain dollar amount before the insurance policy begins to cover them. Certain deductible and out of pocket maximums apply. But, it can get complicated where a family has a group plan covering some individuals and different group or individual plans for other family members. To compensate for this, ACA provides for an embedded out of pocket.

OUT OF POCKET EXPENSES?

Out of pocket expenses include deductibles, coinsurance, copayments and any other required expenditures

Basically, this means that an employee who is part of a family plan and incurs out of pocket expenses for herself won't pay more than the same out of pocket she would incur for an individual plan. Current (2016) out of pocket maximums for HDHP plans are $6,850 for an individual and $13,700 for a family. These amounts are also adjusted annually for inflation. Money spent on medical expenses that are not covered by the HDHP will not be counted towards the plan deductible.

Out Of Pocket Rules for HDHP Plans. Embedding?

ACA says that if a family member incurs costs that exceed the limit she would pay for her own individual plan, the employers health plan must pay 100% of that family members remaining expenses, even if the total of all out of pocket expenses for all family members have not reached the cost-sharing limit for family coverage. The ACA calls this "embedding" an out of pocket limit in the group health plan.

EXAMPLE Suppose an employee and spouse enroll in family coverage with an annual out of pocket limit of $13,700, and during the 2016 plan year, the employee has $7,000 of out of pocket expenses, the spouse has $5,00 and their child $2,000. Under new ACA guidelines, the employees's out of pocket expenses are capped at the individual limit of $6,850 (the plans pays $150), the spouse pays $5,000 because $6,850 + $5,000 is still less than the $13,700 family out of pocket max (the plan pays $0), and for his child, the employee pays $1,850 because $6,850 + $5,000 + $1,850 reaches the $13,700 family maximum out of pocket. So, overall, the plan pays out only $150.

Self-Funded Health Plans are a self insurance arrangement where an employer provides health or disability benefits to employees with its own funds. This is different from fully insured plans where the employer contracts an insurance company to cover the employees and dependents. In self-funded health care, the employer assumes the direct risk for payment of the claims for benefits. The terms of eligibility and coverage are set forth in a plan document which includes provisions similar to those found in a typical group health insurance policy. Unless exempted, such plans create rights and obligations under the Employee Retirement Income Security Act of 1974 ("ERISA").

Health Savings Account (HSA) HSA's are tax-exempt accounts set up by an employer or individual to pay eligible health care expenses including insurance deductibles, co-payments and other out-of-pocket expenses. HSAs give employees more control over their health care money and employers are generally pleased with their own reduced compliance burden when compared to other benefit programs like flexible benefit plans. An HSA must be established with a high deductible health plan so that the HSA is used to pay routine expenses, and the plan is used to pay more significant expenses. HSA's were created to replace Medical Savings Accounts (MSA's), another special account used to pay eligible health care expenses.

Employers that want to allow employee pretax payroll deferrals into an HAS must first establish a Section 125 cafeteria style plan which allows the employee a choice of tax enhanced benefits, including health cae, life insurance, dependent care and, of course, HSA

contributions. An HSA custodian or trustee stands between the employee and the employer, usually a bank. His job is to account for deposits and distributions from the HSA. HSA's allow employers and consumers to set aside funds on a tax-free basis to pay health care expenses, including expenses that may not be covered by traditional health insurance.

For example, HSA's may be used to cover:

- Vision and dental services
- Prescription drugs
- Over-the-counter drugs
- Long-term care services
- Certain health insurance premiums in retirement

Medical Savings Account (MSA) The MSA was the predecessor to HSA's, employers allowed employees to set aside money into a special "medical" savings account, earmarked to pay eligible health care expenses, including the policy deductible. In order to open a MSA you must have health insurance coverage. This coverage can be either a group, or an individual policy. Like HSAs,, money kept in the account is allowed to grow without tax.

Starting in 2004, MSA's began being phased out in favor of HSA's. And, someone with an existing MSA can still roll it into an HSA. Overall their popularity has waned, few people even know what they are. In an odd twist they remaine available (in some states) to Medicare enrollees who can't open an HSA. Alas, NO Medicare MSAs are available in California.

Health Reimbursement Account (HRA) Health reimbursement accounts are a plan that reimburses employees for qualified medical expenses. The U.S. Department of the Treasury issued guidance on health reimbursement accounts in a revenue ruling in June 2002. Because these plans are just emerging, their designs are still evolving. Health reimbursement accounts consist of funds set aside by employers to reimburse employees for qualified medical expenses, just as an insurance plan will reimburse covered individuals for the cost of services incurred. The guidance provided by the Department of the Treasury makes it clear that health reimbursement accounts are not a new type of account designated within the Internal Revenue Code. Rather, employers qualify for preferential tax treatment of funds placed in a health reimbursement account in the same way that they qualify for tax advantages by funding an insurance plan. Employers can deduct the cost of an insurance plan, and now a health reimbursement account, as a business expense under Internal Revenue Code section 162. Health reimbursement accounts are open to employees of companies of all sizes, unlike medical savings accounts that are only available for small business employees. A health reimbursement account provides "first-dollar" medical coverage until funds are exhausted. For example, if an employee has a $500 qualifying medical expense, then the full amount will be covered by the health reimbursement arrangement if the funds are available in the account. Under a health reimbursement account, the employer provides funds, not the employee. All unused funds are rolled over at the end of the year. Former employees, including retirees, can have continued access to unused reimbursement amounts. Health reimbursement accounts

remain with the originating employer and do not follow an employee to new employment.

Flexible Spending Account (FSA) Health care flexible spending accounts are employer-established benefit plans that reimburse employees for specified medical expenses as they are incurred. These accounts are allowed under section 125 of the Internal Revenue Code and are also referred to as "cafeteria plans" or "125 plans." The employee contributes funds to the account through a salary reduction agreement and is able to withdraw the funds set aside to pay for medical bills. The salary reduction agreement means that any funds set aside in a flexible spending account escape both income tax and Social Security tax. Employers may contribute to these accounts as well.

There is no statutory limit on the amount of money that can be contributed to health care flexible spending accounts. However, some companies place a limit of $2,000 to $3,000 on flexible spending accounts. Once the amount of contribution has been designated during the open enrollment period that occurs once each year, the employee is not allowed to change the amount or drop out of the plan during the year unless he or she experiences a change of family status. By law, the employee forfeits any unspent funds in the account at the end of the year. There have been proposals introduced in Congress to ease this "use it or lose it" rule by allowing up to $500 to be carried over to the next year; such proposals have not been enacted.

Coverage For Dependents and Domestic Partners

Generally, coverage must be offered to an employee's legal spouse and dependent children. Group insurance plans must extend coverage for all adult children of the employee up through age 26.

Coverage may also be extended to unmarried domestic partners of employees. If the employer chooses to do this, coverage to the domestic partner must match the coverage extended to spouses. Employees must sign an affidavit of domestic partnership to establish that they are living in a committed relationship and intend to stay that way indefinitely (Section 10121.7).

Any dividends or refunds from a group policy shall be applied to the benefit of insured employees or their dependents (Section 10270,65)

Blanket Insurance

Blanket insurance in common in health, business and home policies. In the health arena, blanket coverage is that form of health insurance covering groups of people under one blanket policy. A group policy at work covering all full-time employees is a form of blanket insurance. When the ACA requires individual health plans to cover dependent children through age 26, that is another form of blanket insurance.

Other Legislative Issues that affect group policies include the following:

ERISA (Employee Retirement Income Security Act) – Private and union plans are protected where those managing the plan are considered fiduciaries with specific responsibilities under the law.

COBRA (Consolidated Omnibus Budget Reconciliation Act) – Provides former employees, retirees, spouses and dependent children temporary continuation of health coverage at group rates if the employee is terminate. Applies to companies with 20 employees or more. COBRA requires that companies with more than 20 employees offer extended health coverage to departing employees for up to 18 months, and that this offer be extended to the employee within 60 days after the termination of group coverage. COBRA coverage may be offered at the group rate or at a higher rate. Continuation of coverage does not require a medical exam or proof of insurability. This same extension includes the terminated employee's covered dependents named on their group policy.

ADA (Americans With Disabilities Act) Under ADA, an employer must continue health insurance, at the same level of benefits, for an employee taking leave for a medical treatment so long as the employee continues to pay his portion of the premiums.

Cal-COBRA – California health coverage legislation requiring employers with 2 to 19 employees to provide them and their dependents the right to continue health coverage after a qualifying event.

FMLA (Families and Medical Leave Act) and ADA (Americans with Disabilities Act) – Both required a covered employer group plans to

grant medical leave to an employee in certain circumstances, e.g., pregnancy, serious health condition, dependent care, etc. ADA prohibits discrimination against a person regarded as having a disability. FMLA applies to companies of 50 employees or more. ADA applies to companies of 15 employees or more.

HIPPA (Health Insurance Portability and Accountability Act of 1996) – Imposes privacy requirements on health plans. Portability provisions prohibit plans from discriminating against enrollees on the basis of health status. The Health Insurance Portability and Accountability Act (HIPAA) of 1996 provides rights and protections for participants and beneficiaries in group health plans regarding portability and continuity of health insurance coverage.

HIPAA includes protections for coverage under Group Health plans that:

- Limit exclusions for preexisting conditions
- Prohibit discrimination against employees and dependents based on their health status
- Allow a special opportunity to enroll in a new plan to individuals in certain circumstances
- HIPAA may also give you a right to purchase individual coverage if you have no group health plan coverage available, and have exhausted COBRA or other continuation coverage

Pregnancy Discrimination Act Discrimination on the basis of pregnancy is a violation of the Civil Rights Act. California law goes further by provides significant protection for pregnant employees. Discrimination and harassment are prohibited and employers must

allow a pregnant employee a leave of absence Any health insurance provided by an employer must cover pregnancy expenses and related conditions on the same basis as expenses for other medical conditions.

Mental Health Parity Act. Health insurers must provide equal coverage for physical AND mental health conditions. That means the same co-payments, co-insurance, deductibles, out of pocket expense, medications, visits and days of coverage.

PPACA Affordability. Under the Patient Protection and Affordable Care Act, large group employers (100 full time employees and more) are now subject to Employer Shared Responsibility penalties if they do not offer affordable health coverage or coverage meeting certain minimum standards.

Other California Specific Regulations

CIC 10202 Eligible Groups: Persons eligible for insurance shall be all of the employees of the employer or unions members. This can include retired employees and the company partners (if actively engaged in the business) as well, but not a board of director.

CIC 10203.4 Dependents: "Dependent" includes a member's spouse and all unmarried children from birth through 20 years of age or age 24 is the child is attending an education institution or a child age 21 years of age or older who is mentally retarded or physically handicapped and dependent upon the employee for support.

CIC 10200 Policy Types: Any life insurer may issue life, disability, term and endowment insurance for a group plan, with or without annuities, and with premium rates less than the usual rates.

CIC 10206 Contestability – Group policies are not contestable (subject to cancellation for misrepresenting information on an application) after two years of being issued, except for non payment of premium.

CIC 10206.5 Liability Limits – insurers are not responsible or have limited liability for losses due to war, military service or aviation accidents.

CIC 10208 Mistatement of Age – an equitable adjustment can be made for any misstatement of age.

CIC 10209 Certificate of Coverage – employees are entitled to a certificate of coverage stating the protection being provided and that continued and equal coverage is available without insurability upon the employees termination upon payment of applicable premiums and an application by the insured in 31 days.

CIC 10209 Conversion– employees who are entitled, may convert their group plan to an individual plan without evidence of insurability subject to making application and paying premiums.

CIC 10220 Blanket Insurance – Blanket insurance in the health arena is that form of health insurance covering groups of people under one blanket policy. When the ACA requires individual health

plans to cover dependent children through age 26, that is a form of blanket insurance. A group policy at work covering all full-time employees is another form of blanket insurance. . In California, blanket policies may be issued for a term not exceeding one year

END SECTION

Study Required Minutes before taking the Section Quiz. Answer all questions correctly on the Quiz to move to the next Study Section. Re-take Quiz if needed.

√ **Search this section using CTRL+F**
√ **Please study required minutes before taking Section Quiz**
√ **CAUTION: 20-Minutes or more idle time (no study activity) will cause disconnection and loss of study session minutes**

Section AH 3

LONG TERM CARE & WORKERS' COMPENSATION

Objectives

Today, health care is a rapidly changing area of insurance. This is especially true for long tem care and workers' compensation policies. Consumers have many misconceptions about long term care, including false assumptions that long term chronic care is covered by their health insurance or Medicare. Likewise, the workers' compensation system has been laundered through major state reforms, creating a real need for you to educate the public.

LONG TERM CARE INSURANCE

1. What is Long Term Care?

Long Term Care (LTC) is becoming perhaps the most important type of health insurance in the U.S. As a large portion of the population nears their twilight years, funding for programs and policies to provide **LTC** is getting a lot of attention.

Generally, when discussing **LTC**, we mean long-term institutional care (nursing home, convalescent facility, extended care facility, custodial care facility, skilled nursing

facility or personal care home) as well as ***home care*** coverage (home health care, personal care, homemaker services, hospice or respite care).

A Legal Definition of Long Term Care Insurance

The State of California determines that you are legally selling long term care insurance if the policy you are marketing includes:

- Coverage for diagnostic, preventative, therapeutic, rehabilitative, maintenance or personal care services that are *not* provided in a setting other than an acute care unit of a hospital.

- Products containing coverage for *institutional care* (nursing home, convalescent facility, extended care facility, custodial care facility, skilled nursing facility or personal care home); *home care* coverage (home health care, personal care, homemaker services, hospice or respite care).

- Long-term disability care, but not policies designed to cover Medicare supplement or major medical expense coverage.

Long Term Care Coverage

Long term care insurance can be issued on an individual basis, through group plans or as an ***endorsement to a life policy or annuity contract.*** Long term care coverage is not necessarily uniform. Policies may cover a ***range of daily expenses and/or policy limits*** based, resulting in a range of premiums.

The National Association of Insurance Commissioners developed a model to address the key issues:

- A benefit period of at least one year
- A free-look period
- Prohibitions of exclusions against Alzheimer's patients
- Standards for preexisting conditions
- Strict restrictions on cancellation, cancellation due to aging, guaranteed renewability

Why is Long Term Care Insurance Needed?

LTC issues have made consumers more aware of the importance of this type of policy. Many people are not eligible for Medi-Cal and Medicare and Social Security do not cover LTC. The statistics are a wake-up call:

- **1** in **4** people over **65** will spend some time in a nursing home
- **1 in 3** people over **85** will spend some time in a nursing home.

The average cost for nursing home care (**LTC**) is approximately between **$4000** and **$6000** a month, and these costs continue to grow.

Note: Medicaid plans do not provide enough coverage for nursing home care and yet, according to statistics, they pay more than **40%** of nursing home care in the US. It's becoming more and more important to prepare and plan for **LTC**.

A. Risk Assessment

LTC policies differ from standard health policies in many ways, but especially in respect to risk assessment. This makes sense, since the insured group in an older group of people. A standard Health insurance policy would classify an individual with heart disease or cancer as extremely high risk, thus affecting their coverage. But with **LTC**, the classifications lie with the individual's ability to perform the **activities of daily living (ADLs)**:

- Dressing
- Bathing
- Eating
- Walking
- Continence
- Generally caring for oneself

Putting it Into Context:
Dean, aged 72, is confined to a nursing home facility because of diabetes. Dean has an **LTC** policy he purchased ten years ago. While he is in need of nursing home care and is very ill, he is still able to walk and feed himself. Dean would be classified as a standard risk under his **LTC** policy. However, under a major medical policy, Dean would be classified as a substandard risk and might not receive the same level of benefits as he gets under his **LTC** policy.

Note: If an LTC applicant is 80 or older, he/she is required to provide one of the following:

- Report of a physical examination
- An assessment of functional capacity
- An attending physician's statement
- Copies of medical records

Qualified vs. Non-Tax Qualified LTC Policies

Individual and group LTC policies can be sold as Tax Qualified and Non-Tax Qualified.

Tax Qualified Policies -- Intended to be federally qualified long term care contracts must comply with ***IRS***

97-31 definitions and provide that the ***chronically ill*** insured qualifies for benefits if there is:

1) Impairment in two out of six activities (ambulating is now added to TQ policies in California) of daily living expected to last at least 90 days
2) Impairment of cognitive ability needing substantial supervision

Non-Tax Qualified Policies -- In every long term care policy or certificate that is NOT intended to be federally qualified the insured must qualify for benefits if either of the following criteria are satisfied:

1) Impairment in ***two of seven*** activities of daily living .
2) Impairment of cognitive ability.

C. Benefit Triggers

This is the beginning of the benefit process under an **LTC** policy. These triggers, as follows, are defined by federal law:

- The inability to perform a minimum of two ***activities of daily living (ADL's).***
- ***Cognitive impairment*** or loss of abstract reasoning that requires supervision or assistance. This includes Alzheimer's and other mental dysfunctions with medical causes

All of these benefit triggers must be substantiated by a physician who deems the individual chronically ill. This is a qualified **LTC** policy. *Non-qualified* **LTC** polices do not have to conform to these federal standards. This distinction is important at the time of purchase of an **LTC** policy.

2. Places For LTC Services &The Different Levels of LTC

There are different facilities and levels regarding the type of **LTC** one receives and what a policy will cover:

- **Skilled nursing homes**, which means nursing and rehabilitative care is required daily.

- **Assisted Living Facilities (Intermediate nursing care) ,** can be nursing home facilities where custodial care and occasional nursing care are provided.

- **Residential Care Facilities for the Elderly** can be single family residential homes in various neighborhoods where up to 6 individuals receive organized custodial care by a central staff.

- **Home health care** are services performed in the person's home (nursing, household concerns, help with **ADL's**).

- **Adult day care** is a service for anyone who works during the day but also cares for an elderly relative. Adult day care provides company, supervision, and recreational

support during the day for those who live at home but need assistance.

- **Community based LTC services** can be provided by local government, social service agencies or private companies. Examples are adult day care, senior centers, transport services, meals programs and respite care.

- **Custodial care** is help with **ADL's** that can be provided by an individual without specialized medical training or skills.

- **Respite Care** gives family members who are looking after elderly relatives a break from care-giving.

- **Hospice Care** is provided at the home or at a care facility for terminally ill people, usually who have 6 months or less to live.

Note: Custodial care is the most common level of care, and it's also the type of care Medicare doesn't cover.

3. Common Provisions

The following provisions are commonly included in LTC policies:

Youngest and oldest ages

This specifies when **LTC** policies may be purchased, with the minimum usually around 55 and the upper age range between 69-89. However, **LTC** policies are currently being sold to people much younger than 50.

Renewability

Most **LTC** policies are guaranteed to be renewable and cannot be cancelled except by failure to pay the premium

Premiums

The younger the individual at the time of purchase, the lower the premium. Most **LTC** policies have a level, premium that cannot be raised individually. Premiums depend on age when purchased, amount of benefits, level of care covered.

Waiver of premiums

After **90 days** (may be longer, depending on the policy), polices may include a waiver of premium after the insured is receiving care

Note: **Prior hospitalization** is no longer required for **LTC** benefits to be paid.

Care level

This refers to what benefits the policy will pay towards custodial, skilled nursing, or intermediate care when entering a nursing home.

Respite care

This will cover the cost of replacing a primary caregiver for a short period, usually a day or a weekend.

Home health care

Most **LTC** policies cover this type of care as an alternative to nursing homes.

Adult day care

The day care may be provided in the home for an elderly person while the primary caregiver, usually a relative, works.

Benefit amount

This refers to the maximum daily benefit for nursing home care of home health care. Higher daily benefits mean higher premiums.

Benefit periods

This refers to the maximum period for which benefits will be paid, usually from **3 to 5** years. Some polices have unlimited benefit periods.

Preexisting conditions

This is a determining factor in the type of **LTC** policy an individual purchases. Some don't cover preexisting conditions that existed **6 months** before the effective date of the policy.

Exclusions

These depend on the type of policy purchased. Most exclusions include acts of war, alcohol or drug abuse, mental illness or self-inflicted injuries.

Inflation protection

Some **LTC** policies include automatic percentage increases in benefits every year or an opportunity to purchase higher benefit levels for a higher premium.

Elimination period

The period after the onset of a loss and benefits are not paid. The longer the waiting period, the lower the premium.

4. Suitability Standards

California law (SB 1052) introduced an entire insurance code devoted to ***client suitability standards.*** Insurance companies must immediately develop and train agents in the use of suitability standards and make them available to the Insurance Commissioner. In determining client suitability for long term care insurance or replacement/conversion of same, the agent and insurer shall consider the following:

1) The ability to pay (***affordability***) for the proposed coverage and other pertinent financial information related to the purchase of the coverage;
2) The applicant's ***goals or needs*** with respect to long term care and the advantages and disadvantages of insurance to meet these goals or needs;

3) The ***value***, benefits and costs of the applicant's existing insurance, if any, when compared to the values, benefits and costs of the recommended purchase or replacement.

5. **Marketing Standards & Responsibilities**

10234.93 -- To solicit or sell long term care policies in California, agents must take an ***8-hour certification course*** where many stringent laws, guidelines, suitability issues and disclosures require diligence and compliance. New agents (in business for less than 4 years) must repeat this course every year for the first 4 years in business. Senior agents (more than 4 years in business) must repeat this course every renewal period (every 2 years).

Agents must also provide prospective applicants for LTC insurance a copy of the ***long term care shoppers guide*** (California Department of Aging) as well as the number of ***HICAP*** (Health Insurance Counseling and Advocacy Program) at (800) 434-0222 where applicants can receive free advice on their LTC choices.

10234.8 – Agents and insurers of LTC owe policyholders and applicants a duty of honesty and duty of good faith and fair dealing.

10237.1 and 10237.5 – A prospective LTC policyholder must be given the ***option to purchase inflation protection*** where benefit levels can keep pace with anticipated increases in the cost of long term care at not less than 5 percent compounded annually. A ***special form*** is required to be signed by any applicant who rejects this inflation protection.

6. **California Partnership for Long Term Care**

California is also one of many states that has introduced ***partnership*** programs between the state and private insurance carriers. The goal of the California Partnership for Long Term Care program is to find a workable solution to the problem of financial impoverishment that happens when long term care expenses hit low-to-middle income families. In addition to traditional long term care benefits, these policies usually carry an ***asset protection feature*** that assures the beneficiary that he or she will keep a certain amount of assets and STILL qualify for Medicaid or Medi-Cal programs.

7. **Consumer Protection**

10234.8 -- Agents and insurers of LTC owe policyholders and applicants a ***duty of honesty and duty of good faith and fair dealing***.

10234.85 – Agents shall not cause a policyholder to replace his long term care insurance policy unnecessarily, especially if it will result in decreased benefits and increased premiums. ***Unnecessary*** is a 3rd policy sold to a policyholder within any 12-month period.

10234.9 – Advertising designed to produce leads must prominently disclose "an insurance agent will contact you" if that is the case. "***Cold lead***" advertising (methods to disguise the real purpose) must also disclose their purpose is to sell long term care insurance.

10234.97 -- In ***any replacement situation***, keep in mind that agent ***commissions are limited*** to the difference between replacement and original coverage so long as the insurer declares that a "material improvement" in policy benefits has taken place. Commission or compensation includes renumeration of any kind, including, but not limited to bonuses, gifts, prizes, awards and finder's fees.

WORKERS' COMPENSATION

In California, Workers Compensation **coverage is mandatory,** even if the employer only has one employee. There are of course exemptions such as certain domestic employees, charity or volunteer workers, and certain other workers.

There are 3 ways an employer can obtain Workers Compensation coverage:

1) Obtain Workers Compensation from a private insurer
2) Obtain Workers Compensation from a state fund

Note: The California State Compensation Insurance Fund, which is also referred to as the state fund, is an insurer run by the state. The state fund competes with private insurers within the insurance marketplace, for Workers Compensation business. Sometimes, if someone can't obtain Workers Compensation insurance, they'll go to the state fund as a last resort. Despite that, the state fund is still considered competitive with the private insurers.

3) Self-insurance

Premium determination may be based on the job or job classification. The employer pays total payroll and premiums.

A. Workers Compensation Benefits

The types of benefits that are provided under Workers Compensation are:

- **Medical benefits** are provided without limiting the time or dollar amount for all necessary medical/surgical expenses.
- **Income benefits** are provided for employees who've suffered work-related disabilities. There is a **3**-day elimination period, and if the disability continues for **14** days, Workers Compensation benefits are then paid. The benefits are paid retroactively to cover the waiting period as well. For permanent total or temporary total disabilities, the maximum weekly benefit is **66 2/3%** of the worker's weekly income.
- **Death benefits** include burial expenses and these benefits provide income for the surviving dependents in **2** possible ways:
    1) **Lump Sum Burial Allowance**—this method is determined by the number of dependents and how financially dependent they were on the deceased.
    2) **Weekly Income Benefit**—the maximum weekly benefit is **66 2/3%** of the deceased's weekly income.

- **Rehabilitation Benefits**—this method helps to rehabilitate or retrain a disabled person to allow them to

return to work as quickly as possible. This could include paying the expense of altering their lifestyle to incorporate the disability, or it could include vocational training, which trains the disabled person for a completely new job.

B. Workers Compensation Exclusions

The following exclusions apply to Workers Compensation:

- Intentional injuries, either self-inflicted, via prank, or otherwise
- Injuries resulting from intoxication
- Injuries resulting from the employee's failure to use provided safety equipment
- Pain and suffering

C. 24-Hour Coverage

24-hour coverage is the joint issuance of a workers' compensation policy with a disability insurance policy, health care service plan contract, or other medical insurance coverage for non-occupational injuries and illnesses. The concept of combing coverage is unique in that it allows an employer to control care by directing to physicians within a network. This can save costs and reduce fraud and abuse.

An accident and health agent is authorized to sell 24-hour coverage and has completed a course, or seminar of an approved continuing education provider, and proctored examination on Workers' Compensation and general principles of employer liability.

D. Employers Liability

Employers Liability protects the employer when injuries are not covered by Workers Compensation. Employers Liability insurance provides coverage for:

- Lawsuits brought by injured employees
- Lawsuits brought by the family/dependents of injured employees
- Legal defense expenses
- Employee's who aren't eligible for Workers Compensation
- Other supplemental benefits

Exclusions to Employers Liability:

- Contractual Liability
- Anything that's covered under Workers Compensation, Unemployment Compensation, or Disability
- If the employer intentionally caused the injuries
- If the injury happened outside the boundaries of the US, US territories, or Canada
- If a violation of employment laws caused the damages
- Any lawsuits brought by injured employees who were hired illegally
- Work-related injuries to an employee who was knowingly hired illegally

E. Common Law Duties

Employer/Employee relationships and employer obligations have changed since the time of the Industrial Revolution. Prior to the enactment of legislation, this relationship was based on

common law, that is, case law as handed down by a court resulting from litigation.

Employers had to be negligent and were sued for any injury or death.

The Common Law **Duties** owed to employees included:

- A safe workplace
- Competent and trained workers
- Warning employees of any dangers or hazards
- Safety procedures

F. Employer Defenses

Employers raised some of the following defenses to prove they aren't liable:

- **Fellow Servant/Employee Rule** states that if one of the injured worker's fellow worker directly caused the injury, then the worker is liable, and not the employer.
- **Contributory Negligence** means if the injured worker was even a tiny bit responsible for the injury, the employer can't be held liable.
- **Assumption of Risk** means that the injured worker knew the rules or the possible dangers, and went ahead and did it anyway. Therefore, the injured worker is liable for their own injuries.

6. Advertising

Each insurance company must establish and maintain a demonstrable system of control over the content, form, presentation, distribution, and dissemination of all such **advertisements** of the policies they offer. All such

advertisements, regardless who may have produced, created, or disseminated them, remains the responsibility of the insurance company whose policies are being **advertised**.

Alert!

The final exam may ask you who is responsible for the content in a commercial. The answer, as we discussed above, is the insurance company is responsible for the content in the commercial. We're drawing special attention to that point, because the exam wants to make sure you know that inaccurate advertising can't be blamed on anyone other than the company paying for the advertisement.

Advertisements have to be clear and complete in order to avoid outright deception, or unintentional confusion. The Commissioner can decide that an advertisement is misleading. This decision is based on the impression the advertisement is likely to make on any potential buyers.

END SECTION

Study Required Minutes before taking the Section Quiz.
Answer all questions correctly on the Quiz to move to the next Study Section. Re-take Quiz if needed.

√ **Search this section using CTRL+F**
√ **Please study required minutes before taking Section Quiz**
√ **CAUTION: 20-Minutes or more idle time (no study activity) will cause disconnection and loss of study session minutes**

Section AH 4

SPECIAL AND LIMITED POLICIES

Objectives

In this unit we will review Special and Limited insurance policies. Examples of these types of policies can include dental plans, accidental death and dismemberment coverage (AD&D), vision, and travel insurance. Although most of these policies are covered under Group Health Insurance, it's important to know that these are limited policies that provide special coverage.

This unit includes:

- Dental Care Insurance
- Vision Coverage
- Prescription Drug Benefits
- Accidental Death and Dismemberment
- Dread Disease
- Critical Illness
- Travel Accident Insurance
- Hospital Income Insurance

1. Dental Care Insurance

Dental care coverage is increasingly offered as part of a group insurance policy. Usually, these claims are handled separately from basic health claims. A different insurance company may even provide coverage under a specific employer's group plan. Like health coverage, dental usually has a copayment, probationary

period and yearly deductible–although, they are usually separate from health claims.

Some dental care policies are **scheduled**. That is, they will pay a predetermined maximum amount towards specific dental procedures.

However, many dental coverage policies work much like **comprehensive** medical health expense policies. Comprehensive dental policies provide routine care, with no deductibles or coinsurance, in order encourage individual preventative dental care. This is an effort to keep overall costs down. There is usually a maximum dollar amount payable per year for the policy. Sometimes this maximum applies to each family member covered, and there may be a lifetime maximum per individual.

Putting it into Context:
Troy is a math teacher at a local high school, and he has dental coverage for himself, his wife and their two children. Troy's wife Bria, during a routine biannual checkup, finds out from their dentist that she needs a crown on one of her lower teeth. While the routine checkup results in no out-of-pocket expense, the dental plan states it will cover 50% of the cost of the crown. Troy and Bria will have to pay the remainder.

Routine dental procedures typically include:

- Teeth cleanings
- Fluoride treatments
- Routine checkups

- Diagnostic X-rays
- Examinations
- Preventative care

It is important to note that many, non-routine dental procedures may not be covered under some plans:

- **Restorative** – the repair or restoration of damaged dental work
- **Oral surgery** – surgery performed in the oral cavity (e.g., the pulling of wisdom teeth)
- **Endodontics** – treatment of the soft tissue in the center of a tooth
- **Peridontics** – treatment of the supporting structures of the teeth
- **Prosthodontics** – artificial replacements
- **Pediatric dentistry** – treatment pertaining to children
- **Oral pathology** – tissue biopsies, diagnoses of oral diseases
- **Orthodontics** – braces

For these non-routine treatments, a comprehensive policy would pay a percentage (e.g., 80%) of the reasonable and customary charges. However, special treatment such as orthodontic care may have a very high coinsurance payment, such as 50%.

Most dental plans have exclusions and limitations–procedures they will provide no coverage for:

- **Cosmetic exclusion** – work that is not necessary for sound dental health

- **Missing tooth provision** – no coverage for missing teeth when coverage begins
- **Five-year replacement exclusion** – will not pay for prosthetic appliances (retainers or spacers) for five years after a benefit is paid
- **Outside service area** – coverage up to a certain amount for emergency coverage when outside the usual coverage area

Adult Dental and Vision vs Pediatric Dental and Vision

Adult dental and vision is optional coverage under Obamacare. Adults do not have to be offered this insurance, although marketplace and non-marketplace plans have coverage available. However, ***pediatric (under age 18) dental and vision benefits are mandatory*** under Obamacare, i.e., all individual and group health plans MUST cover dental and vision benefits for children as an essential health benefit.

2. Vision Coverage

Basic, comprehensive and major medical policies cover diseases and injuries to the eye. However, there is usually no coverage for eye exams, eyeglasses or contact lenses. Many insurance companies offer **vision care policies** that cover:

- Eye exams
- The cost of eyeglasses lenses and frames
- The cost of contact lenses

Vision care policies usually require the insured to seek care within a specified network of eye doctors and eyeglass providers in order to receive policy benefits. The co-payment varies from plan to plan, and individual and family coverage is available.

It is important to note that policies may have certain limitations, such as:

1. Replacement frames or lenses needed after loss or damage
2. Sunglasses or safety glasses
3. Medical and surgical costs that would be covered by a medical policy
4. Usually one eye exam and set of lenses per year

3. Prescription Drug Benefits

Prescription drug plans are typically a part of a group health insurance policy. However, individuals may purchase a limited plan that provides coverage for doctor-prescribed drugs. Like other special and limited policies, prescription plans operate within a network of participating pharmacies that members must use in order to receive benefits. Co-payments are typically involved with these plans.

It has become common practice to fill almost all prescriptions with a generic equivalent. This keeps down the ever-rising costs of prescription drugs.

It is important to note some policies have limitations to prescription coverage, such as:

- Fertility drugs
- Vitamins
- Experimental drugs
- Smoking cessation drugs

Usually, there is a dispensing limit, such as a months' or three months' supply per prescription. Individual, as well as family coverage is available.

4. Accidental Death and Dismemberment

Accidental Death and Dismemberment (AD&D) is a limited form of disability coverage. This coverage applies to loss of life, limb or sight as a result of an accident. It may be written into an individual health policy, part of a comprehensive group plan, or as a limited rider to another existing policy.

AD&D policies pay a specified amount of money, depending on the severity of the accident. The principal sum is the amount paid if there is an accident within the policy period in which the insured dies, or within a specified period after the accident. The capital sum is the amount paid for a single dismemberment of loss of sight in one eye. This amount is generally half the principal sum.

Death or dismemberment is only covered if they are accidental. It is important to note **AD&D** policies exclude:

- Illness or disease
- Bodily malfunction
- Suicide or any self-inflicted injury

AD&D coverage is usually provided by **2** methods:

1) **Accidental bodily injury** basis requires that the injury result from an accident (e.g., unintended harmful occurrence).

2) **Accidental means** coverage has the same 'unintended harmful occurrence' requirement as *accidental bodily injury coverage*, but also requires that the insured did not contribute to the accident by participating in dangerous or hazardous acts or failed to take reasonable precautions.

AD&D policies can name one or more beneficiaries to the policy. The primary beneficiary will be the first to receive any benefits upon **AD&D** payout (e.g., spouse, parent, child).

A contingent beneficiary could be named if the primary beneficiary dies before the insured. However, a contingent beneficiary will receive no benefits if the primary beneficiary is alive at the time of the insured's death.

5. Dread Disease

A dread disease policy can be purchased to cover any specific disease that is named in this limited policy: heart disease, breast cancer, etc. This type of policy covers diseases that do not occur frequently but result in significant costs when they occur. For this reason, Dread Disease policies are inexpensive compared to full health coverage. This type of policy can be purchased separately or as a rider to an existing policy.

6. Critical Illness

Critical Illness Insurance is an individual policy or rider that pays a lump sum benefit upon diagnosis of a covered illness or condition as defined in the policy.

The following may be covered under critical illness:

- Heart attack (myocardial infarction)
- Life-threatening cancer (malignant neoplasm)

- Stroke
- Alzheimer's Disease
- Major organ transplant
- End-stage renal failure

Because medical technology is more advanced, it's more expensive.

The financial strain a major illness can create may cause severe financial hardship because of the expenses that health and disability insurance may not cover.

Critical Illness is already prevalent in Britain, but interest in critical illness coverage is growing in popularity in the US. Of course there are exclusions and limitations, as well as disclaimers regarding tax issues and government benefits.

7. Travel Accident Insurance

This type of policy can be purchased to cover loss from travel accidents**. Travel accident insurance** may be offered as a benefit of an individual or a group AD&D policy. Benefits are limited to losses that are the direct result of accidents while traveling by common carriers such as airlines or buses.

A special type of **travel accident insurance**–air travel insurance–covers employees who travel often for their employers. It can be purchased at airports for a one-time, individual coverage.

8. Hospital Income Insurance

This type of policy pays a specific amount of insurance for every day the insured is hospitalized. A hospital income insurance policy pays the indemnity directly to the insured. It is meant as a means to provide some income that begins when the insured enters the hospital and ends when they are discharged. Some individuals use this kind of policy to meet the deductible and coinsurance requirements of their medical expense coverage policies.

However, limits may be placed on preexisting conditions or may include an elimination period. Hospital Income Insurance policies are usually indicated as a monthly payment for a specified number of months.

Putting it into Context:

Dan purchased a **hospital income insurance policy** when he went into business for himself as a freelance writer. After a car accident, Dan is in the hospital for six days. His policy, which does not have an elimination period, begins to pay benefits the first day Dan is in the hospital and for the full six days until he is discharged. Since Dan is a freelance writer, he does not have a comprehensive medical expense policy. But since he does have a **hospital income insurance** policy, he does receive some income while in the hospital.

END SECTION

Study Required Minutes before taking the Section Quiz.
Answer all questions correctly on the Quiz to move
to the next Study Section. Re-take Quiz if needed.

√ **Search this section using CTRL+F**
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Section AH 5

SOCIAL INSURANCE, OBAMACARE & GUARANTY FUNDS

Objectives

In this unit we will cover the important concept of **Social** Health **Insurance,** like Obamacare, Medicare, Medi-Cal, Social Security and the implications of the **State Guaranty Funds** that back most insurance sold in California.

This unit includes:

- Social Insurance
- Obamacare: The Patient Protection and Affordable Care Act
- Medicare
- Medi-Cal
- Social Security
- Health Insurance Taxation
- Non-governmental Health Insurance and Taxation
- Other Public Coverage Issues
- State Guaranty Funds

SOCIAL INSURANCE

Social health insurance involves programs where the risks are transferred to the government and benefits are typically legally required by law. This compares with private insurance plans where participation is usually voluntary and benefits are derived by contract.

Until 2014, health insurance for Californians who were uninsurable, due to pre-existing health issues, or who could not afford health insurance .obtained coverage through the State's high risk pool called the Major Risk Medical Insurance Program (MRMIP). Depending on income, premiums were subsidized by the State and in some cases the Tobacco tax funds. Coverage was hard to obtain as there was frequently a waiting list of applicants. Obamacare, highlighting no pre-existing conditions, has since replaced the need for this program and set standards for most healthcare in the State.

OBAMACARE: Patient Protection and Affordable Care Act

Purpose The stated goal of the PPACA was to make health insurance coverage more accessible (by eliminating pre-existing conditions), more reliable (by guaranteed renewability), provide coverage for those who could not afford it (by expanding Medicaid // Medi-Cal) and provide a means where the costs of health care would be shared by employers (imposing "shared responsibility" fines for employers who do not offer affordable health coverage to their employees.

Overview. PPACA includes numerous provisions which have and will be implemented over a period of years. Policies issued before the law was promulgated are grandfathered from most federal regulations. Policies that meet PPACA criteria can be sold in the marketplace, e.g., through a State Exchange like California Covered, or non-marketplace, e.g., you buy direct from an insurer like Blue Shield or Anthem Blue Cross. Subsidies to reduce the cost of health insurance are only available to those who purchase through the marketplace. People who still can't afford coverage through these

portals may be eligible for coverage through Medi-Cal, where eligibility has great expanded under PPACA. There is also an option to buy short-term health insurance if one has missed open enrollment.

Marketplace, State Exchange & Short Term Health Plans

Marketplace vs. Non-Marketplace Plans: A ***Marketplace Plan*** is one that has complied with Obamacare rules (PPACA) and sold through a ***State Exchange*** (Covered California for example). Only Marketplace plans offer premium reductions or subsidies based on income. ***Non-Marketplace plans*** comply with minimum Obamacare rules, including open enrollment restrictions, but are sold directly by the insurer. No premium reductions are available for Non-Marketplace plans.

Short-Term Health Plans: People who miss the open enrollment period for Marketplace or Non-Marketplace plans, can still by health insurance direct from an insurer in the form of a short-term health plan. These are temporary health plans lasting no more than six months. No premium subsidies are available and approval under these plans is subject to preexisting condition underwriting.

- ***MAGI / Medi-Cal*** Medicaid eligibility is expanded to include ***all*** individuals between 19 and 64 with incomes up to 138% of the poverty level along with a simplified enrollment process. Children under 19 qualify if the household income is up to 266% of the poverty level. Prior to PPACA, Med-Cal applicants had to fit into one of several categories in order to be eligible, e.g., children, pregnant women, caretaker relatives, children without parental support, etc.
- ***MAGI / COST CHARING REDUCTIONS (CSR)*** Cost sharing reductions are subsidies that lower a consumer's out of pocket

health costs including their copayments, coinsurance, deductibles and out of pocket maximums. Individuals who are eligible for premium assistance and have annual household income between 138% and 250% of the poverty level can qualify for cost saving reductions. Advanced Premium Tax Credits, for individuals up to 400% of the federal poverty level, are cost sharing reductions paid in advance to your insurer through the Marketplace.

- ***Guaranteed issue*** and partial community rating means insurers are required to offer the same premium to all applicants of the same age and geographical location without regard to most pre-existing conditions (excluding tobacco use).
- ***Open Enrollment*** is the period (normally November through January) in which shoppers can enroll, switch plans and get subsidies on health plans. If you don't shop during this time frame the only option you will have to buy coverage is by ***special enrollment*** which is a time frame of 60 days (30 days for job-based plans) following certain life events that involve a change in family status. Examples of such life events include:

  - Losing your job
  - Losing individual health coverage
  - Losing eligibility for Medi-Cal or Medicare
  - Losing coverage through a family member
  - A new marriage
  - Had a baby or adopted one
  - Got divorced and lost your health insurance
  - Death of someone in your plan
  - Changed your residence
  - Changes in your income that affect coverage you qualify for
  - Becoming a U.S. citizen
  - Release from jail

- ***Advanced Premium Tax Credits (APTCs)*** may be available to low income persons and families above the Medicaid level and

between 138% and 400% of the federal poverty level will receive federal subsidies on a sliding scale if they choose to purchase insurance via an exchange (persons at 150% of the poverty level would be subsidized such that their premium cost would be of 2% of income or $50 a month for a family of 4). The amount of the subsidy credit is calculated by Covered California, based on income provided by the insured, and the amount of the subsidy is paid directly to the insurance company or a policyholder can deduct the tax credit form his tax return. If a policyholder's income changes, he may be subject to a reduction or increase in his subsidy. If his subsidy is reduced, he may be subject to additional taxes at year end.

- ***Minor and adult children*** are required to be covered up to age 26 with guaranteed issue for children under age 19. A child who "ages out" or becomes too old to qualify may continue coverage under the COBRA program for up to 36 months.
- ***Minimum standards*** for health insurance policies are to be established and annual and lifetime coverage caps will be banned.
- Firms employing 50 or more people (100 or more starting in 2016) but not offering health insurance will also pay a ***shared responsibility*** requirement if the government has had to subsidize an employee's health care.
- Very small businesses will be able to get subsidies if they purchase insurance through an exchange (California Covered's SHOP Plan)..
- Insurers must spend a certain percent of premium dollars on eligible expenses, subject to various waivers and exemptions; if an insurer fails to meet this requirement, there is no penalty, but a rebate must be issued to the policy holder.

- Co-payments, co-insurance, and deductibles are to be eliminated for select health care insurance benefits considered to be part of an "essential benefits package" for Level A or Level B preventive care.
- Changes are enacted that allow a restructuring of Medicare reimbursement from "fee-for-service" to "bundled payments."
- The Patient Protection and Affordable Care Act (PPACA) included a provision that requires all health plans to adhere to a ***Medical Loss Ratio (MLR)*** established in law. The MLR refers to the percentage of premium revenues for health insurance plans spent on medical claims. Thus, if a plan received $100 of premiums and spent $85 on medical claims its MLR would be 85%***. Individual plans*** require a MLR of 80% or better; ***group plans*** require an MLR of 85%. If an insurer ***fails the MLR test*** in a calendar year for all plans in a given market segment (individual or group), it must refund the excess premiums back to consumers enrolled in plans in that market group.

PPCA Definitions

- ***Qualified Health Plan (QHP)*** An insurance plan that is certified by the health insurance marketplace (California Covered) and meets ACA requirements such as essential health benefits.
- ***Guaranteed issue*** and partial community rating will require insurers to offer the same premium to all applicants of the same age and geographical location without regard to most pre-existing conditions (excluding tobacco use).
- ***Advanced Premium Tax Credits.*** A tax credit that can reduce what you pay for a qualified health insurance plan. The reduced

cost is paid direct to the insurer or taken off the policyholder's tax return.

- ***Essential Health Benefits*** Like individual plans, the ACA requires all group health insurance plans to cover the ***10 essential health benefits***: Outpatient services, emergency services, hospitalization, maternity, mental health, prescription drugs, rehabilitation, laboratory services, preventative or wellness management and pediatric services.

Adult Dental and Vision vs Pediatric Dental and Vision

Adult dental and vision is optional coverage under Obamacare. Adults do not have to be offered this insurance, although marketplace and non-marketplace plans have coverage available. However, ***pediatric (under age 18) dental and vision benefits are mandatory*** under Obamacare, i.e., all individual and group health plans MUST cover dental and vision benefits for children as an essential health benefit.

- ***Open Enrollment Period (OEP)*** the period (normally November through January) in which shoppers can enroll, switch plans and get subsidies on health plans.
- ***Special Enrollment Period (SEP)*** If you don't purchase your health insurance during Open Enrollment, the only option you will have to buy coverage is by ***special enrollment*** which is a time frame of 60 days (30 days for job-based plans) following certain life events that involve a change in family status like losing a job, a new marriage, losing existing health insurance, etc.
- ***Cost Sharing Reductions (CSR)*** Cost sharing reductions are subsidies that lower a consumer's out of pocket health costs

including their copayments, coinsurance, deductibles and out of pocket maximums.

- ***Health Plan Metal Tiers*** ACA Qualified Health Plans plans are identified by metal tiers: Platinum, Gold, Silver and Bronze. Platinum plans having the highest premiums and therefore most benefits and least deductible / out of pocket costs and Bronze plans with the lowest premiums and benefits. Gold and Silver plans offer benefits and premiums in the middle.
- ***Individual Mandate / Shared Responsibility*** The ***individual mandate***, requires that all persons not covered by an employer sponsored health plan, Medicaid, Medicare, or other public insurance programs purchase and comply with an approved private insurance policy or pay a penalty. Under ACA ***Shared Responsibility*** rules, employers must offer their employees affordable health care coverage or pay a penalty.

QHP and Minimum Essential Coverage

An insurance plan that is a ***Qualified Health Plan (QHP)*** is certified by the health insurance marketplace (California Covered, for example) and meets ACA requirements such as essential health benefits. If you fail to obtain health care under ACA you will pay a penalty. To avoid the penalty one needs to obtain a ***Minimum Essential Coverage (MEC) policy***. Such a policy might be obtained in a number of ways:

- Purchase a non-marketplace Obamacare policy
- Buy coverage through Medicaid or Medicare Part A
- Buy military Tricare coverage
- Buy a self-funded or association policy
- Buy coverage through a state high risk pool

If you fail to obtain coverage from these sources and miss open enrollment for an Obamacare policy (marketplace or non-marketplace plan), you can still obtain private coverage through a ***short-term health care plan***. This is temporary insurance, lasting no more than six months, and subject to preexisting conditions underwriting. Health coverage may be limited ($1 or $2 million maximum benefits), but can be purchased anytime during the year.

California Health Benefit Exchange

The ***California Health Benefit Exchange***, a.k.a. California Covered, is the State Exchange organized under the auspices of the Patient Protection Affordable care Act (ACA).

The mission of the California Health Benefit Exchange is to increase the number of insured Californians, improve health care quality, lower costs, and reduce health disparities through competitive marketplace that empowers consumers to choose the health plan and providers that give them the best value.

Small businesses can purchase group health plans through California Covered's ***Small Business Options Program Exchange (SHOP***. SHOP plans are only available to businesses with up to 100 employees.

Health insurance plans purchased through California Covered are certified as ***Qualified Health Plans (QHP)*** under the PPACA. Only qualified health plans purchased through California Covered (the marketplace) qualify for premium tax credits or subsidies. Policyholders who purchase non marketplace policies will NOT be entitled to tax credits or subsidies of any kind.

Agent Training For California Covered

Licensed California Agents who wish to write applications for qualified health plans through Covered California must complete the following:

- Be currently licensed as a California Insurance agent.
- Complete all California Covered agent agreements.
- Complete California Covered's Agent Training and Certification
- Be appointed to California Covered if selling individual policies (small business policies do not require an appointment)
- Complete recertification every 5 years following the initial certification

MEDICARE

Medicare is the most familiar social insurance program in the United States. Created in 1965, it is meant to provide health care coverage to the elderly and disabled. The Social Security Administration handles claims and other paperwork involved with Medicare.

Medicare benefit payments are the result of contracts between the Department of Health and Human Services and selected insurance companies. These insurance companies are known as intermediaries, such as home health providers, hospitals or hospices. Other insurance companies, known as carriers, handle services and claims provided by doctors or other providers. When any claim is processed, Medicare sends a notice, the Explanation of Medical Benefits (EOMB) informing the beneficiary what services were involved, how much Medicare paid and what to do next. Claims are further detailed on a special Medicare Summary Notice (MSD), sent quarterly, showing details of services and the amount billed.

Original Medicare vs. Other Medicare Plans = Choices

People who are eligible for Medicare have choices as to how they get health care services. One can choose Original Medicare aka Straight Medicare, OR choose a private Medicare provider like a Medicare Advantage insurance company. Original Medicare is thought to be accepted by more doctors, but only 80% of services (costs) are covered. One needs to buy Medicare Supplement Insurance to cover the 20% gap. Medicare Advantage plans are run like HMO or PPO organizations where the insured must go to specific "in-network" doctors for their health care, but everything, including prescription drugs are typically included (less deductibles, coinsurance and copayments) As you will learn below, each has their advantages and drawbacks. The important thing to know is that there are choices for Medicare services.

Medicare Eligibility

Eligibility for Medicare usually begins with individuals over the age of **65**. Individuals eligible to enroll in Medicare must enroll when first eligible or be subject to ***late enrollment penalties of 10%*** of the applicable premium for twice the length of time a beneficiary was not enrolled. To be eligible for Medicare an individual must have been a ***legal resident of the United states for at least five years***.

Anyone who is eligible for Social Security benefits is automatically eligible for Initial Enrollment in Medicare, Parts A and B. Generally, this means earning a total of 40 work credits (about 10 years of work) to be ***fully insured***. For those who don't qualify, an extra premium can be paid in order to be Medicare insured. A person with ***30-39 credits***, for example, would pay a monthly 2016 Part A premium of $226 per month instead of $121 for one who is fully insured. Credits of only ***0-29*** would be $411 monthly.

Circumstances also exist that would allow a person of any age to receive coverage under Special Enrollments. If someone is disabled, for example, he or she could qualify for ***Social Security Disability Insurance (SSDI) benefits for up to two years***. Those who suffer from kidney failure or ***End Stage Renal Disease (ESRD)***, no matter their age, are eligible to receive Medicare benefits. Also, surviving spouses of those who qualified for Social Security at the time of their spouse's death would then be entitled to Medicare coverage. Further, there are Annual and Open Enrollment Periods where people can sign up for Medicare plans like the Part D Prescription Drug Plan (typically the months of November and December).

Medicare Services

Original Medicare – Part A, Part B, etc (see below) where doctors submit bills direct to Medicare of patient services. There are no limitations on the doctors one can use.

Medicare Advantage – (Part C) Medicare beneficiaries have the option to receive Medicare treatment through private plans of many types. The private insurers receive a set amount each month from Medicare for each patient and must provide equivalent or better service. Services can be provided through *HMO or PPO* groups where the doctors one can see are limited or specific. Many are operated on a ***managed care basis*** where the gatekeeper system helps reduce costs. A *private fee for service plan* allows one to choose doctors he wants as long as the doctor agrees to the Medicare payment terms. A *special needs plan* for those who qualify for both Medicare and Medi-Cal; a *demonstration plan* for chronic and serious medical conditions and

Medicare Part D Prescription Drug Plans – Coverage is ***optional***, but available to anyone eligible for original Medicare Part and Part B or any Medicare-approved private plan. There is a separate monthly premium (about $25/mo), annual deductibles (about $300) and co-pays (about 25% up to $2,500 in drugs). It covers brand-name and

generic prescription drugs at participating pharmacies. The idea is to lower the cost of prescription drugs, but people in the program may have monthly premiums, deductibles and/or pay a portion of prescription costs.

Medicare is divided into **4** parts:

1) Part A – hospital insurance
2) Part B – supplementary medical coverage
3) Part C – supplements to existing Medicare coverage
4) Part D – a new prescription drug coverage plan

Medicare Enrollment

There are 4 ways to enroll in Medicare:
Initial Enrollment Period (IEP) – when one turns 65 he may enroll 3 months before or after his birthday.
Annual Enrollment Period (AEP) – anyone age 65 or older can also enroll between Nov 15 and Dec 31 of each year for coverage effective January 1.
Open Enrollment Period (OEP) – between Jan 1 to Mar 31 of each year one can switch to a different Medicare plan, e.g., you can switch to Medicare Advantage from Original Medicare or visa versa.
Special Enrollment Period (SEP) – available anytime if one forgot to sign up and has been covered by a group medical plan since turning age 65

Here's a closer look at Medicare:

Medicare Part A

Medicare Part A covers major services like hospital care, skilled nursing (limited time), nursing home (not custodial care), hospice and certain home health services. Enrollment in Part A is automatic for anyone who is eligible for Social Security. Individuals become eligible for Part A benefits the first day of the month of their 65th birthday. Let's take a closer look:

Inpatient Coverage Hospital inpatient care refers to the benefits Medicare pays towards the usual and reasonable charges that are incurred while hospitalized. *See PPACA & Medicare below.* This benefit pays the full cost of hospitalization up to **60** days (for each benefit claim period) after the patient pays a deductible. But, from the 61st day to the 90th day, Medicare pays all but a certain coinsurance amount per day. For stays over **90** days, the patient may draw upon 60 lifetime reserve days, which are available only once in a lifetime. After these reserve days are exhausted, the patient's daily co-payment amount greatly increases. A benefit period begins when the patient is admitted, and ends 60 days after discharge. Any readmission during this benefit period would be considered the same benefit period; readmission after the **60** days would be considered the beginning of a new benefit period. Like all healthcare, ***unreasonable Medicare claims will be excluded.***

PPACA & Medicare

If you ***enrolled*** in Medicare Part A or Part C (Medicare Advantage), you are considered to have ***minimum essential coverage*** and won't owe the PPACA penalty for not having health insurance. Having only Part B (Medigap Insurance), however, does NOT count as "minimum essential coverage".

Obamacare does NOT affect ***premiums*** paid for Medicare (although Medicare had its own increase in 2016). High income individuals, however, earning more than $85,000 (single) or $170,000 (couple) are set to rise under PPACA.

Private Medicare Plans (like Medicare Advantage or Medigap) are now subject to the 85% rule: 85% of premiums must be paid back as benefits to the insured leaving 15% for the profits to the insurance company.

Medicare Enrollment Medicare Part A Terms To Know

Inpatient coverage -- pays for any usual and reasonable charges that are incurred while hospitalized.

Benefit period -- begins when the patient is admitted, and ends **60 days** after discharge.

Hospital Admissions Deductible: For 2009, the Part A deductible is $1,288. This is paid when the beneficiary (patient) is admitted to a hospital. This is the ONLY cost he pays for up to 60 days of care. An additional $322 deductible ***per day*** is paid for days 61 through 90 and $644 ***per day*** beyond 90 days.

Co-payments: From the **61st** day to the **90th** day, **Medicare** pays a certain coinsurance amount per day. For stays over **90 days**, the patient may draw upon **60 lifetime reserve days**, which are available only once in a ***lifetime***. After these reserve days are exhausted, the patient's daily co-payment amount increases significantly, i.e. ***there is no out-of-pocket maximum.***

Specialized Nursing Facility Care benefits are paid up to **100** days of each benefit period. For days 21 through 100, the patient pays coinsurance, while Medicare covers all reasonable charges for the first 20 days. The nursing facility must be Medicare approved.. The nursing care received must be from licensed nursing professionals and *must* be the result of a physician's order.

Hospice care involves the support of terminally ill patients, and the benefit covers both inpatient and outpatient hospice care. Medicare benefits will not cover curative treatments. If a physician certifies the need, Medicare may provide Hospice care for an unlimited period of time. In fact, Medicare usually pays all costs related to Hospice care,

and with no deductible required from the patient. However, there are **2** services that do require co-payments:

1. Prescription drugs (patient pays **5%** or **5$** per prescription, whichever is less)
2. Respite care (patients pay **5%** of Medicare approved rates)

Home health care benefits are provided when the patient is confined at home and receives certain health services by a participating home health agency. **Medicare** pays this benefit as long as the care is intermittent, as opposed to constant long-term care. The benefits paid by **Medicare** are:

- Intermittent, part-time nursing care
- Occupational, physical or speech therapy
- Home health assistants
- Medical supplies
- Medical social services
- **80%** of durable equipment, such as wheelchairs or home hospital beds

Medicare Claims

Submitting Claims – Individuals do not need to file claims. As long as they are enrolled as Medicare service providers, doctors or hospitals, submit all claims.
Medicare Assignments – an "assigned claim" is one that is submitted and paid by Medicare. A "non-assigned" claim is paid by the beneficiary and later reimbursed by Medicare directly.
Contracted Medicare Providers and Suppliers – doctors and hospitals contracted with Medicare who are ***required*** to submit claims on your behalf.
Medicare Summary Notice – a summary of claims (covered and not covered) processed for an individual in the past 3 months. These notices are mailed direct to beneficiaries.
Exclusions – claims that are not reasonable or necessary may not be paid.

Medicare Part B

Part B is meant as an optional and supplemental insurance to Part A. It covers things like medically necessary doctor services, preventive care, outpatient services, clinical research, x rays, ambulance services, medical equipment, mental health, limited prescription drugs.

Medicare Eligibility Windows

When eligible for Medicare, enrollees have a ***seven month window*** to sign up. ***Failure to enroll*** may result in a lifetime payment penalty of 10 percent for every 12-month period. ***Enrollment can be delayed*** if a Medicare eligible person still has his primary healthcare with his employer. Likewise, Medicare may ***reject enrollment*** if the enrollee is covered by an employer-sponsored health plan.

Medicare Enrollment Periods

Annual Enrollment Period (AEP) – anyone age 65 or older can also enroll between Nov 15 and Dec 31 of each year for coverage effective January 1.
Open Enrollment Period (OEP) – between Jan 1 to Mar 31 of each year one can switch to a different Medicare plan, e.g., you can switch to Medicare Advantage from Original Medicare or visa versa.
Special Enrollment Period (SEP) – available anytime if one forgot to sign up and has been covered by a group medical plan since turning age 65

Those who are enrolled in Part A are ***automatically enrolled in Part B***, unless they request otherwise. It is important to note that Part B requires a ***monthly premium payment***. ***High income beneficiaries*** are assessed higher monthly premiums. And, Part B always requires the following ***co-payments***:

- The ***annual deductible*** amount (about $166 per year).
- **20%** ***coinsurance*** of all reasonable charges for medically necessary services
- The cost of the first three pints of blood used in medical procedures.
-

NOTE: ***Enrollment*** in Part B can be delayed if a person's employer's coverage is still considered "primary". If **Medicare** deems any expense as medically unnecessary, the patient will pay the entire cost.

Medicare Part B Benefits

1) Medically necessary services**.** Includes outpatient health and diagnostic services.

2) Physicians', surgeons in and out of hospital. The care can be received in any type of facility: hospital, skilled nursing facility, physicians' office, at home, or in a clinic.

3) Home health care and hospice not covered by Part A is provided to people who participate in Medicare Part B but not Part A. Part B would cover all costs related to medically necessary home health visits. The patient would pay no deductible or coinsurance except for **20%** of the cost of durable medical equipment.

4) There are no out-pocket maximums for Part B claims. A senior with significant medical bills and no Medicare Supplement in place could be facing responsibility for some major costs. That is why people who have Medicare only plans should ALWAYS buy a medigap policy (Medicare supplement insurance) or instead of going Medicare Only, purchase a Medicare Advantage Plan.

5) Approved Physicians. Medicare or Medicare Advantage enrollees could be liable for the cost of using a non-approved plan physician, when he should have used an approved physician. This is typically referred to using a doctor that is "out of the network", versus using a doctor "in network".

Medicare Supplement Plans (Medigap)

If one gets healthcare form Original Medicare, 80% of health care costs are covered, 20% are not. Thus the need for supplement insurance. Medicare Supplement Insurance a.k.a. Medigap plans are supplemental health insurance plans sold to Medicare eligible beneficiaries. They provide coverage for medical expenses, i.e., ***THE GAPS***, that are not covered or only partially covered by Original Medicare. There are many ***federally standardized*** Medicare Supplement plans which have been designated ***A through N***. ***Insurers offering*** Medicare Supplement policies ***must offer Plans A and either Plan C or F***.

It also of note that ***a person CANNOT HAVE more than one Medicare Supplement plan****.* ***Applications*** *for a supplement policy* ***must include a question*** *to identify persons who are already enrolled in a Medicare Supplement plan.*

Take a look at the chart below to see plan benefit comparisons:

Medigap Insurance Alternatives

One who has Medicare Only coverage, should always a Medicare Supplement or Medigap Policy to cover the ***20% gap*** that Medicare does not cover.

An alternative, however, would be to buy a Medicare Advantage Policy that covers, with reasonable deductibles and co-pays, everything that Medicare covers, including the ***20% gap***.

Medicare Supplement Insurance Plans (Medigap)

Benefits	A	B	C	D	F	G	K	L	M	N
Medicare Part A Coinsurance and Hospital Costs (up to an additional 365 days after Medicare benefits are used)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medicare Part B Coinsurance Or Copayment	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓
Blood (first 3 pints)	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓
Part A Hospice Care Coinsurance or Copayment	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓
Skilled Nursing Facility Care Coinsurance			✓	✓	✓	✓	50%	75%	✓	✓
Medicare Part A Deductible		✓	✓	✓	✓	✓	50%	75%	50%	✓
Medicare Part B Deductible			✓		✓					
Medicare Part B Excess Charges					✓	✓				
Foreign Travel Emergency (up to plan limits)			✓	✓	✓	✓			✓	✓

Note: Plans K and L have maximum annual out-of-pocket limits of $4640 and $2320 respectively.

A ***federal law*** stipulates that insurance companies provide a *6-month* ***open enrollment period*** for supplement policies. A person who is **65** years or older cannot be denied Medicare supplement insurance or receive different treatment due to a medical condition for six months after becoming enrolled in Medicare Part B. During

this guaranteed issue period, applicants may sign up for any Medigap policy regardless of health problems.

Note: Medigap policies DO NOT duplicate benefits provided by Medicare. Severe penalties can be levied on agents who knowingly sell gap policies promoted to “duplicate” Medicare

Note: Agent commissions on Medigap policies are limited to no more than twice the commissions for renewal policies in order to reduce “churning” or needless replacements to generate commission income.

Medicare Select is a version of the Medicare Supplement / Medigap Policies discussed earlier. Medicare SELECT plans offer more affordable supplement coverage. How? SELECT plans negotiate with a provider network of doctors, hospitals, and specialists so they charge less for their medical services. These lower rates keep costs down for the SELECT plan provider, and plan members get lower premiums.

It's important to remember that plan members *must* receive their care from the provider network. Most of these networks include thousands of health care professionals, so finding a doctor or hospital near you usually isn’t a problem. Plan members will also need to get a referral from their Primary Care Physician in order for hospital or specialist care to be covered by the plan.

Medicare Select operates on a preferred provider basis. Insurance companies list participating doctors and hospitals from which the insured must pick in order to receive benefits. This typically results in lower premiums than other Medigap policies.

Medicare Supplements - Agent World Rules

If you are planning to sell Medicare Supplement Policies, you should be aware there are numerous California State Insurance Codes that apply to the soliciting, enrollment, issuance and replacement of these policies . . . CIC 10192 through 10194. Following are important highlights:

10192.8 – ***Preexisting conditions*** cannot be excluded for more than 6 months; sickness and accident losses are considered one and the same; all policies are considered guaranteed renewable and noncancelable (except for nonpayment of premium) without regard to health status.

10192.10 – ***Medicare Select*** - A policy shall not be advertised as a "Medicare Select Plan" unless it has contracted with providers to establish responsibilities as well as alternative or discount pricing or provide certain advantages; there is reasonable access to the network; there is a system of quality assurance; if not reasonable to get to a network provider (as in an emergency) outside services are covered; a system for complaints and appeals is established.

10192.11 & 10192.12 – ***Guaranteed issue***: a person who is 65 years or older can't be denied Medicare supplement insurance or receive different treatment due to a preexisting condition or medical condition for 6 months after they've enrolled.

10192.16 – ***Agent commissions*** for selling policies shall be spread over 5 years minimum with the first year commission being no more than 200% of the second year (high first year commissions might encourage unnecessary replacement or churning).

19192.17 – Outline of Coverage. Issuers of medigap policies shall provide an outline of coverage to all applicants at the time of application. In 12 point text or larger, the OOC must include premium information, required disclosures and charts displaying benefits.

10192.18 – Application. Applications for Medigap policies must determine if the applicant already has a Medicare Supplement Policy and warn that multiple coverage is not needed.

10192.18 – Replacement. Applicants should be warned and advised that if they decide to cancel or replace and existing Medigap policy, they should wait until the new policy is issued before canceling the old policy. Also, applicants have 30 days to return a policy for any reason.

10192.20 – **Rate Guide** / ***Twisting*** Applicants for Medigap policies must be given a Department of Insurance Rate Guide that compares the policies sold by different insurers. Applicants need to know that "this policy may not cover all of your medical expenses". Agents are warned that the twisting of facts or high pressure techniques to induce a person to cancel an existing policy in order to buy another of the same or lesser value is strictly prohibited.

Medicare Advantage Plans (MA)

Medicare Advantage Plans are know as Medicare Part C. MA is NOT a separate benefit or a Medicare supplement plan. Rather it is an approved Medicare plan that takes the place of Original Medicare. The government actually pays private MA health insurance companies to provide the same coverage of Medicare AND the gaps of original Medicare much like a supplement or Medigap policy, i.e., an MA plan typically covers everything, not just 80% or 20%.. So, applicants can choose to buy original Medicare along with a Medicare Supplement policy, OR, by a Medicare Advantage Plan that includes BOTH.

MEDICARE ADVANTAGE PLAN(MA) COVERAGE FACTS

- A MA Plan ***MUST cover all benefits*** provided under Original Medicare.
- MAs ***may also cover MORE ben***efits than Original Medicare. This may include value added services (like optional dental care) and other benefits (like free gym memberships).
- MA plans ***may reduce out-of-pocket maximums*** for seniors
- MA plans typically ***INCLUDE prescription drug coverage***.

NOTE: ENROLLMENT IN A STAND ALONE PRESCRIPTION DRUG PROGRAM (PDP) AUTOMATICALLY TERMINATES ENROLLMENT IN A MEDICARE ADVANTAGE PLAN.

Virtually all Medicare Advantage (MA) plans utilize a ***managed care*** approach using ***HMO or PPO health care models***. All MA applicants must also be signed up for Medicare Part B and pay the Medicare Part B monthly premium of $124. However, unlike Medicare Supplement policies, MA policies typically have low or zero associated monthly premiums, i.e., they can be more affordable than choosing Medicare plus a supplement. Some like the idea having original Medicare as they feel they can go to any doctor, including specialists, surgeons, etc. MA plans may require that you first go through a "gatekeeper" primary doctor before being referred to a specialist. And, most have very specific restrictions of using doctors outside their network, unless there is an emergency.

Medicare Private Fee For Services Plans (PFFS). In yet another twist on Medicare coverage, there are Medicare Advantage plans offered by private insurance companies. There is no primary doctor or gatekeeper. They allow an insured to go to any Medicare-approved doctor, health care provider or hospital that accepts the plan's payment terms. If you join a PFFS, you will be shown that

network providers who have agreed to treat PFFS members. If you go outside of these network providers, you pay more. Always, is the case of an emergency, any doctor or hospital, whether in network or not, is covered.

Medicare Special Needs Plan (SNP) These plans are Medicare Advantage types with the exception that membership in the plan is limited to people with specific diseases or characteristics.. Providers tailor their benefits, choices and drug formularies to best meet their very unique needs. ***Eligible enrollees*** can be people who now live in a nursing home; people who are ***dually eligible*** for both Medicare and Medi-Cal or people who have specific chronic or disabling conditions like ***End-Stage Renal Disease (ESRD)***, HIV, AIDS, dementia, etc. If you have Medicare and Medi-Cal, the SNP cannot charge you higher ***cost sharing*** amounts than you would pay in original Medicare or Medi-Cal.

Medicare Part D – Prescription Drugs

Individuals or ***beneficiaries*** of Medicare are eligible for prescription drug coverage under a Part D plan if they are signed up for benefits under Medicare Part A and/or Part B. ***Part D enrollment is optional***, i.e., coverage may already be included (***embedded***) through various Medicare programs like Medicare Advantage or you can ***buy a stand alone*** Part D policy. About two-thirds of all Medicare beneficiaries are enrolled directly in Part D or get Part-D-like benefits through a public Part C Medicare Advantage health plan. Another large group of Medicare beneficiaries get prescription drug coverage under plans offered by former employers.

Coverage Periods: As long as you are enrolled in Medicare Part A or B , you are eligible for coverage under Part D. Eligible seniors should be advised that failure to maintain ***creditable coverage*** for prescription drugs after age 65 is not only risky, it ***may result in penalties*** of one percent per month for each month without such coverage.

Costs of Medicare Part D: There are four types of costs associated with Medicare Part D: premiums, deductibles, copayments and coverage gaps. .

PDP Premiums vary by plan. For stand alone policies, i.e., where a Medicare plan, like Medicare Advantage, doesn't already pay for prescription drugs, premiums can range from $10 to $100 per month. Higher income consumers pay more.

The Deductible for 2016 is $360.

Copayments. After you pay the deductible (assuming you buy a standalone policy), your Plan D plan pays most of the cost of covered drugs. You are personally responsible for the remainder or copayment.

Coverage Gap: Some Medicare presciption Drug Plans have a coverage gap (also called the "donut hole"). In 2016, once you and your plan have spent $3,310 on covered drugs, you're in the coverage gap. Thereafter, you pay 45% of the plan's cost for covered brand-name drugs. Once you have spent $4,850 out of pocket, you're out of coverage gap. Once out of coverage gap, you

automatically get ***catastrophic coverage*** with a small coinsurance or copayment for the rest of the year.

Enrollment Periods: Enrollment times for Part D is the same for Part C

- ***Open enrollment*** is between October 5 and December 7.
- ***Special enrollment*** is also similar: you can enroll outside open enrollment times when you have had special changes in your life: lost previous coverage, moved, moved from an institution to home, released from jail, etc.

Formularies: Insurance companies must create and file an ***annual formulary*** or list of drugs covered by their plan. Many have ***different tiers*** on their formularies. A ***formulary must include at least two drugs*** in each treatment category. However , the formulary is not required to include all drugs. A drug in a lower formulary tier will generally have a lower cost than a drug in a higher tier.. If the drug you think you need is on a higher tier and you can't afford it, you can ask for an ***exception*** to get a lower copayment.

Other Medicare Services & Facts

Medicare Fee For Service (FFS)*:** FFS is a program that provides hospital insurance (Part A) and supplementary medical insurance (Part B) to eligible citizens over age 65 who qualify for Social Security.. Claims are submitted by Medicare contracted providers to Centers for Medicare and Medical (CMS). Doctors who accept the Medicare-approved amount for full payment are said to be under ***assignment. ***Non-assignment*** occurs when a doctor has not

accepted assignment . . .also called non-participating. A doctor in this case can choose to accept assignment for certain individual services. If not, the patient might have to pay the entire amount of the claim. In such a case, the patient could submit their own claim to Medicare for reimbursement for some or all of the amount he paid.

Medicare Summary Notice (MSN): These notices apply only to people who choose Original Medicare. An MSN is a paper you receive in the mail that summarizes of all services or supplies that were billed to your Medicare account during a given 3-month period. It shows what Medicare paid and the amount you owe. If you don't use medical services in a given 3 month period, you will not get a MSN. The purpose of this accounting is too reduce Medicare fraud.

Common Coverage Exclusions: Medicare doesn't cover everything. And, even where it does, you will still likely have a deductible, coinsurance and payments. Items tat are expressly not covered include:

- Long term care / Custodial care
- Most dental care
- Eye exams related to prescribing glasses
- Dentures
- Cosmetic surgery
- Acupuncture
- Hearing aids
- Routine foot care

Right of Appeal: No matter where one gets their Medicare coverage, there is always a right of appeal for an unjust charge,

denial of treatment, the cost of treatment or any other differences between patient and doctor. Appeals move through several levels, starting with a redetermination (the process of the provider or doctor re-evaluating his charge or decision), reconsidering by an outside contractor, hearing before a judge, review by the Medicare Appeals Council and finally, a judicial review by a federal court.

HICAP

HICAP is a state and federally funded program to provided free assistance to Medicare beneficiaries. In California, the ***Department of Aging*** and operated locally by ***Area Agencies on Aging*** offers counseling services to all parties interested in locating long term care providers. Known as Health Insurance ***Counseling and Advocacy*** Program or HICAP, they help in the review life insurance policies, file medical claims and advise on long term care services and counsel on other consumer health concerns. They also provide follow-up to ensure that these services were received. HICAP provides assistance by phone or in person. Some HICAPs can also provide legal assistance in regard to Medicare and Medical. A complete list of HICAP offices is provided at on the Department of Aging Website -- www.aging.ca.gov/hicap/countyList.aspx

MEDI-CAL

Medi-Cal (Medi-Cal in other states) is a welfare health insurance program established under the Social Security Act, for individuals who live well below the poverty line. It is administered by the State of California.

Eligibility usually requires:

- Qualification for public assistance or welfare
- Qualification for Supplemental Security Income (a program for impoverished people who are over 65 years of age, blind or disabled in some way.

Medi-Cal covers most health care costs, including hospital bills, physician bills, and nursing home care.

Generally, those eligible for **Medi-Cal** include:

- Low-income individuals over the age of **65**
- Low-income individuals under the age of **21**
- The blind and other disabled persons
- Low-income families with dependent children

As stated earlier, the state establishes its own income and financial limitations for eligibility. These include a maximum value of assets of $4,000, or $6,000 for a couple. Nationally, (Medi-Cal) the program pays for almost half of all nursing home care.

The California Partnership for Long Term Care is a California project that allows someone to purchase an LTC policy and to retain shelter or assets without having to “spend down” to qualify for Medi-Cal.

Medi-Cal is required by law to pay certain costs of impoverished Medi-Cal patients:

- Medicare deductibles
- Part B premiums
- All Medicare co-payments

- When required, Part A premiums

SOCIAL SECURITY

This program in the United States provides death, survivor, retirement, and disability benefits for those who qualify.

Types of Social Security Benefit Payments:

Survivor Benefits -- On the death of a qualified wage earner, a surviving spouse and unmarried children under 18 can receive an income as well as a one-time $255 death benefit.
Disability Benefits -- A qualified wager earner who cannot work due to a medical condition that is expected to last at least one year or result in death can receive monthly income.
Retirement Benefits -- A qualified wage earner can receive a monthly income for life at retirement age. At death, a surviving spouse can receive partial benefits.
Medicare Benefits – Persons age 65 (under 65 if disabled) receive monthly income for life. Upon death, a surviving spouse can receive partial income.

Typically, the following must apply:

- Totally and permanently disabled for at least **5** months
- Expected to be disabled for **12** months or longer, or disability will end in death
- 'Fully insured' or 'partially insured' as defined under Social Security regulations

Fully Insured vs. Partially Insured

Fully Insured – means one is entitled to full social security benefits (see below) *Example* . . . Ron is 53 years old. He has worked full-time since he was 23 (30 years consisting of 120 quarter years of coverage, paying FICA ax). Ron is well over the 10-year, 40-quarter

minimum, entitling him to Social Security old-age retirement income when he reaches retirement age. Ron is fully insured.

Partially Insured – entitles a worker to disability benefits but not to old-age retirement payments. *Example* . . . Bill just began working five years ago sohe has 5 years consisting of 20 quarter years. He must work another 20 quarters to meet the 40 quarter minimum to be covered by old-age retirement when he becomes retirement age. However, because Bill has met the minimum 6 quarter out of 13 coverage, he is partially insured. If he dies his family cold receive Social Security benefits. He could also receive disability benefits.

Social Security disability benefits are based on the level of an employee's earnings up to the time of disability. Benefits are equal to **100%** of the individual's **Primary Insurance Amount (PIA)**, which is the dollar amount the individual would receive as a retirement benefit. And, after being qualified for disability benefits for **2** years, that individual would then be eligible for Medicare benefits.

The Three Income Periods

There are 3 distinct income periods a surviving family may experience after the death of a loved one. As you will see, the three income periods change and vary as the situation of the family changes after their loss. The 3 periods are:

The **Dependency period** is the time when the surviving spouse has children (dependents) at home. The family's needs are typically largest at this point.
The **Blackout period** is the period when a surviving spouse no longer has children at home, but is not yet old enough to receive Social Security retirement benefits.
The **Retirement Period** is the period when the surviving spouse is now old enough (age 60) to receive retirement benefits from Social Security.

Under **Social Security**, an individual's average earnings are reduced by a specific formula to calculate the PIA:

- A disabled worker would receive a benefit equal to **100%** of their PIA
- A spouse who cares for an unmarried child, under the age of 16, of the worker who was disabled before age 22, equal to **50%** of the worker's PIA.
- Each unmarried child under 18 (or 19 if still in high school) or disabled before age 22 would receive a benefit equal to **50%** of the disabled worker's PIA.

The total dollar amount a family may receive does have a cap: the *Maximum Family Benefit* amount. This is also based on the worker's average earnings.

Social Security benefits usually continue so long as the insured cannot engage in any *substantial gainful activity*. This is similar to the concept of *any occupation* we discussed in Unit 1: Disability Insurance.

Putting it into Context:

Theresa is a carpenter and the sole breadwinner for her family. After suffering total disability in an accident that was not job-related, it is determined that Theresa will be permanently disabled for at least two years. Under Social Security, she is fully insured and disability insured. She would receive a 100% PIA benefit, along with any other disability insurance income and health insurance policies she may have in effect.

HEALTH INSURANCE TAXATION

This section will discuss how most Social Insurance programs are funded:

A. Medicare Part A

Medicare Part A (Hospital insurance) is primarily supported by the very familiar Social Security payroll taxes. This is the payroll deduction we see in our paychecks.

B. Medicare Part B

Medicare Part B (Medical Insurance) is generally supported by general tax revenue and the premiums from the beneficiaries.

C. Social Security

Social Security disability benefits are financed through a payroll tax. The tax rate is applied to a worker's gross wages and the appropriate amount is deducted from their wages each pay period. The employer contributes a similar amount. Those who are self-employed pay **100%** of the combined employee/employer tax rate.

Social Security benefits are generally received free of any income tax. However, it is important to note a federal income tax is placed on some benefits if the taxpayer possesses a substantial amount of additional income.

Non-governmental Health Insurance Taxation

To review how non-governmental health insurance is taxed, we need to examine the different groups that provide coverage:

- Individual policies
- Group policies
- Sole proprietors and partners
- Business

Here's a closer look at those different groups:

A. Individual Policies

Individual policies have premiums that are not deductible to the individual taxpayer. But, if the individual's medical expenses exceed **7.5%** of their adjusted gross income for a tax year, then any medical expenses, including premiums for accident and health insurance, can be deducted. This does not apply to Disability insurance.

B. Group Policies

Group policies have premiums that are deductible as a business expense. These premiums usually include group accident, health, and dental coverage that are paid for the employees of a company. These premiums are not taxed to the employee, and the benefits received by the employees are tax-free. The premiums paid by a business for group disability insurance for its employees are deductible by the company as a business expense. Here, the premiums are not taxed to the employees but the benefits are taxable.

C. Sole Proprietors and Partners

Sole proprietors and partners (the self-employed) are permitted to deduct from their gross incomes **100%** of what they pay for health insurance. However, to meet the requirements for this deduction, the self-employed must show a net profit for the tax year and cannot claim this deduction for any month in which they were eligible to participate in any health plan from a previous employer or the employer of their spouse.

D. Business Policies

Business policies have premiums that are deductible as a business expense whether it happens to be a sole proprietorship, corporation, or partnership. The proceeds of the business overhead expense insurance are taxable, however. Premiums paid for a disability policy that is used during a buy-sell agreement are not deductible, and the proceeds are not taxable.

OTHER PUBLIC COVERAGE ISSUES

Access for Infants and Mothers Program (Section 12695 CIC)

The Access for Infants and Mothers (AIM) Program is low-cost health coverage for pregnant women. Their newborns may be automatically eligible for enrollment in the Healthy Families Program. AIM is designed for families in the middle-income bracket who do not have health insurance and whose income is too high to qualify for no-cost, Medi-Cal. One may also qualify for AIM coverage if one has

healthcare insurance but a separate maternity services deductible or co-payment of more than $500.

Health Families Program (Section 12693 CIC)

Administered by the Managed Risk Medical Insurance Board (MRMIB), to arrange for the provision of health care services to children less than 19 years of age who meet certain eligibility requirements.

California Pre-Existing Condition Program (PCIP)

As a result of the federal Affordable Care Act of 2010, California has a contract with the federal Department of Health and Human Services to establish a federally-funded high risk pool program to provide health coverage for eligible individuals. The program will last until December 31, 2013 when the national health reform is set to begin. After that date, there will no longer be a need for high risk pools because federal rules will not allow insurers to reject persons with pre-existing conditions or charge them higher rates than those without such conditions.

The federally-funded program is called the California Pre-Existing Condition Insurance Plan (PCIP). The PCIP offers health coverage to medically-uninsurable individuals who live in California. The program is available for individuals who have not had health coverage in the last 6 months. The California PCIP is run by the Managed Risk Medical Insurance Board (MRMIB).

Health E-App

Health-e-App is the official State of California secured online application system for California residents. Health-e-App is used to apply for health coverage through Medi-Cal for Families or the Healthy Families Program (see above).

GUARANTY FUNDS

California law mandates a system to pay insurance claims and benefits of insolvent insurance companies. All insurers must belong to and contribute to one of the following guarantee associations. If a member is found to be insolvent and ordered liquidated, a special receiver takes over the insurer and the appropriate guaranty association makes good on any insurance claims up the limits stated below.

A. *California Life and Health Guarantee Association*

The **California Life and Health Guarantee Association** is under the Commissioner's authority, and protects annuity policyholders, beneficiaries, and payees of Life and Health policies.

The California Life and Health Guarantee Association guarantees any payments of benefits and continued coverage if an insurance company becomes insolvent. This association guarantees the following:

- **80%** of contractual limitations
- Up to **$250,000** for Life insurance Death benefits
- Up to **$100,000** for cash surrender value
- Up to **$100,000** for the present value of annuities
- Up to **$200,000** for Health benefits

Note: The maximum amount an individual can receive for all policies is **$250,000**.
The maximum amount a firm or corporation can receive for all policies is **$5 million**.

The **California Life and Health Guarantee Association** DOES NOT cover:

- Variable Life or Variable annuities that aren't guaranteed by the insurer
- Risks the policyholder accepted
- Any part of the policy that's reinsured
- Policies issued by a health care service contract
- Anyone that's self-funded or uninsured
- Parts of a policy subject to dividends or experience credits
- Policies issued by an insurer that doesn't have a Certificate of Authority in California
- Any coverage issued by the California Medical Insurance Pool

B. California Insurance Guarantee Association for Property and Casualty

The **California Insurance Guarantee Association for Property and Casualty** protects Property and Casualty policyowners from insolvent insurance companies.

Every California insurance company that transacts Property and Casualty insurance has to be a member of the California Insurance Guarantee Association for Property and Casualty.

The limits of coverage for all Fire and Casualty (excluding Workers Compensation) are:

- A minimum of **$100**
- A maximum of **$500,000**

The California Insurance Guarantee Association for Property and Casualty pays claims for most types of Property and Casualty policies, including Workers Compensation.

Alert!

There is no limit on Workers Compensation claims. The California Insurance Guarantee Association for Property and Casualty doesn't put any limits on Workers Compensation claims. We're drawing attention to this fact, because we've seen this actual question on the test.

Claims are paid if they are filed within **30** days of a company becoming insolvent. Once the Commissioner receives notification that a company is insolvent, the Commissioner notifies the CIGA within **3** days.

The Commissioner could request that the policyowners also be informed of the insolvency and their rights regarding the insolvency. Claims are paid up to **$500,000**.

Marketing Note: While having a guaranty association available to back up a client's insurance claims and investments is a good thing, an agent cannot use them as a marketing tool. Doing so would encourage clients to be less than diligent in choosing an insurer, i.e., knowing the State will reimburse him, a client might tend to always choose weak insurers with cheap rates.

Admin Note: It is a misdemeanor to refuse to deliver any books, records or assets to the Commission pertaining to any insurance company insolvency.

END SECTION

Study Required Minutes before taking the Section Quiz.
Answer all questions correctly on the Quiz to move
to the next Study Section. Re-take Quiz if needed.

√ **Search this section using CTRL+F**
√ **Please study required minutes before taking Section Quiz**
√ **CAUTION: 20-Minutes or more idle time (no study activity) will cause disconnection and loss of study session minutes**

Section AH 6

HEALTH POLICY PROVISIONS, CLAUSES AND RIDERS

Objectives

In this unit we will cover the many different Provisions, Clauses, and Riders that are part of Health insurance policies.
This unit includes:

- Provisions
- Required Provisions
- Optional Provisions
- Riders
- Other Provisions
- Rights of Renewability

1. Provisions

There are **3** types of Provisions found in Health Insurance policies:

1) Required Provisions –including maximum & minimum benefits
2) Optional Provisions
3) Other Provisions

2. Required Provisions

There are six required specifications for all insurance policies in California:

In an insurance policy or contract, there are ***six required specifications*** that must be included.

- First and foremost, the parties between whom the contract is being made must be notated.
- The property or the person that is being insured must be clearly stated.
- The interest of the insured in the property or person being insured must be stated, if he or she is not the owner of the policy.
- Also the policy must expressly state the risks that the insured is being insured against.
- The period of the insurance policy is also required to be specified.
- Lastly, the statement of premium or the statement of the basis upon which the final premium is to be determined and paid.

Insurance policies are required to specify all of the above, however **they are not required to list the A's Best Financial Strength Rating** (FSR) of the insurer. An Insurer's FSR is based upon their ability to meet ongoing insurance policy and contract obligations.

Other Policy Provisions:

1) **Entire contract**

This is simply the insurance policy itself, and any endorsement or any riders attached to it. The original application may be considered part of the original, entire contract. Any changes to the contract must be approved by an executive officer of the insurance company, and the insured must be notified of any changes by the attachments or riders to the policy

2) **Incontestability**

2 years after an insurance policy is issued (given there are no errant or fraudulent claims made on the application for insurance, that policy then becomes incontestable. The insurance company can't use any errors on the application to void a policy or deny any claim. This **2**-year period includes pre-existing conditions and sicknesses. A claim cannot be reduced or voided on these grounds.

3) **Grace period**

Insurance companies must allow a grace period for the payment of premiums towards a policy. This is a specific period of time that follows the premium due date in which coverage continues as if the premium had been paid on time. Also, the coverage continues with no reductions or penalties. This grace period usually depends on how frequent premium payments are made:

- Weekly payments require a **7**-day grace period
- Monthly premiums require a **10**-day period
- All other policies require a **31**-day grace period

4) **Reinstatement**

If an insurance policy lapses or is canceled, it can be reinstated (with certain exclusions) when the insurance company accepts further premium payments from the insured. An application for reinstatement may be required. Once the policy is reinstated, there is a **10**-day waiting period for illness benefits. There is no waiting period for any accident coverage. Reinstatement is subject to any provisions or riders that may be attached to the policy.

5) **Notice of claim**

This requires the insured to inform the insurance company in writing of any claims within **20** days of their loss. This notice is subject to reasonable factors (e.g., the insured is incapacitated for more than **20** days after an accident). In this case, the insurance company would still be expected to pay the claim.

However, if this policy continues to pay disability income for a long period, the insurance company can require the insured to provide written notice every **6** months that the claim is continuing. Again, this is subject to reasonable circumstances.

6) **Claim forms**

The insurance company must provide the insured with the proper forms to document their loss within **15** days after receiving a notice of claim (see above). However, if the insurance company fails to provide the required the forms, the insured must file a written and detailed claim with as many facts and figures as possible.

7) **Proof of Loss**

Written proof of a loss must be provided by the insured to the insurance company within **90** days after the loss. Again, the coverage is not canceled if the insured is incapable, because of a medical condition, of providing proof of loss. In this case, proof of loss must be furnished within one year of the original due date.

8) **Time of Payment of Claims**

Except for special claims involving periodic payments over a specified period of time, the insurance company must make the benefit payment immediately after receiving the required proof of loss (see above). Payments for a disability over a specified period of time must be made to the insured at least once a month. This provision is always contingent of the insurance company receiving written proof of loss.

9) **Payment of Claims**

This required provision states that any Death benefits shall be paid to the beneficiaries named in the policy. If there is no beneficiary named, then the insurance company shall pay the benefit to the insured's estate. Also, any accrued benefits at the time of death (e.g., any monthly indemnities) must be paid to the named beneficiary or the insured's estate. However, as long as the insured is alive, all benefits must be paid to them unless otherwise stated in the policy.

10) **Physical Exam and Autopsy**

This provision allows the insurance company to require the insured to undergo a physical exam while they are receiving benefits. These examinations are performed by a skilled caregiver and must be paid for by the insurance company. However, if the insured has died due to an accident, the insurance company is permitted to have an autopsy performed to determine the exact cause of death. State laws may apply.

11) **Legal Actions**

This provision provides the insurance company with a **60**-day period after receiving a claim to make sure it is valid. During this time, the insurance company may investigate the claim, and is protected from being sued by the insured for those **60** days. The statute of limitations for suing an insurance company is three years after provision of written proof of loss.

12) **Change of Beneficiary**

The insured may name a beneficiary as revocable, meaning the insured may change the named beneficiary at a later time; or irrevocably, meaning the named beneficiary may not be changed. Any changes in benefit payments concerning a policy with an irrevocable beneficiary must by made with the insured's and the irrevocable beneficiary's permission.

3. Optional Provisions

There are **4** important Optional Provisions:

1) Change of Occupation

This provision protects the insurance company from having to pay benefits when the premiums for the policy were established. This usually occurs when the insured's occupation changes and is much more or less dangerous than before.

The insured needs to submit, in writing, proof that their occupation is either less dangerous or more dangerous than when the policy was established. Failure to notify the insurance company could result in a reduced benefit payment to the

insured; or an overpayment of premiums by the insured to the insurance company, based on the more hazardous occupation.

2) Misstatement of Age

If the insured claimed to be older on the application, the insured has probably been paying a premium that is too high. In this case, the insurance company usually increases the coverage to match the insured's age.

If the insured understated their age (claimed to be younger) the benefits received by the insured would be significantly reduced. Thus, the coverage matches up to the premiums paid.

3) Illegal Occupation

This is a common exclusion to all insurance policies. No benefits whatsoever will be paid out for injuries or death suffered while committing or attempting to commit a crime.

4) Narcotics

This is another common exclusion. Most policies will not pay any benefits towards injuries or death suffered while under the influence of drugs and/or alcohol. This does not include legally prescribed medications issued by a doctor.

5) Automatic increase provision

A simple rider that serves a simple purpose. It increases your total monthly benefit each year to help keep pace with inflation.

4. Certain Disability Income Provisions

Social Security benefit integration and riders provide that if an insured is unable to collect, or if Social Security denies his/her disability benefit, additional income will be paid to offset the loss.

Rehabilitation benefits provide coverage to pay for any physical therapy and vocational training in addition to income payments.

5. Riders

Riders allow the original insurance policy to be modified or updated. A Rider is a separate item that is created and printed out. It then is physically attached to the standard contract policy. One or more officers of the insurance company must sign the agreement spelled out in the Rider. However, if the Rider reduces or ends any coverage, an officer of the insurance company and the insured must sign it.

A Social Security Rider? Yes, you can purchase a rider to your disability plan that makes payments until Social Security disability payments kick in. If SS payments stop, the insurer picks-up the payments again.

The important types of Riders include:

- Impairment Rider
- Guaranteed Insurability Rider
- Cost of Living Rider
- Waiver of Premium Rider
- Return of Premium Rider
- Multiple Indemnity Riders
- Transplant Rider

Here's a closer look at those riders:

A. Impairment Rider

An **Impairment Rider** excludes any existing medical illness or chronic physical ailment from coverage. This would include any pre-existing conditions that an insurance company would otherwise exclude from a health policy. The Impairment Rider allows the insured to get insurance coverage that might have otherwise been refused, and protects the insurance company from high risks.

B. Guaranteed Insurability Rider

A **Guaranteed Insurability Rider** allows the insured to buy more disability income coverage at ages that are specified in the Rider. The insured is not required to provide the insurance company with proof of prior insurance. This type of Rider states specifically the ages when the additional coverage can be purchased (e.g., 40, 45, and 50) and exactly how much additional coverage can be purchased at that time. This amount is usually no more than twice the monthly indemnity at the date of original purchase of coverage.

C. Cost of Living Rider

A Cost of Living Rider provides for annual increases in coverage due to inflation and is based on a rise in the Consumer Price Index (CPI).

D. Waiver of Premium Rider

Provides the waiver of any further premium payments if the insured should become totally disabled. The disability must be **90** days or longer for the waiver of premium rider to be effective. When the disability ends, the insured starts paying the premiums again. However, if the disability is deemed permanent, the policy coverage remains in effect with full Waiver of Premium until the insured turns 65.

E. Return of Premium Rider

The Return of Premium Rider provides for a return of all premiums paid if by a certain age (such as 65), the insured hasn't had a claim, or hasn't received benefits over a particular threshold amount.

Note: An additional premium charge makes this rider expensive for anyone over 40.

F. Multiple Indemnity Rider

A **Multiple Indemnity Rider** doubles or triples the amount of benefits paid out towards AD&D, depending on the cause of the death or dismemberment. The insured can purchase these double or triple indemnity riders, which would result in a higher pay out to beneficiaries should AD&D occur.

Putting it into Context:
Jeff has an AD&D policy that stipulates, should he die by accident, that his wife would receive $500,000. Jeff wants to increase that amount should the unthinkable occur, and purchases a double

indemnity rider. His wife would then receive $1,000,000 should he die accidentally.

G. Transplant Rider

While somewhat new, transplant riders are surfacing that supplement medical expense plans with higher limits and special benefits for an insured needing an organ transplant. This can include higher limits, post transplant evaluations, experimental treatments and more.

5. Other Provisions

Here are some other important provisions you should know:

A. Insuring Clause

The first important aspect of Common Provisions is the Insuring Clause. This simply states the insurance companies promise to pay out certain benefits, as stated in the policy.

The Insuring Clause serves **3** functions:

1) States the general coverages provided in the policy
2) Provides required definitions
3) Describes the conditions under which benefits shall be paid

The Insuring Clause, often considered the foundation of a health insurance policy, contains the terms of the insurance company's agreement to provide coverage.

B. Consideration Clause

This clause describes the promises of the insurance company in exchange for a Consideration, usually in the form of:

- The insured providing the policy premiums required
- The statements made in the original application

The Consideration Clause also states the exact day coverage would begin and the length of the contractual coverage period.

C. Free Look Provision

Many states require this provision, which requires the insured to look over a new policy for a **10**-day trial period. Some states require an even longer free look–anywhere from 15 to 20 days. And, in some states, law requires the Free Look Provision.

This period begins on the day the insured gets the policy. If the insured should find a reason to return the policy by the end of the Free Look period, they would receive *a* full refund of the original premium paid.

Alert!
We've bumped into several final exam questions that look a little like this:
Victor buys a Health insurance policy on September 1, but the agent doesn't deliver it until September 10. If Victor decides he doesn't want the policy, and returns it on September 20, what action will the insurance company take?

Just remember that the 10-Day-Free look period starts when the person actually has their policy delivered to them, so Victor would get a full refund of any premiums paid.

D. Probationary Period

The Probationary Period (see also Unit 2) is a specified time period that starts the day a new policy goes into effect. It is important to note that no benefits will be paid during this period, usually 15, 30, or 60 days.

The Probationary Period protects the insurance company from having to pay out towards any preexisting conditions.

E. Elimination Period

Disability Income policies include an Elimination Period. This is a period of time between the beginning of a disability and the beginning of benefits payments (see also Unit 2). The insured may choose the length of the Elimination Period when they purchase a disability policy, usually from 30 days up to a year. The length is based on how long the insured feels they can go without benefit payouts, depending on other financial resources available to them. A longer Elimination Period usually means a lower premium payment.

F. Coordination of Benefits (COB)

Coordination of Benefits is a provision used when a couple, both employed, are each covered by a group health policy as a dependent on the other's plan. This 'double coverage' results in being overinsured, and the law in almost every state requires this provision.

In cases of 'double coverage', one company that covers the individual filing the claim is called the primary insurance

company. This primary company is required to pay as much of the claim as the particular policy states. The additional insurance company is known as the secondary company. Generally, the secondary insurance company pays towards whatever costs the primary insurance company did not cover.

COB, simply stated, is the primary insurance company paying toward the claim as if double coverage were not in place; the secondary insurance company then pays whatever the primary company did not.

Putting it into Context:
John and Karen have been married for six years. They both have Group Health coverage at heir jobs and both list the other as a dependent. When John has a heart attack, his plan at work (primary insurance company) pays out benefits over a certain time, as stated in his policy. After his policy benefits are exhausted, Karen's policy (secondary insurance company) begins to pay out the reminder of the medical expenses since John is named as a dependent on Karen's policy.

G. Family Deductible

The **Family Deductible** clause provides a maximum deductible for more than one family member who requires coverage, an amount less than the sum total of individual deductibles combined when a calendar year deductible, rather than a per cause deductible

H. Carry Over Provision

The Carry Over Provision allows claims in the last **3** months of the year to carry over toward the next year and the deductible.

I. Pre-Existing Conditions

This exclusion means that no coverage will be provided for a condition that existed a period of time before the coverage was in force. This clause can be overridden by the no loss-no-gain rule, which requires a replacement policy to pay existing claims presented under the old policy.

J. Waiting Periods

The period of time specified in a health insurance policy which must pass before some or all of your health care coverage can begin. The most common is referred to as the employer waiting period and is found in an employer group plan in which a new employee must wait a given time period, often within three months, before being eligible for health care services. This waiting period is imposed by the employer and is usually done to avoid **hit and run behavior** by their new employees, in which they file a large claim right after joining, and then quickly leave the company.

K. Take-Over Benefits

The terms used in the health insurance industry for coverage that will take someone with a pre-existing condition are open enrollment or takeover benefit's. Most U.S. health plans do not offer these features. Also, these plans have different meanings within specific health plans and both do not always go

together, especially when enrolling in a new health plan without prior coverage.

L. Deductible Carryover

During the last three months of a calendar year, charges incurred for health services can be used to satisfy the deductible for the following calendar year. These credits may be applied whether or not the prior calendar year's deductible had been met.

M. Coinsurance

Having a health plan that requires you to pay a coinsurance, or percentage participation, rate means that you'll essentially be splitting the cost of your healthcare with your insurance carrier.

For instance, if your health plan has an 80/20 co-insurance rate, (coinsurance rates of 70/30 90/10, and flat rates of $5.00 to $20.00 per doctor's office visit are also common) your insurance plan pays for 80% of your eligible medical expenses and you're responsible for the remaining 20%.

N. No Gain / No Loss

If a health plan replaces a policyholder's prior plan of group insurance, everyone who was covered by the prior plan on the day before that plan was replaced by this Plan, whether or not they are working, must be offered coverage by the replacement plan, unless otherwise specified.

O. First Dollar Coverage

An insurance policy where the insurer pays for all expenses once an insured event occurs. There is usually a (high) maximum amount limiting first dollar coverage, but the policy does not include a deductible, coinsurance, or anything else; the insurer is responsible for all expenses up to that maximum amount. Because these plans carry more risk for the insurer, first dollar coverage comes with higher monthly premiums.

P. Restoration of Benefits

Most Major Medical policies contain a Restoration of Benefits provision that allows a dollar amount of coverage to be restored each year following a claim.

6. Common Exclusions and Limitations

Most Disability Income and Medical Expense policies have Exclusions and Limitations. Exclusions provide no coverage whatsoever, while Limitations may pay out reduced benefits:

- Pre-existing conditions
- Self-inflicted injuries
- Suicide
- Acts of War
- Military duty
- Injury while committing a felony
- Injury or illness while under the influence of drugs or alcohol
- Noncommercial air travel
- Cosmetic surgery
- Dental expenses
- STD's
- Vision coverage
- Care provided by a VA or Workers Compensation
- Experimental medical procedures
- Organ transplants
- Alcohol/drug abuse treatment
- Infertility services
- Subrogation, the right of the company to seek reimbursement from a responsible third party

7. Rights of Renewability/The Right to Terminate

This is also known as policy continuation. There are **5** important concepts:

1) Optionally renewable
2) Conditional renewable
3) Guaranteed Renewable Policies
4) Cancelable Policies
5) Non-cancelable Policies

Here's a closer look at those **5**:

A. Optionally Renewable

The insurance company can elect to not renew a policy, buy may only do so on the date the premium is due. This option is only open to insurance companies. The insured may elect to cancel a policy at any time by communicating with the insurance company or by not paying the premium.

B. Conditionally Renewable

The insurance company may choose not to renew a certain policy, but only under certain conditions that are specified in the policy.

C. Guaranteed Renewable Policies

The insurance company passes on it's right to cancel a policy at any time or to deny a renewal.

Guaranteed Renewable Policies contain **5** important elements:

1) Guaranteed renewal so long as the insured continues to pay premiums
2) The insurance company can only cancel when the insured fails to pay premiums
3) Premiums may not be increased individually
4) Premiums may be increased on a group basis or occupational classification
5) The Guaranteed Renewal ends at a specified age

Putting it Into Context:
Just in case that isn't perfectly clear—an insurance company can raise the premium rates on a guaranteed renewable policy, if the company is raising the rates for everyone in the class/group/etc. So, the company can raise premiums, if they decide to raise premiums for all construction workers.

They can't just raise Joe Schmo's individual rates.

A Guaranteed Renewable Policy means the insurance company must renew. However, the terms of this renewal can be limited. The insurance company reserves the right to raise premiums for an entire occupational class, based on the risks involved with insuring that class.

Also, the policy may deny Guaranteed Renewal when the insured reaches a certain age: anywhere from 60 to 70. In most states, if the insured purchased this type of policy after the age of **54**, then the insurance company must not cancel or

deny renewal for a minimum of **5** years. Obviously, a Guaranteed Renewable Policy will have a higher premium than a cancelable policy.

D. Cancelable Policies

This type of policy allows the insurance company to cancel a policy at any time. Any unearned premiums must be returned to the previously insured at time of cancellation. Today, these policies are fairly uncommon. If a policy is cancelled, the insurance company must notify the previously insured in writing. A cancellation of a policy does not relieve the insurance company of paying out benefits towards existing claims.

E. Noncancelable Policies

The term **Noncancelable Policy** is often used interchangeably with a Guaranteed Renewal Policy. The insurance company may not cancel this type of policy.

It is important to note the difference between a Noncancelable Policy and a Guaranteed Renewal Policy: the insurance company may not raise premiums for any reason. The original premium paid is the same premium that will be paid throughout the life of the policy.

Again, Noncancelable Policies have higher premiums and usually apply only to Disability Income Policies.

END SECTION

Study Required Minutes before taking the Section Quiz.
Answer all questions correctly on the Quiz to move
to the next Study Section. Re-take Quiz if needed.

√ **Search this section using CTRL+F**
√ **Please study required minutes before taking Section Quiz**
√ **CAUTION: 20-Minutes or more idle time (no study activity) will cause disconnection and loss of study session minutes**

Section AH 7

APPLICATIONS, UNDERWRITING & CLAIMS

Objectives

Sometimes very important things in our lives start with simple steps. **Life Insurance** is no exception. The **application** not only begins the process to provide an individual with coverage, but there are also crucial legal aspects to the **application for insurance**. As a licensed agent, accurately completing the application is an important step in developing long-term and enriching relationships with your customers, and to your career. So, do not take this Unit lightly. Take notes and remember: this is what you will actually be doing once your career as a licensed agent begins.

APPLICATION FOR LIFE INSURANCE

The agent completes the **application** as they question and converse with the applicant. The applicant is the person asking the company for insurance. Remember, *the applicant is not necessarily the individual who would be insured.* At this point, that person is known as the **proposed insured**. The insurance company will determine if

the person will be insured, by the information on the **completed application**. Again, it is crucial that both the agent and the applicant fill out the application accurately and completely. The **application will become part of the legal contract of the policy** and be a physical part of the policy itself. The applicant must sign the application, stating that they have provided accurate information to the best of their knowledge. The agent must also sign the **application.** It is important to note that most **applications** contain space for additional comments from the agent during the customer interview process.

Answers the applicant provides may indicate that additional information may be required by the company to make an underwriting decision. A questionnaire regarding specific details of a medical condition such as asthma, or a hazardous sport such as skydiving or scuba diving, completed and signed by the applicant is a common request.

Insurance Discrimination

Insurers may not refuse an application or the issuance of insurance or charge higher premiums for reasons of race, color, religion, sex, gender, gender identity, national origin or sexual orientation.

Insurers may not charge higher premiums

MINORS

Individuals under the age of 18 cannot enter into a legally binding contract. A person is considered a minor–for the purposes of life insurance–until they have reached the age of 15. If the individual is under the age of 15 (or, some insurance companies even if they are older than 15) the **application** must be signed by a parent, grandparent or legal guardian who is the owner of the policy.

CORRECTIONS

Any mistakes that are corrected on the **application for insurance** must be done by the agent and **initialed by the applicant**. This is true for any mistake or omission. A mistake on an application could be costly to the agent, the customer and the insurance company. It could result in improper premiums being charged or incorrect and insufficient coverage being supplied to the customer. It is the *total responsibility of the agent* that the application is delivered to the insurance company **completely and accurately**. Incomplete or incorrect applications can be cancelled or voided by the insurance company before the policy's incontestable clause comes into effect.

REPRESENTATIONS, MISREPRESENTATIONS AND WARRANTIES

A **representation** (including **ALL** of the statements made on the application) is a statement an individual has made and believes to be **true and correct to the best of their knowledge**. It is considered to be a **representation** of the truth.

A **warranty**, however, **is a statement made that is guaranteed to be true.** It is important to note that no statement made on an application for life insurance is considered to be a **warranty**.

A **misrepresentation** is the presentation of false information by the proposed insured or applicant. It is considered *fraud* when the **misrepresentation** is an intentional effort to gain an advantage, and results in a loss by the insurance company. There is a major difference between an honest mistake and an intentional *fraud*.

Concealment is a term closely related to misrepresentation and is the **withholding of information** from the agent or insurance company that would be a material factor in determining if coverage would be provided.

CONDITIONAL RECEIPT

Once the application has been completed accurately and fully by the agent, they usually then collect the first policy premium payment and

issue a **conditional receipt**. Even though the policy has not yet been approved and issued, the agent still collects the payment.

The **conditional receipt** serves four functions as it:

- States that the policy will be issued if approved by the insurance company
- Serves as a receipt for the first full premium and acts as a temporary policy
- States the conditions that the policy *will pay out* should the proposed insured die before the policy is issued, if the policy *would have been approved* by the insurance company
- States that the policy *will not pay out* should the proposed insured die before the policy is issued, if the policy *would have not been approved* by the insurance company

With payment of the first premium and issuance of the **conditional receipt**, coverage may begin immediately, as long as the policy is later approved. If the policy is denied, the customer is notified immediately and is given a full refund of the payment.

A binding receipt and/or a written binder, is not used in life insurance.

POLICY EFFECTIVE DATE

The **policy issue date, or effective date** is the actual day the policy begins providing full protection. The policy's incontestable clause is also based upon the **policy effective date**. Also, the policy's suicide clause is based on the **policy effective date**. This date must be made clear to the insured because so many important matters are based on this date.

The **delivery date of a policy** is important with regard to many of the disclosures mentioned below. **It is from this date that any free look period begins.** Delivery of a life insurance policy should always be **in person**. It is an opportunity to review the policy, answer any question, make any changes, and to build on the client relationship,

a key aspect of **policy retention** and multiple sales opportunities for the agent, the company, and of course the client, who benefits from the insurance protection.

If not practical, delivery may also be **by registered or certified mail**.

REPLACEMENT

State regulations are in place to protect insurance consumers in transactions that involve the **Replacement** of a life insurance policy or annuity. **Replacement** refers to any transaction involving a policy

being lapsed, surrendered, or borrowed on to purchase new insurance.

The laws involving **Replacement** are meant to regulate the activities of insurance companies and their representatives, to **protect the insurance buying public** by establishing minimum standards of conduct, and to insure that an insurance consumer receives timely and accurate information so they may make an informed decision that is in their own best interest. **Replacement** regulation also reduces the risk of misrepresentation or lack of disclosure. Finally, these regulations establish the penalties for failure to comply.

Replacement regulations require an agent (and company) who replaces or offers to replace an existing policy, to provide the policyholder with written, signed, and dated documents, comparing the terms, conditions and benefits of an existing policy with the proposed new policy.

Replacement is defined as; the purchase of a new life insurance policy or annuity when a current policy or annuity is going to be:

- Lapsed, surrendered, partially surrendered, forfeited, or otherwise terminated
- Changed to lower the policy's term or benefits
- Reissued with a reduced policy cash value
- Converted to a nonforfeiture benefit

- Used in a purchase with money withdrawn, borrowed or obtained from the surrender of an existing policy

Any company that is replacing the policy of another must notify the existing company of the **Replacement** within 3 days of receiving the new application for insurance. The new insurance company must also keep the notice of replacement for *at least* 3 years or until their next Insurance Division audit. The insured must also be provided with a **30-day Free Look provision**.

It is important to note that there are *5 important Exemptions* where **Policy Replacement** regulations do not apply:

- Credit Life Insurance
- Group Life Insurance or annuities
- When the existing policy is being replaced by the same insurance company
- A policy that is used to fund a pension or other retirement plan
- A new policy that is entirely paid for by the insured's employer

DISCLOSURES AND AUTHORIZATIONS

Insurance producers and companies are required to provide certain **Disclosures** to potential buyers of insurance. The purpose is to avoid any confusion or misrepresentation on the part of the insurance company or it's representatives. The buyer must be made

fully aware of what type of insurance they are considering and the type of policy they might buy. In order to make sure this happens, an insurance company must provide a prospective buyer with;

- A Buyer's Guide
- A Policy Summary
- Policy Illustration with Cost Comparison Indexes

BUYER'S GUIDE

This is an informative booklet that helps the potential customer make good decisions about what type of insurance they need, how much insurance they need, and allows them to compare the costs of the different types of policies they are considering. The **Buyer's Guide** also clearly defines **Whole, Term and Universal** Life policies. The company must provide the potential customer with a **Buyer's Guide** at policy delivery or when requested.

POLICY SUMMARY

A **Policy Summary** is a separate written document that describes the specific elements of the insurance policy. The **Policy Summary** must contain the following 8 items:

- A clearly placed title such as,

"**STATEMENT OF POLICY COST AND BENEFIT INFORMATION"**

- The name and address of the agent and the insurance company
- The generic name of the type of policy (e.g. term, whole life, etc.)
- With respect to the first 5 years of the policy, the annual premiums, guaranteed amount payable upon death, the total guaranteed face value, the guaranteed cash surrender value, the cash dividends due to the policyowner annually, and any guaranteed endowment amounts
- The annual percentage rate that would be charged on any **Policy Loans**
- The Surrender Cost and Insurance Net Payment Cost Indexes for 10 and 20 years
- A statement to the effect that an explanation of the intended use of these indexes is provided in the **Buyer's Guide**
- The date the **Policy Summary** was prepared

Like a **Buyer's Guide**, a **Policy Summary** must be provided to any prospective customer at policy delivery or upon their request.

POLICY ILLUSTRATIONS

Policy Illustrations may be of 3 types:

- Basic Illustration
- In Force Illustration
- Supplemental Illustration

A **Basic Illustration** is a proposal that shows the both the policy's **guaranteed and non-guaranteed** elements.

A **Supplemental Illustration** is usually provided in addition to the Basic Illustration. It can only show non-guaranteed policy elements that are similar to the **Basic Illustration**.

An **In Force Illustration** is provided to the policyowner at any time the policy has been in force for more than one year.

Guaranteed elements include the premiums, death benefits, cash values and riders that are established and guaranteed when the policy is issued.

Non-guaranteed elements include the premiums, death benefits, cash values and riders that are shown by illustration over a number of years and are not guaranteed when the policy is issued.

ALL **Policy Illustrations** must be clearly labeled 'Life Insurance Illustration' and must include:

- The name of the insurance company/provider
- The name and address of the insurance company/provider

- The name, sex, and age of the proposed insured
- The rate classification under which the illustration is based (e.g., smoker, non-smoker)
- The generic name of the policy, form number and company product name
- The initial death benefit
- Any dividend option if applicable

Life insurance policies that use illustrations must also include annual reports that show the following:

- Annual premiums
- Current dividends
- Current death benefits
- Outstanding loan amounts
- Current cash surrender values
- Application of current dividends

It is important to note that any interest rates used in an illustration cannot be higher than rates currently being offered by the insurance company. If a **Policy Illustration** is used, the insurance company must keep copies, including any revisions or updates, for at least 3 years after the policyowner terminates the policy.

When a **Policy Illustration** is to be used during any sales presentation of a Life Insurance policy, the insurance company, or it's representative, may not:

- Claim or mention that the policy is anything but a Life Insurance policy. Prohibited are claims of it being an 'investment' or a 'retirement savings account'
- Mislead or describe that any non-guaranteed elements in the policy are actually guaranteed
- Use or make reference to any **Policy Illustration** that does not comply with state laws and regulations
- Provide or show any incomplete illustrations
- Use the term 'vanishing' or 'vanishing premium', or any term that implies the policy becomes paid up or that future premiums can be paid by non-guaranteed elements
- Use a **Policy Illustration** that shows policy performance as more favorable to the policyowner than the insurance company's illustrated scale
- Use a higher interest rate to increase cash value or other non-guaranteed elements than the insurance company's underlying rate scale

Regulations concerning **Policy Illustrations** applies to all life insurance policies *except* for the following:

- Variable life insurance
- Group term life insurance
- Credit life insurance
- Individual and group annuity contracts
- Any life insurance policy with a face value of less than $10,000

Any **Policy Illustration** used in a sales or marketing presentation must also be signed and dated by the potential insurance consumer to indicate that the illustration has been explained to them and they understand it.

COST COMPARISON INDEXES

The **Cost Comparison Indexes** show the cost of the benefits provided in an insurance policy. These indexes factor in the concept of the **time value of money**. For instance, a lower cost index would be a sign of lower costs for the benefits being paid for. These indexes are useful when comparing similar policies. Generally, there are 2 types of indexes used.

A **Net Cost Comparison Index** is useful if the buyer's main concern for the policy is the benefits paid at the time of death. The level of

the policy's cash value is of secondary importance. This index helps compare costs at a future time, usually 10 or 20 years ahead. These predicted amounts are based on the premiums being paid and no cash values being taken from the policy.

A **Surrender Cost Comparison Index** is useful if the level of the cash value of the policy is the more important concern. This index helps the buyer compare costs if in the future (again, 10 or 20 years) the policy was surrendered for some reason and the cash value of the policy taken.

If the application for insurance includes a request for certain riders, additional signed disclosure is required for the following;

Accelerated Benefit Rider Disclosure – provides a disclaimer regarding any tax consequences, possible loss of any state or federal benefits such a Medicare or Social Security, and a reduction in death benefit.

Critical Illness Disclosure – in addition to the notices, it also provides a definition of covered and not covered conditions under the rider as well as exclusions and limitations.

AUTHORIZATIONS

Disclosure may also be considered to include any required **Authorization** forms for the release of any personal, financial, or

medical information to be used in the underwriting of the applicant for insurance with the applicant's signature.

In addition to the signed application as consent and disclosure, there are supplemental forms including:

HIPAA Authorization for Release of Medical Information – The HIPAA Privacy Rule (2002) requires compliance in protecting the health information of individuals by health care providers. Release of any medical information by them, including to an insurer, require a signed release.

HIV Notice and Consent (State Specific) – Requires insurance applicants to be advised of any blood testing for HIV in determining insurability, and to choose the disclosure of HIV positive results, with a signed notice and consent form approved by the state insurance department.

Authorization to Obtain and Disclose Information (State Specific) – A predecessor to the HIPAA form, this signed release may be still be required in many state jurisdictions.

Attending Physician's Statement -- A report by a physician, hospital or medical facility who has treated or treating a proposed insured.

DO NOT CALL LIST

The Federal Trade Commission (FTC) amended the Telemarketing Sales Rule to give consumers a choice in receiving telemarketing calls.

Effective October 1, 2003, it is illegal to call a number listed on the National Do Not Call Registry. (Many states have established similar laws). Solicitation of names and telephone numbers should be “scrubbed” against the Do Not Call List by the list provider, or by the company you are calling on behalf of. A violation of the law provides for a civil penalty. It is not a violation to call an existing customer.

Underwriting

Objectives

This Unit will cover some of the actual day-to-day functions of your career as a licensed insurance agent. **Field Underwriting** is the most direct way for you to positively influence and improve the lives of potential customers. We will discuss basic definitions and principles of **Field Underwriting,** as well as several resources you will have to help you make good decisions about underwriting policies

Legal Relationship and Responsibilities

An agent appointed by an insurance company is **acting on behalf of the company** when soliciting, selling, and servicing insurance with the public. The agent is considered to be a **fiduciary**, that is, in a position of trust and as such, he must act in good faith in dealings with the public, as well as insurers.

Responsibilities to an insurer include;

- a duty to the insurer
- conducting themselves prudently
- remitting all monies promptly
- completing applications accurately
- disclosing all information to the insurer
- delivering the policy
- obeying insurance laws

Insurer responsibilities to the agent include;

- act in accordance with agent contract
- paying all compensation due
- informing the agent of product changes

The agent also faces responsibilities **to the insurance buying public** including;

- soliciting applications
- explaining coverage
- assessing needs
- putting the client interest first
- providing service and reviews
- protecting confidences

Underwriting determines which individuals are acceptable to insure, according to the company's standards. Selling a policy to just anyone would be profitable in the short term, but ***adverse selection*** would make it disastrous in the long term. So, **Underwriting** provides insurance companies with methods to determine **who can be insured** and ***classify risks between those who are preferred, standard and substandard.***

Initial, or ***field underwriting***, begins with the agent. This underwriting is done ***prior to the application*** compared to other forms of underwriting done after the application by the insurance company.

Insurance Applications

The application must be completed ***accurately and truthfully*** to the best of the agent's ability.

Basic underwriting requirements will vary based on the company.

Agent Report (Statement)

The agent has a responsibility to the insurer to report on the application information such as how long the agent has known the applicant, whether the agent has knowledge that the proposed insurance is being purchased to replace existing insurance and to supply basic information the agent has knowledge of regarding the applicant's health, financial situation and general character.

RISK SELECTION

Important to successful **risk selection** are 8 factors insurance companies use to determine **insurability.** Additional considerations are **insurer expenses** and **investment return:**

- Age
- Occupation
- Medical history
- Lifestyle
- Place of Residence
- Financial condition
- Physical condition
- Moral condition

Age concerns the age of the proposed insured. This, of course, has to do with how many years the individual is likely to live. By using mortality cost tables, companies are able to determine how likely a person of a certain age is of dying within the next year.

Occupation is the type of work a person does. A teacher would be considered to have a less hazardous occupation than a construction worker.

Medical history is the record of the person's past health. Chronic ailments could be a factor in the determination of a person's

insurability. Medical questions are asked and answered by the applicant. Depending on the applicants age and the amount applied for, the application could be **"non-medical"** though a company reserves the right to request a medical examination before issuing a policy.

Lifestyle factors in dangerous hobbies (e.g., deep-sea diving, private pilots, mountaineering).

Place of Residence is important to determine insurability because of the negative health effects that are sometimes associated with living in underdeveloped countries.

Financial condition is simply the proposed insured's ability to pay premiums, along with all other bills. A large life insurance policy would lapse if the insured were unable to pay the premiums over a long period of time.

Physical condition takes into consideration the person's overall health at the time of application for insurance. Although pre-existing conditions are no longer a factor.

Moral condition typically concerns the known use of illegal drugs, which would be a factor in the proposed insured's moral condition as well as their insurability.

Unfair Distinctions & Discrimination

Race, Sex or Religion -- Insurers may not refuse an application or the issuance of insurance or charge higher premiums for reasons of race, color, religion, sex, gender, gender identity, national origin or sexual orientation.

HIV and AIDS Discrimination – Due to medical advances, the longevity of HIV and AID's infected individuals is prolonged. While insurers can still decline an application on the basis of a positive ELISA test (the HIV test), they cannot indiscriminately test for HIV without the informed consent of the applicant. Once a test has been conducted, the insurer must maintain strict confidentiality regarding the results.

Genetic Testing – insurers cannot indiscriminately test for an applicant's genetic characteristic for disease without informed consent. Results must be handled in a strict and confidential manner. ***Genetic characteristic*** means a gene that is known to cause a disease even though it may not have symptoms.

ADDITIONAL UNDERWRITING

If an application reveals certain health conditions or other risk exposures, the insurer may require additional information in the following forms:

Medical Information Bureau (MIB)

In the process of underwriting, where additional information is requiredThere are many external organizations that provide insurance companies with information about those who apply for Life Insurance. The **Medical Information Bureau** is an association of several hundred life insurance companies that stores information about any person who applies for insurance. The information reflects the person's health and physical condition. The **MIB's** main purpose

is to lessen the effects of *misrepresentation, fraud and withheld information*. This sort of information is also stored by the **MIB**. However, there are four procedures the **MIB** and insurance companies must follow in order to protect the person's right to privacy:

- The insurance company *must* notify the applicant in writing that they may report their findings to the MIB
- The MIB *must* have authorization from the applicant to provide information to other member insurance companies
- The individual may request *in writing* that the MIB disclose any information in their records
- The applicant *must* be made aware that an application for coverage or a claim may cause the MIB to supply any information to another member company.
-

Attending Physician's Statement & More – a report requested by the insurer but filled out by a physician, hospital or medical facility who has treated or is treating a proposed insured. It is a summary of all pertinent medical conditions, illnesses and treatments of the insurance applicant. Inconsistent or missing information will compromise the risk analysis process. An applicant or APS that reveals a condition needing more information can delay approval of the policy pending confirmation and possible rating of the proposed insured.

Credit Reports

Agents for health insurance may advise the applicant that a credit and/or medical information report may be requested. Following are necessary requirements before such reports can be accessed:

- The insurer has to get the applicant's consent before obtaining medical information.

- The insurer has to give the applicant written disclosure within **3** days of requesting a consumer report.
- If the insurance coverage is denied because of the consumer report, the consumer can find out what that information is, just in case it's inaccurate.

If the person receives an adverse notice report, that report has to include:

- The contact information for the consumer reporting agency
- A legal statement that the consumer reporting agency didn't have anything to do with the person getting denied for insurance
- A notice that the applicant has the right to dispute the information in the report. Upon request, the consumer reporting agency (NOT THE INSURER) will then supply the person with a free copy of the report within **60** days

DMV Reports show if you have been involved in an accident that could effect your health or the type of coverage you need.

Hazardous Activity Questions are typically asked to determine if you have a "death wish" or will be prone to accidents based on dangerous hobbies like aviation, scuba diving, auto or motorcycle racing.

Medical testing, like EKGs, treadmill or physical exams might be requested to determine your health suitability.

UNDERWRITING OUTCOMES

Health Insurance Underwriting, under Obamacare, has changed dramatically. Basically, there is ***no more medical underwriting for the insured or agent*** to handle as there are NO pre-existing conditions under the law.

For marketplace or non-marketplace policies, ***insurers*** cannot ask for health information on an application, increase premiums based on

the level of health risk, exclude benefits based on health or refuse coverage.

Policies sold outside the exchange and disability income policies may still require underwriting and assign ***Standard, Substandard or Preferred Risk Ratings –***

Even if a person is determined to be a high risk, many insurance companies will still be able to offer some kind of policy. The healthy individual would be a **preferred risk**, while the unhealthy person would be considered a **substandard risk.** Insurance companies may issue the substandard risk a ***rated policy***. A rated policy is one that takes into account the higher risk the insurance company is taking by issuing a policy to this person. The premiums on this policy would be higher. An insurance company may add a **flat extra premium charge**, which is a flat charge to the premium that may be permanent or temporary with respect to the life of the policy. Or, they may use a **multiple table extra premium method**. This method would cause the high risk to pay a percentage higher of the standard established premium rates. For example, a standard risk is assigned a 100% rate. A substandard risk, given a 150% rating, would pay 1.5 times the standard established premium rate. The third option is called a **lien plan**. Lien plans reduce the death benefit of the policy in the early years based on the proposed insured's risk. Then the insurance company places a lien against the policy, stating that if the death occurs within this lien period, the face value of the policy will be reduced by the amount of the lien.

Rate-Making Components of a Policy Premium – Underwriting and ratings are just one part of the process that determines premiums. Other factors include:

Morbidity – more deaths than expected can create upward pressure on premiums.
Insurer Expenses – higher costs than projected influence the bottom line and the need for higher premiums.
Investment Return – poorly performing investments can haunt the ability to pay claims and create a need for higher premiums.
Reinsurance – the ability to transfer risk to other insurance companies can be critical to proper reserves, claims and the need for more premium income.
Benefit Duration – The length of time one requires coverage canbe a determining factor in premium. A long term care policy with lifetime benefits, for example, will likely cost much more than one that promised benefits for two years. Liekwise, the benefit duration could be reduced by a ***probationary period***, before coverage begins or an elimination period, or an ***elimination or waiting period*** after an accident occurs.

Mortality is the biggest element of how insurance companies calculate their premiums. The ability to accurately predict how many people of a certain age will die in one year is crucial. This allows the insurance companies to figure how long those they insure will live, when they will have to pay out benefits to the insured, and how much revenue they can expect to earn on Premiums in respect to a person's life span.

RATING METHODS

Even if a person is determined to be a high risk, many insurance companies will still be able to offer some kind of policy. Common sense dictates that a healthy person (no illnesses, non-smoker, non-hazardous occupation, healthy life habits) will probably be offered a policy with a lower premium than a person who is determined to be

unhealthy (smoker, history of heart disease). The healthy individual would be a **preferred risk**, while the unhealthy person would be considered a **substandard risk.**

Insurance companies may issue the substandard risk a ***rated policy***. A rated policy is one that takes into account the higher risk the insurance company is taking by issuing a policy to this person. The premiums on this policy would be higher. An insurance company may add a **flat extra premium charge**, which is a flat charge to the premium that may be permanent or temporary with respect to the life of the policy. Or, they may use a **multiple table extra premium method**. This method would cause the high risk to pay a percentage higher of the standard established premium rates. For example, a standard risk is assigned a 100% rate. A substandard risk, given a 150% rating, would pay 1.5 times the standard established premium rate. The third option is called a **lien plan**. Lien plans reduce the death benefit of the policy in the early years based on the proposed insured's risk. Then the insurance company places a lien against the policy, stating that if the death occurs within this lien period, the face value of the policy will be reduced by the amount of the lien.

EXCLUSIONS An insurance company can still insure a person who is classified as a substandard risk by attaching an **exclusion or rider** to the policy that eliminates the specific high risk element. The policy would then only cover normal risk losses. Examples of specific high risks could be a hazardous occupation or hobby.

INSURABLE INTEREST

In cases where the individual being insured is different than the person applying for insurance, **insurable interest** must be present. It's not difficult to imagine how dangerous or unethical things could occur if one person takes a life insurance policy out on another. Murders and other terrible acts could be committed, as beneficiaries stand to make a lot of money upon the benefit pay out.

Insurance companies will consider the applicant's **insurable interest** before insuring another person's life. This is the applicant's interest that the insured remain alive. Examples of this are usually 'love and affection' or other economic factors.

The following is a standard list of accepted **insurable interest:**

- A person who applies for a policy on their own life
- A person's spouse, child, parent or other close family member

- The owner of a business, a partner or other important employee
- A creditor or associated debtor (only for the amount of the debt)

CONSENT Obviously, a person applying to insure another person must have that individual's **consent**. The person who would be insured is required to sign the application, as well as the applicant or owner and the agent.

Claims

Objectives

In this Unit we will learn the basic definition and structure of a **Life Insurance claim**. The payment of a **claim** is the fulfillment of the "promise to pay", the end result of the insurance process that you've studied in previous Units. We will cover the importance a beneficiary, proof of death, and the responsibilities of the insurance company are upon the payment of a **Life Insurance claim.**

There are four important elements of **Life Insurance claims**:

- Death Claims
- Payment of Claims
- Payments of Claims at Less Than Face Amount
- Responsibilities of the Agent

LIFE INSURANCE CLAIMS

With Life Insurance, the payment of a **claim** means the insured has died, and the beneficiary named in the policy will receive the death benefit proceeds. It is important to note that these claims are rarely negotiated; the claim is either paid or denied. Upon delivery of the claim form and proof of death to the insurance company, the policy is checked for coverage, timelines etc. When the insurance company

has established these, the beneficiary is paid the proceeds under the policy.

PAYMENT OF CLAIMS

The insurance company should be notified immediately upon the death of the insured. Once the proper claim form and supporting paperwork has been received, such as *a death certificate or autopsy report* from a coroner, the insurance company usually does not delay in paying the **claim**. The company will verify that the policy was in force at the time of death, the rightful beneficiary is named, and that there is no evidence of suicide or foul play within the claim. When has been completed, the insurance company usually pays the **claim** within a matter of days. This is a valuable service provided by insurance companies: it is why people buy Life Insurance, and the speedy payment of the **claim** is the right thing to do. Legally, insurance companies have 60 days to pay the claim.

PAYMENTS AT LESS THAN FACE AMOUNT

There are three situations where a Life Insurance claim might be paid out at less than the face value of the original policy.

First, if there were a **loan against the policy**, the outstanding loan principal and interest would be deducted from the amount by the

insurance company. The remainder would be promptly paid to the beneficiary.

Secondly, if the insured dies when the policy is **in the Grace Period**, the amount of the past due premium would be deducted from the face value of the Life Insurance policy before payment is made to the beneficiary.

Thirdly, the benefit payout could be lessened if any discrepancy in the age of the insured is discovered. Protected by the Misstatement of Age or Gender clause when this occurs, the insurance company would determine exactly how much coverage would have been purchased by the premiums paid, and that amount, whether higher or lower than stated in the policy, would be paid to the beneficiary.

RESPONSIBILITIES OF THE AGENT

The agent, after being made aware the insured's death, notifies the company immediately. The agent may then contact the beneficiary or the beneficiary's legal representative. The Agent may assist, but the beneficiary must complete and sign the death claim, and submit it along with the proof, a certified death certificate, to the insurance company.

END SECTION

Study Required Minutes before taking the Section Quiz.
Answer all questions correctly on the Quiz to move
to the next Study Section. Re-take Quiz if needed.

√ **Search this section using CTRL+F**
√ **Please study required minutes before taking Section Quiz**
√ **CAUTION: 20-Minutes or more idle time (no study activity) will cause disconnection and loss of study session minutes**

Section AH 8

INSURANCE TERMS & LAW

Objectives

Insurance has a language of its own: in Life insurance, Health insurance, Property insurance, and in Casualty insurance, as well as Individual or Group. We'll look at some of the common terms in this unit, but refer to the glossary for additional information.
This unit includes:

- General Terms and Concepts (no big mystery there)
- More Terms and Concepts

Insurance Terms and Concepts

1. General Terms and Concepts

Just so you know, In California, the word:

- "***Shall***" means mandatory
- "***May***" means permissive
- "Person" means any individual, association, organization, partnership, business trust, limited liability company, or corporation.

Note: Any provision of the code can be sent out by mail. Or, if not prohibited, sent by ***electronic transmission***

Here are some general terms and concepts you're going to frequently run into when dealing with insurance:

A. Insured

In Life insurance, the **insured** is the person on whose life an insurance company writes a policy. The insured and the policyowner may not be the same person.

In Property or Casualty insurance, it usually means the "named insured," or the one(s) named on the policy.

B. Insurable Interest

Insurable interest is required in the purchase of insurance to protect against an economic loss.

In **Life insurance**, the insurable interest has to exist <u>when someone first applies for the policy</u>.

In **Property** and **Casualty** insurance, insurable interest has to exist <u>at the time of loss</u>.

B. Insurable Events

Insurable Events are any contingent or unknown event, which may indemnify a person having an insurable interest, or create a liability against him, may be insured against.

C. The necessary Elements in a Policy

All insurance policies must contain:

1) Information about the parties involved in the contract
2) Description of the property or the life insured

3) The insured's insurable interest
4) Information about the risks the insurance covers
5) The policy period
6) Premium rates

Note: The financial rating of the insurer is not required.

D. Principle of Indemnity

The Principle of Indemnity is the restoration to the approximate financial position occupied prior to the loss, in whole, or in part, by payment, repair, or replacement.

E. The Law of Large Numbers

The Law of Large Numbers is a theory regarding probability.

The Law of Large Numbers states that:

1) If you take a random sample from a larger population, it's more likely to represent the whole, than if you took a random sample from a smaller population.
2) The more people there are, the more the chance of risk increases.

F. Loss Exposure

Loss Exposure is defined as someone's potential for loss, or their loss exposure/exposure to loss. For example, a homeowner in a particular region of the country will have different kinds of exposures than a homeowner in another region. They may be more vulnerable to hail, tornadoes, or forest fires, so they have a higher exposure to loss to those particular perils.

Exposure is measured in **exposure units**, for which the price of insurance is the rate.

G. Adverse Selection

Adverse Selection is selection against an insurer by insuring more poor than good or average risks, and the tendency of poorer risks to buy and maintain insurance.

H. Concealment

Concealment is the withholding of facts or information by an applicant or insured that may materially affect the decision regarding an insurance risk.

I. Risk

Risk is the chance of loss. The term “risk” is often used in a general way to designate the entire subject matter of insurance covered under a policy or upon which an application for insurance has been received. Risk is also sometimes used to designate a policyholder (e.g. poor, standard, etc.).

There are **2** categories of risk:

1) **Pure Risk** is defined as the uncertainty as to whether or not a possible loss will actually happen. There could be a loss, but no one knows when or how. A pure risk is the chance of loss only.
2) **Speculative Risk** is a loss that’s more predictable, such as gambling, business ventures, or playing the stock market. Speculative risk assumes that, based on the

person's actions/decisions, a loss is inevitable. A speculative risk also has the chance of gain.

Note: Insurance only protects against pure risks.

J. Ideally Insurable Risks

The following criteria describes an ideally insurable risk:

- The loss must be **measurable**
- The loss must be **accidental**
- The loss must be **predictable**
- The **law of large numbers** has to apply
- The loss must create **financial hardship**
- Insurance must be **affordable and practical**
- The loss must not be **catastrophic**

K. Risk Management Methods

There are **4** Risk Management methods used to deal with the uncertainty of loss:

1) **Avoid** the risk
2) **Reduce** or control the risk
3) **Retain** the risk
4) **Transfer** the risk (insurance)

Risk Management Techniques In Healthcare- The overall goal of risk management in healthcare is to reduce the risk of harm to patients, limit liability exposure to healthcare providers and insurers, and limit, even try and prevent, substantial financial loss. In the 1970's, at the dawning of the Medical Malpractice era, risk management techniques became a necessary component in healthcare. Some of the most widely used risk management techniques in healthcare are ensuring

the initial and on-going competency of any and all staff members, maintain compliance with government regulations and contractual agreements, and the constant review and thorough documentation of quality of patient care and patient complaints.

Risk and the Possibility of a Loss- Risks in life are inherent and nearly unavoidable. Everything from getting into your car and going to work to getting in a workout at the gym poses a risk. Insurance is a practical necessity to help mitigate the risks of drivers who do not pay attention or gym equipment that may be faulty. In insurance, healthcare risks are no different. Patient care reigns supreme and must be monitored as such. There are a few categories or health risks that may present the **possibility of a loss**: an adverse event, a patient safety incident, or an inherent clinical risk. Adverse events are events that are unintentional in nature and circumstance. Patient safety incidents are unexpected in nature and usually unintentional as well. Inherent clinical risk is unavoidable in nature and the risk that comes with, for instance, participating in a drug trial or undergoing a necessary surgery.

L. Hazard

Hazard is any factor that creates or increases the chance of loss.

There are different types of **hazards**:

- A **physical hazard** is created by the condition, occupancy, or use of the property itself. Examples include

faulty breaks that increase the chance of collision, and faulty electrical wiring that increases the chance of fire.

- A **moral hazard** is a characteristic of the insured that increases the chance of loss. Examples include arranging an accident to collect the insurance, or inflating the amount of a claim.
- A **morale hazard** is carelessness or indifference to a loss because of the existence of insurance. One example is leaving the car keys in an unlocked car.
- A **Legal Hazard** is created by decisions or actions of the courts. If something could result in big, expensive lawsuits, this is considered a legal hazard.

M. Peril

Peril refers to the specific event causing a loss, such as fire, windstorm or collision.

N. Fraud

Fraud is the intentional and fraudulent omission, or the communication of information of matters, proving or tending to prove false, and entitles the insurer to rescind.

O. Concealment

Concealment is the neglect to communicate that which a party knows, and ought to communicate, and whether intentional or unintentional, entitles the injured party to rescind.

Information you aren't required to communicate includes information that is:

- Already known or should be known
- Waived by the other party
- Not material to the risk

Concealment, whether intentional or unintentional, entitles the injured party to rescind insurance.

P. Rescission

Rescission means the same as revoke or remove. An insurer could legally rescind an insured's policy if:

- There's been intentional or unintentional concealment
- There's been an intentional and fraudulent omission
- A misrepresentation comes to light after a policy has gone into effect
- A material warranty or a material policy provision has been violated

Q. Materiality

Materiality has to do with facts and information relevant to an insurance policy. Materiality can be determined using **3** questions concerning the information:

1) Can the information convince or dissuade either party to enter a contract?
2) Does the information create a disadvantage for either party?
3) Does the information have any affect on the risk or insurability involved?

Materiality concerns both the insurer and the insured. Each party involved in the contract has to have all the relevant information that could have any positive or negative affect on the contract.

R. Insurable Interest, Indemnity and Utmost Good Faith

Insurable interest- Essentially an insurable interest is an economic stake in an event and it is what makes an insurance contract legal and valid. Insurance law requires that the policyholder must have an insurable interest in the insured item or person. If not, the purchaser or beneficiary may not be able to claim or enforce the insurance policy.

Insurable Interest Example:
If you own a house that is damaged by a fire, you have a financial loss that can be claimed. If you neighbor's house burns down, you might feel sorry for him, but you have no financial loss from his fire and therefore no claim against his insurance.

Principles of Indemnity- People purchased insurance for "in case of" scenarios to cover potential losses. If said "in case of" loss occurs, indemnity is the payment of loss to the insured to cover the loss BUT the amount given to the insured for the loss cannot be greater than the actual amount of the loss.
Indemnity is in place to ensure that an insured cannot profit off of a loss.

Utmost Good Faith– Uberrimae fidei, also known as, upmost good faith, is one of the basic principles of insurance in which both parties, insured and the insurer enter into the insurance contract in absolute good faith and trust. Although the Patient Protection and Affordable Care Act (Obamacare), forbids insurers from denying health cover to applicants with pre-existing conditions, there is utmost good faith that the person entering into the health insurance policy is being truthful about their identity (name, date of birth, and such) and whether or not they are a smoker. Insurers must also practice the utmost good faith by promptly and fairly dealing with claims after an insured has claimed a loss.

S. Representations

Representations are statements on an application that the applicant represents as true and accurate, to the best of their knowledge and belief. Representations may be considered to be an implied warranty.

A representation may be altered or withdrawn before the insurance is effected, but not after. A representation is considered false when the facts fail to correspond with its assertions or stipulations.

Misrepresentations are the false representation of the terms or benefits of a policy by an agent, or an applicant who falsely represents the health or other condition of the proposed insured.

T. Warranty

A **warranty** is a statement made by the applicant that becomes a condition of the contract. False warranties void the entire contract.

Warranties do not apply to Life insurance. No statement made on a Life insurance policy is ever considered to be a warranty.

A warranty is either:

- **Expressed** warranties are in written form and attached to the policy.
- **Implied** warranties are not written but still exist under the law. Some representations may qualify as implied warranties.

Warranty & Rescission

A violation of a material warranty allows the other party to rescind the contract, e.g., an insurance company has the right to deny the claim because the **material warranty** was breached when the insured was dishonest about their smoking habits

Materiality

A good test in determining whether or not **materiality** has occurred is to ask whether or not the knowledge of the particular fact would have caused the insurer to reject the risk or accept it and charge higher premiums.

U. General Rules of Agency

An agency is established when an Insurance agent signs an agency agreement to become appointed with an insurance

company. Once an agent for an insurer, the insurance agent is authorized to act on behalf of the insurer to transact certain classes of insurance. A broker, on the other hand, transacts insurance with the insurer, but not on behalf of the insurer.

Producer Responsibilitites.

So, does the agent's or broker's responsibility end there . . . being a good representative of the company? NO. You might have the best health policy around and know it better than any other agent, but it would be immoral, and probably bring a lawsuit to your doorstep, if you sold it to a senior who already signed up for Medicare. Thus, a primary role and responsibility of **health insurance agents, in addition to a duty and loyalty to his insurer,** is to provide clients with the most appropriate health insurance plan to fit their needs, wants and budget. With that being said, it is vital for any health insurance agent to stay up to date on the ever-changing health insurance marketplace.

There are two types of insurance agents: ***captive agents*** and ***independent agents***. Captive agents transact (conduct business) on behalf of one company, such as a Farmers Insurance agent. Independent *typically* agents transact on behalf of multiple different insurance companies.

Brokers differ from insurance agents because they have more flexibility in the products they offer and can provide a multitude of different options because of the variety of carriers they have

to choose from. Brokers also have much more stringent education requirements because they have a higher duty to their clients by analyzing and correctly providing and ensuring complete and adequate coverage. Pursuant to proposition 103, brokers in California are allowed to charge additional fees for their services, while insurance agents are not.

Insurers Responsibilities

Insurers also have duties, when entering and maintaining the contract (policy) with the insured to always act in the best interest of the client and to honor and uphold the contract.

Insurance agents and brokers have certain authorities when it comes to their respective designations as licensees. These authorities are express authority, implied authority, and apparent authority. With regards to **express authority**, this is the authority granted to the agent by the insurance company that details what they can specifically do relating to the sale of the policy, such as, “you can submit applications for our policies and bind coverage”. **Implied authority** is authority an agent has, by virtue, of being reasonably necessary to carry out his or her express authority. For example, it is reasonably “implied” that a licensed insurance agent or broker can accept and collect premium payments on behalf of or for an insurance company. **Apparent authority** can often be a gray area. Apparent authority is neither expressed nor implied but a reasonable third party (namely the insured) would assume that an agent or broker was authorized to act on behalf of the

insurance company, even if said agent or broker had not discussed such a relationship with the insurance company.

Apparent Authority

If an agent or broker is wearing an Anthem Blue Cross shirt, driving a vehicle with an Anthem Blue Cross logo on it and using Anthem Blue Cross stationary, one would reasonable assume that this agent or broker has apparent authority to act on behalf of Anthem Blue Cross.

V. Loss

Loss may refer to the claim itself, the amount sought in a claim, the reduction in value of an insured's property, or the amount paid on behalf of an insured under an insurance policy.

The **2** categories of loss are:

1) **Direct loss**, which is a loss that is the direct result of an insured peril.
2) **Indirect loss**, which is a subsequent loss, such as being unable to use a building after a fire.

W. Liability

Liability is something for which you are legally responsible. Liability insurance provides coverage and pays for losses to other people and their property caused by negligence.

X. Negligence

Negligence is the result of carelessness, thoughtlessness, or inaction, but it's never intentional.

Before a court will award any damages to an injured party due to another's negligence, the **4** elements of negligence must be present:

1) **Legal duty** means the person has a legal responsibility to take the necessary precautions to avoid being negligent.
2) **Breach of duty** means the person failed to uphold their legal duty.
3) **Damage or losses** occurred as a result.
4) **The breach of duty** caused the damages or losses.

Here's a surreal story to help you remember the **4** elements:

Bob decided to put quicksand outside his driveway. He thought to himself, "I should really tell people about this here quicksand." (Legal duty)

When Gwen was walking by, she said, "Is that safe?"
Bob forgot about the quicksand, and said, "Yep. Safe as safe can be!" (Breach of duty)

Trusting him, she went on her way, and was promptly sucked into the quicksand. Luckily, she just happened to have a copy of "How to Escape from Quicksand," so she survived, but she still lost one of her tennis shoes. (Damages or losses)

"Hey," she said, "I lost one of my tennis shoes because you said it was safe!" (Damages or losses caused by the breach of duty)

True, it's a weird story, but we're sure you'll remember the **4** elements of negligence long after you've developed senility and forgotten everything else.

Note: If these **4** elements of negligence are present, the injured party has a good chance of winning a lawsuit.

Y. Accident

Accident is an unforeseen and unintentional act identifiable in time and place.

Z. Occurrence & Reinsurance

Occurrence is an event that results in a loss. ***Reinsurance*** Reinsurance is the transfer of risk between insurance companies. Used in both Life and Health, as well as Property and Casualty, it's an agreement or "treaty" between insurance companies where one company may transfer, and one company will accept, all or part of the risk of loss of the other.

End of Business /|Change of Business and Notifications

California law requires that notices important to the transaction of insurance be notified by mail, postage prepaid. OR, if nor excluded by electronic transmission. Following are such notifications:

A. Cancellation

Cancellation is the termination of coverage in the policy period by the insurer.

B. Lapse

Lapse is the termination of coverage for non-payment of premium. A policy will lapse at the end of the grace period.

C. Policy Renewal

Renewal is the continuation of coverage from one policy period to the next. ***Non-renewal*** is termination of coverage at the end of the policy period. ***Optional renewable*** is where the insurer reserves the right to renew or not. ***Conditional renewable*** allows the insurer to not renew a policy of certain conditions have not been met. ***Guaranteed renewable*** obligates the insurer to renew the policy as long as premiums are current. Obamacare is an example of a guaranteed renewable health care plan.

D. Unearned versus Earned Premiums

Unearned versus earned premiums are based on whether or not someone has paid for future coverage.

If someone pays an annual premium, and six months have gone by, then they have six months of:

- **Unearned premium**, for the six future months that are prepaid

- **Earned premium**, for the six months that have already gone by

Binders

A **binder** gives the insured temporary coverage. An insured may have just requested or applied for the insurance, and he/she doesn't actually have the official documentation in hand, but the **binder** means the insurer has agreed to provide temporary coverage pending approval.

Someone can receive a binder and still be denied insurance. If the insurance company gives the person a binder while the insurance application is being processed, that binder doesn't guarantee a certificate of insurance. If the insurance company decides not to insure someone, the company has to issue a legal notice of cancellation. Until then, the binder will continue to provide coverage.

Note: Binders are not used with Life insurance.

Insurance Law

Objectives

A contract is defined as: “a legal document between 2 or more parties, in which a certain performance is promised, in exchange for a valuable consideration.” In this unit we’ll discuss the elements of a contract, as well as other contractual terms that apply to insurance.
This unit includes:

- The Elements of a Legal Contract (C.L.O.C)
- Different Kinds of Contracts
- Legalities

1. The Elements of a Legal Contract (C.L.O.C)

There are certain elements that make a contract a legal contract, and therefore a legally binding contract. The term legally binding means that the terms of the contract will be upheld by a court of law.

There are **4** important elements to a legal contract:

1) **Competent Parties** means the people entering into the contract have to be considered “legally capable” (of age, mentally stable, etc.).
2) **Legal Purpose** means a contract has to have a lawful purpose. If it doesn’t have a lawful purpose, it’s not enforceable.
3) **Offer and Acceptance** means both parties agree on the terms of the contract and now the contract is considered legally binding.

4) **Consideration** means the physical return both parties get from the contract. In insurance terms, the consideration the insurer gets is premium payments, and the consideration the insured gets is insurance coverage.

Easy To Remember

We can't think of anything that's more fun than a mnemonic! Well…okay, so there's a couple of things that are more fun than a mnemonic, but only one or two. What was that? We need to reevaluate our definition of fun, is that what you said? Shows what you know!

The elements of a legal contract spell **C.L.O.C**.:

Competent parties
Legal Purpose
Offer and Acceptance
Consideration

2. Different Kinds of Contracts

There are different characteristics of insurance contracts that can change the entire tone of the contract. These include the following:

A. Contract of Adhesion

This kind of contract means "take it or leave it." In this type of contract, one party has all the bargaining power, and the other party has no bargaining power. This type of contract doesn't allow for negotiation or quibbling over contract wording.

B. Aleatory Contract

This kind of contract means the amount of money paid by one party could be a lot more or less than the other party. Most

insurance contracts are considered Aleatory contracts, because the insured could make premium payments for years for an occurrence that never happens, or the insurer could end up compensating an insured after only a few premium payments.

C. Unilateral Contract

This kind of contract means that someone promises to do or not do something in return for consideration. This is also referred to as a "one-sided contract." A very simplified example of this would be: if you pay me $500, I'll paint your house.

D. Conditional Contract

This type of contract depends entirely on an event actually happening. An easy example of this is if someone is selling their house, they won't get paid until the house actually sells.

E. Personal Contract

This type of contract insures the person, and not the property. This applies in Life and Health insurance.

3. Legalities

Here are some important legal characteristics affecting contracts:

A. Indemnity

This refers to a type of contract, such as insurance, that serves to restore the individual to the approximate financial position occupied prior to the loss.

B. Representations/Misrepresentations

Representations are statements made by the applicant for insurance before the policy is issued. These statements aren't considered set in stone: usually the wording is "true and correct to the best of my knowledge."

If the information turns out to be incorrect, this is called a **misrepresentation**. Intentional **misrepresentations** can void an insurance policy, because it affects the determination of potential risks.

Putting it into Context:

Here's an example of intentional **misrepresentation**: Chris's Short Term Health insurance application asked if Chris has any family history of heart problems. Chris is completely healthy, but there is an extensive history of heart problems in Chris's immediate family. Worried that checking "yes," would affect her premiums, Chris checked "no." If the producer/agent finds out about Chris's intentional misrepresentation, it could keep Chris from being insured, or it could void Chris's policy.

A representation can be corrected and/or withdrawn before a policy has gone into effect. Once the policy has gone into effect, a misrepresentation can void the policy.

A representation is considered false when the facts fail to correspond with its assertions or stipulations
Representation in an insurance contract cannot qualify as an ***express provision***, meaning the statements made by the insured at the time the insurance application is taken. However, in some cases representation may qualify as an **implied warranty**, which is a presumed fact.

C. Warranties

A **warranty** is a statement made by the applicant that becomes a condition of the contract. False warranties void the entire contract.

Alert!

Warranties do not apply to Life insurance. No statement made on a Life insurance policy is ever considered to be a warranty.

A warranty is either:

- **Expressed** warranties are in written form and attached to the policy.
- **Implied** warranties are not written but still exist under the law. Some representations may qualify as implied warranties.

D. Concealment

Concealment means withholding important information regarding a loss or the events surrounding a loss. Concealment immediately voids coverage.

E. Insurable Interest

Insurable interest is required in the purchase of insurance to protect against an economic loss. Insurable interest may not be significant in health policies as it is unlikely that someone can benefit from another's health insurance.

In **Life insurance**, however, the insurable interest has to exist when someone first applies for the policy.

In **Property** and **Casualty** insurance, insurable interest has to exist at the time of loss.

F. Waiver and Estoppel

Waiver is the giving up or surrendering of a known right or privilege.

Estoppel is the legal principle that holds that anyone whose words or actions have caused a waiver of a right or privilege, can't later reclaim the waived right or privilege if a third party has relied upon it.

For example, Angie's house burns down and she loses everything. Because she's having a really difficult time coming up with an inventory of items lost to submit her proof of loss form on time, her insurance company tells her they'll give her an extra 30 days to submit the form. Even though the insurance company has the legal right to demand the form by a certain date, they are **waiving** that right.

Estoppel is a court/judge blocks someone from asserting the original right they chose to **waive**. The exact definition of this can be along the lines of: If someone behaves in a manner that's inconsistent with their behavior in the past. This is a very circuitous way of saying, "if someone goes back on their word," but look out for that answer on the final exam.

An example of **estoppel** would be if Angie's insurance company suddenly changed their minds and said they wouldn't

reimburse her loss because she didn't submit her Proof of Loss on time. Angie takes the company to court and the judge issues an **estoppel**, which forces the insurance company to honor the conditions of the **waiver**.

G. Rescission

Rescission means the same as revoke or remove. An insurer could legally rescind an insured's policy if:

- There's been intentional or unintentional concealment
- There's been an intentional and fraudulent omission
- A misrepresentation comes to light after a policy has gone into effect
- A material warranty or a material policy provision has been violated

H. Utmost Good Faith

Insurance policies are considered contracts of **utmost good faith**, which basically means all parties involved were completely honest and disclosed any and all relevant information and facts. Utmost good faith means mutual trust during the negotiation of a contract.

4. Tort Law

Tort means a civil wrong for which the law provides a remedy. A simple way of looking at this is that a tort has more moral than legal implications, but someone who has been wronged can still turn to the law for protection and compensation. There's such

thing as an intentional tort, which means someone intentionally wronged someone else.

Note: Someone who commits a tort is called a **tortfeasor**.

The differences between tort law and contract law stem from the fact that tort law deals with civil wrongs, and contract law protects against and handles legal wrongs.

5. Known and Unknown

Neither party to an insurance contract is bound to communicate information below unless the other party asks:

1) Known information
2) Information that ought to be known, e.g., Just because you have chest pain does not mean you need to say you have heart problems.
3) Information the other party waives
4) Information excluded by warranty and not material to risk
5) Information excepted from insurance and not material to the risk, e.g., If omitted or misstated information left out of the health insurance application is found but it is **not material to the risk** insured and has been made in good faith, insurers will usually uphold the contract.
6) Parties of the insurance contract are not allowed to make **personal judgment** calls upon any matters in question. *Example: Health insurance coverage is often determined by services that are deemed "medically necessary". An insured's personal judgment that he had to have an operation is not acceptable. A doctor's judgment, however, will be accepted*

END SECTION

Study Required Minutes before taking the Section Quiz.
Answer all questions correctly on the Quiz to move
to the next Study Section. Re-take Quiz if needed.

√ **Search this section using CTRL+F**
√ **Please study required minutes before taking Section Quiz**
√ **CAUTION: 20-Minutes or more idle time (no study activity) will cause disconnection and loss of study session minutes**

Section AH 9

INSURANCE COMPANIES, THE COMMISSIONER & LICENSING

Objectives

This Unit will cover information you should know about **Insurance Companies** and how they are organized. This Unit will also give you the required information you'll need to answer the questions on the **state licensing exam**, as well as give you some information about future employers.

Insurance Companies

The basic types of **Insurance** companies include:

- Stock companies
- Mutual companies
- Fraternal Insurers

Stock insurers consist of stockholders who own shares in the insurance company. These stockholders provide capital for the

insurer in exchange for their share of the profit; they also share in the losses as well. The caveat here being that these stockholders can only receive dividends after what is referred to as an **earned surplus**, which means that all the expenses and losses have to be paid first before a dividend can be earned, has occurred.
Mutual Insurers write nearly about one-third of the insurance for the P&C market and about half of the life insurance market.

Mutual insurers do not have stockholders; instead company ownership consists of policy owners. Policy owners elect a board of directors that in turn elects officers that operate the company. Policy owners in a mutual insurer receive what are known as **policy dividends**. After all expenses (including claims) and operating costs are paid, the remaining monies are distributed back to the policy owners in the form of a policy dividend.

Fraternal Insurers, also known as benefit societies, are unusual in that their membership usually consists of members of fraternal organizations or lodges. An example of a fraternal insurer is GBU Financial Life; they support and offer benefits to Habitat for Humanity and Ronald McDonald House. Fraternal insurers operate under a special section of the insurance code and are generally given numerous tax breaks, as they are not for profit organizations.

DOMESTIC, FOREIGN AND ALIEN COMPANIES

You may want to get out a notepad and a pen for this section. The distinctions between **Domestic, Foreign and Alien companies** are very important and will be covered on your licensing exam. It will

also be important for you to know these distinctions during your career as an agent. You will also read about insurance companies that are **Authorized or Unauthorized** to sell insurance within a state.

DOMESTIC COMPANY

Companies organized, incorporated and chartered under the state regulations where it's home office is located are referred to as a Domestic Company. **A company incorporated in California would be a Domestic Company**.

FOREIGN COMPANY

A **Foreign Company** would be a company that is organized and **chartered in another state** from which it is doing business. For instance, when the same company that is chartered in California does business in any other state, it would be referred to as a **Foreign Company**. The same would be true for a company chartered in another state doing business in California.

ALIEN COMPANY

Companies that are domiciled in countries other than the United States are called **Alien Companies**.

AUTHORIZED COMPANY

It is up to the Insurance Commissioner of each to state to determine if a life insurance company is authorized to sell insurance within that

state. The Insurance Commissioner will conduct a thorough investigation to see if a life insurance company can be authorized to sell insurance. The Commissioner looks at such factors as the company's financial health, the nature of the policies the company will offer, and the type of advertising the company will use.

UNAUTHORIZED COMPANY

If an insurance company does not meet the Insurance Commissioner's requirements, that company is denied permission to sell insurance in that state and is known as an unauthorized company. Agents cannot sell polices for insurance companies that are unauthorized to sell in a state.

OTHER COMPANIES

The following is a brief description of other organizations that offer different types of Life Insurance policies.

Reciprocals- These kinds of companies have participants who agree to share the responsibilities and losses with all the other members of a reciprocal. A reciprocal is unincorporated. Simply, the participants insure one another as well as share the losses of the reciprocal. An attorney-in-fact manages these organizations.

Surplus Lines- These organizations may come into play when an individual is considered uninsurable by an authorized insurance

company. This may be because of the person's occupation, health, or dangerous hobby. States have different laws as to what companies can sell surplus lines and be known as a surplus lines broker.

Lloyd's- Lloyd's is a voluntary insurance organization of individuals or associations of individuals, a syndicate, who agree to share in certain insurance contracts.

Rating Organizations- While not an insurance company, rating organizations are important to the health and vitality of the insurance industry. These companies track and rate insurance companies based on important statistics, such as financial history. A well known rating company is the A.M. Best Company, which publishes a ratings guide. This can be an important resource for insurance agents and consumers alike. They assign a rating to the operations and financial condition of insurance companies, an 'A+ - Superior' through 'D - Poor' grade, as well as comments about the financial and regulatory conditions.

MAJOR OPERATING DEPARTMENTS OF INSURERS

Insurers divide their company in major departments organized by function and include;

- Actuarial; responsible for data analysis, loss predictions, mortality and morbidity, premium determination

- Underwriting; determines standards for risks, evaluates applicant information, approve, decline, and rate risks
- Claims; investigation and settlement of claims
- Administration; policy issue, billings, commissions
- Investments; responsible for investment return for the insurer
- Marketing; sales, advertising, promotion and recruiting, training
  agents

The Commissioner & Insurers

Objectives

In this unit we will discuss the office of **Commissioner of the California Department of Insurance (DOI)**. Another section of the Unit will describe the different types and classifications of Insurance Companies.

1. General Duties and Powers

The ***California Insurance Code (CIC)*** contains all the law relating to insurance in California. The CIC also applies to bail bonds agents, worker's compensation, and motor club services. The CIC is composed of different statutes written and passed by the California Legislature and signed in to law by the government. Statutes are changed when the legislature passes a new statute that amends, modifies or repeals an existing statute. The California Department of Insurance (CDI) oversees the enforcement of the code and execution of its policies.

The California Code of Regulations (CCR), under Title 10, chapter 5 of the CIC, is composed of rules that are issued by the insurance commissioner. The commissioner is authorized to issue these rules. However, the Office of Administrative Law must approve the rules before they can become effective. These rules or regulations are not law, but carry the same weight as law and a person who violates any of the CCR is subject to the same penalties as someone who violates a statute.

The ***Insurance Commissioner*** is an elected state executive position. The commissioner is head of the California Department of Insurance and is **responsible for regulating the state's insurance industry**. This regulation includes, licensing insurance providers, approving rates or premium increases, investigation consumer complaints, and analyzing insurance policy issues. This position is a four year term and just like the President of the United States, one can only hold the position for two terms. Dave Jones is the current insurance commissioner in California, and has been since January 2011. It is important to note that the **Commissioner** may *not* make changes to the Insurance code. Only the state legislature may make those changes. However, the **Commissioner** *may* review the Insurance Code and issue recommendations for changes.

The ***CDI has jurisdiction over any person or other entity that provides health coverage in the state of California*** such as a chiropractor, a doctor, a physical therapist, mental health specialists, hospitals, etc., **unless** the person or entity providing health services is subject jurisdiction of another governmental agency, like the Department of Managed Healthcare (DMHC) or the federal government.

In California, there are two agencies that regulate health insurance plans, the CDI and the Department of Managed Healthcare (DMHC). The ***CDI is the primary regulator*** over traditional indemnity insurance and some ***Preferred Provider Organization (PPO) and some Exclusive Provider Organization (EPO) plans*** as well. ***The DMHC,*** traditionally, has ***jurisdiction over Health Maintenance***

Organization (HMO) plans, but has recently started regulating some ***PPO plans***.

Within the CIC, there is a statute devoted to ***unfair practices*** within the insurance industry. The code states that no one shall engage in any trade practice defined as an unfair method of competition or an unfair or deceptive act or practice in the business of insurance. There are numerous prohibitions within this code, some of the more severe being the following:

- Misrepresenting to claimants pertinent facts or insurance policy provisions relating to any coverage at issue Failing to affirm or deny coverage of claims within a reasonable time after proof-of-loss requirements have been completed and submitted by the insured
- Attempting to settle a claim by an insured for less than the amount to which a reasonable person would have believed he or she was entitled by reference to written or printed advertising material accompanying or made part of an application
- Attempting to settle claims on the basis of an application that was altered without notice to, or knowledge or consent of, the insured, his or her representative, agent, or broker
- Making known to insureds or claimants a practice by the insurer of appealing arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration
- Delaying the investigation or payment of claims by requiring an insured, claimant, or the physician of either, to submit a

preliminary claim report and then requiring the subsequent submission of formal proof-of-loss forms, both of which contain substantially the same information

Penalty for Violation of the Unfair Practices Act

The insurance commissioner has sole discretion to establish what constitutes a violation of the Unfair Practices Act.
The penalties will range between $5K and $10K per act

Other Disciplinary Actions By The Commissioner

A. Issuing Orders

The Commissioner can issue orders, which are oral or written actions given to an insurance company, any representative of an insurance company, or anyone outside the DOI. An official order must include its intent, its effective date, the information the order is based on, and the specific Insurance Code provision that directly relates to the order.

A **Cease and Desist Order** is a written order from the Commissioner that tells someone they need to stop what they're doing. If the Commissioner determines that a Producer is doing something illegal or dishonest, the Cease and Desist Order means "knock it off or else…"

The Commissioner can issue a Cease and Desist Order to an authorized individual who is:

- Transacting insurance without the proper authorization
- Involved in dishonest or unfair acts
- In a hazardous condition
- In a hazardous financial condition
- Dangerous to the safety of the general public

Note: “Hazardous condition” is a legal term meaning the insurer/company is doing something construed as shifty. This could be filing a falsified financial report, not filing a financial report when its due, or claiming it has more/less money than it really does.

A **Cease and Desist Order** has to contain:

- The name and last known address of the person/organization
- A statement regarding the violations, and which parts of the code or which regulations were specifically violated
- The danger the violations could pose to the public
- The proposed penalty
- A command for the person/organization to immediately stop violating the code

B. Hearings

The Commissioner has the power to hold hearings. These hearings must be held upon written demand to the Commissioner. The written demand must include the reason for the Hearing. During the hearing, the Commissioner may:

- Deliver oaths and affirmations, subpoena witnesses and examine under oath any person who may be able to offer information towards the investigation
- Require the individual being investigated to produce any relevant evidence

The Commissioner may appoint examiners, administrators or deputies in order to collect evidence or conduct hearings. The Commissioner is responsible for the actions of these appointees and may revoke these appointments at any time. The Commissioner may act under the Insurance Code in a quasi-judicial capacity, in that the Commissioner may apply to any judge of any county circuit court for court-ordered contempt orders.

C. Issuing Penalties

The Commissioner can issue **3** different types of penalties towards those in the insurance industry:

1) Civil Penalties
2) Criminal Penalties
3) Disciplinary actions towards applicants or licensed agents

Here's a closer look at those **3** types of penalties:

Civil Penalties can be imposed on any insurance company that violates any provision of the Insurance Code. These penalties could be as high as:

- **$1,000** per violation for individuals
- **$10,000** per violation for companies

A Civil Penalty must be paid within **10** days after the order becomes final.

The Commissioner will impose **criminal penalties** if a violation of the Insurance Code leads to a criminal conviction for an individual. These penalties could be as high as:

- Up to **1** year in county jail, or a maximum fine of **$1,000** for individuals
- A maximum fine of **$10,000** for companies

Disciplinary actions towards applicants or licensed agents are actions the Commissioner may take against any licensed individuals or applicants for license. The Commissioner may revoke, suspend or refuse to renew a license for any business or classification of insurance. Also, the Commissioner may refuse to issue a license or grant authority for license to transact or engage in any business or class of insurance.

The following is a list of violations the Commissioner may penalize for:

- Incompetence or untrustworthiness of an agent
- Any dishonest or deliberately false act in relation to the insurance application or examination
- Violation or noncompliance with the Insurance Code
- Misappropriation, embezzlement or any illegal withholding of customer monies
- Conviction of any felony or imprisonment
- Material misrepresentation of policy terms

- Fraudulent or dishonest practices in transacting insurance business
- Failure to pay a civil penalty, fee, or charge assessed by the Commissioner
- Improper or illegal use of an insurance license
- Cancellation, revocation, suspension or refusal to renew the license by any other state or government agency
- Failure to comply with Continuing Education requirements
- Evidence of dishonesty, fraud, or misrepresentation of an agent even if such activity is not related to the insurance business

D. Financial Statements and Investments

All California insurers are required to submit a financial report to the Commissioner by December 31st **and due by June 30th**. This annual report includes information on the company's/insurer's:

- Capital
- Stock
- Assets
- Liabilities
- Income
- Expenditures
- Balance sheet
- All insurance and premiums written in California.

Note: Audits determine the insurance company's financial condition, nature of operation, ability to fulfill insurance obligations and the presence of any Insurance Code violations. The insurance company under examination pays for any costs associated with these audits. The report becomes a public record.

Also regulated is an insurer's **policy dividends** (profits to share with shareholders. Typically, these dividends come from an insurer's **earned surplus** (accumulated earnings).

2. National Association of Insurance Commissioners (NAIC)

The **NAIC** is an organization formed by the **Insurance Commissioners** from all **50** states, Washington, D.C., and Puerto Rico.

The purpose of the NAIC is to promote and support uniformity between the states in regards to the insurance business. The NAIC keeps a registry of all agent and producer licenses granted in each state that require such licenses.

Note:
With respect to the NAIC, insurance "agents" are now known as "producers," unless you're in a state where they're still known as "agents." In California, we call them producers, but if you think of the two as synonymous, you'll do just fine.

This registry lists both licenses and appointments by state. The NAIC has formed a 'model bill' for each state to present to their state legislatures when attempting to make changes to State Insurance Code.

3. Classification of Insurance Companies

In California, **any person** capable of making a contract **may be an insurer**, subject to the restrictions imposed by this code. The formation of an insurance company can be made up of a person or

individual, association, organization, partnership, business trust, limited liability company, or corporation.

There are **3** different types of insurance companies for classification purposes:

1) Domestic
2) Foreign
3) Alien

Here's a closer look at those **3** classifications:

A. Domestic

Domestic insurance companies are ones that are incorporated and domiciled in California.

B. Foreign

Foreign companies are ones formed under the laws of any other state in the U.S.

C. Alien

Alien companies are formed and originate in another country outside of the U.S.

Alert!
Some of the final exam questions are danged hard…and some are a relaxed stroll through the park on a lovely summer's day. An example of the latter is that there are a number of questions about the **3** categories of insurers. Memorize the **3** categories of insurers, which should take you all of five seconds.

No matter the classification, all insurance companies in California must have a **certificate of authority**, which is issued by the Commissioner.

An **Admitted Insurer** has a certificate of authority and is permitted to do business and appoint agents in the state of California.

All authorized insurance companies have to:

- File detailed annual financial reports
- Pay all fees and expenses of the DOI examiners
- Contribute to appropriate insurance guaranty funds
- Agree to abide by all insurance Laws and Regulations
- Produce insurance business through licensed producers/agents

Regulation of Admitted & Non-Admitted Insurers

Admitted insurers are extremely scrutinized and regulated by the Department of Insurance (DOI) in California. **Admitted insurers are subject, by the DOI**, to mandatory reporting, claim audits, audits of underwriting, and market conduct. Conversely, the DOI does not regulate any of the rates set by non-admitted insurance, nor do they audit underwriting or market conduct. There are **potential consequences** for choosing either an admitted insurer or non-admitted insurer. With an admitted insurer their rates may not be flexible or fluid with the current market because all rates must be approved with the DOI before being offered to the public. Also admitted insurers because of the strict guidelines that must be followed, have less of an opportunity to meet the needs of all potential insureds. For example, say a non-US resident needed insurance for their business, an admitted insurance agency, because of the strict guidelines and less financial flexibility will not be able to cover this individual's business. However, a non-admitted insurance agency most likely will be able to cover because they generally allow higher risk clients and have more latitude in defining their policies. That being said, anything higher risk with a non-admitted insurer will likely cost a pretty penny as they do not have the same regulations and can charge higher premiums.

Note: If someone violates the requirement for a certificate of authority, they could face penalties of:

- Imprisonment in state prison, or in a county jail for up to **1** year
- A fine of up to **$100,000**
- All of the above

An **Nonadmitted Insurer** is one that does not have a certificate of authority and is not permitted to appoint agents in the state of California. A surplus lines broker is specially licensed to represent unauthorized insurers.

Putting it into Context:

You might assume that “nonadmitted or unauthorized insurer” is simply the exact opposite of an authorized insurer, but it isn’t. An unauthorized insurer isn’t allowed to transact normal kinds of insurance, and so they deal with Surplus Lines brokers.

Surplus Lines brokers handle insurance for very high risks. For example, if someone wanted to insure a shipment of volatile chemicals, it would be difficult for them to insure such a high risk through the normal insurance market. The person would then contact a Surplus Lines broker, who would arrange insurance through an unauthorized insurer.

Certificate of Authority

All insurance companies in California must have a **certificate of authority**, issued by the Commissioner, to be admitted to transact insurance. It is a **violation** to act as an insurer without a certificate of authority. A public offense punishable **by imprisonment not exceeding one year** or by **fine** not exceeding **$100,000** or both.

4. Distribution Systems

Companies may further be classified by their marketing or distribution systems, such as:

A. Direct Writers (or Direct Response), companies that market by mail, phone, and /or the internet with their own employees.

B. Exclusive or Captive Agency, companies whose agents represent only one company.

C. Independent Agency, agents represent and are appointed with several companies.

D. Managing General Agent (MGA), any person, firm, association, corporation, or partnership who manages all/part of an insurer’s business. MGAs act as an agent and can

underwrite up to **5%** of the insurer's annual policyholder surplus and may adjust or pays claims in excess of an amount determined by the Commissioner as well as negotiate reinsurance on the insurer's behalf.

E. **Home Service,** also known as "debit" companies, sell small face amount policies and "industrial" insurance.

5. Fraud and Prevention

The Department of Insurance, Division of Enforcement, has created the Fraud Division to enforce the provisions of the Code and to identify and **combat insurance fraud**. The business of insurance involves many transactions that have the potential for abuse and illegal activities. This division is intended to permit the full utilization of the department so that they may more effectively investigate and discover insurance frauds, halt fraudulent activities, and assist and receive assistance from federal, state, local and administrative law enforcement agencies in the prosecution of persons who are parties in insurance frauds.

Note: Preventing all types of insurance fraud significantly reduces the cost of insurance premiums.

The following statement is required on all claims forms in California:

"Any person who knowingly presents false or fraudulent claims for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison."

Note: An insured signing a fraudulent claim form may be found guilty of perjury.

It is unlawful to do any of the following:

- Make or cause to be made a knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying any compensation
- Present or cause to be presented a knowingly false or fraudulent written or oral material statement in support of, or in opposition to, a claim for compensation for the purpose of obtaining or denying any compensation
- Knowingly assist, abet, conspire with, or solicit a person in an unlawful act under this section.

Anyone who commits fraud can be punished in one or more of the following ways:

- Imprisonment in a county jail for one year
- Imprisonment in the state prison, for two, three, or five years,
- Required to pay a fine that could be as high as **$150,000** or required to pay a fine that's double the value of the fraud (whichever is higher)
- Required to pay restitution for any necessary medical evaluations or treatment services
- Possibly required to pay for the costs of the investigation

Note: Anyone who has had a prior felony conviction will also receive an extra **2**-years for each prior conviction in addition to one of the penalties mentioned above.

The point we're trying to make here, folks, is **FRAUD BAD**.

A. The National Automobile Theft Bureau

Every insurer in California is required to report covered automobiles involved in theft and salvage total losses, including the vehicle identification number to the National Automobile Theft Bureau (NATB) or a similar organization engaged in automobile loss prevention.

B. The Arson Information Reporting System

The **Arson Information Reporting System** was created to permit insurers, law enforcement agencies, fire investigative agencies, and district attorneys to deposit arson case information in a common database within the Department of Justice.

C. Fraud and Workers Compensation

When an insurer or rating organization knows or reasonably believes it knows the identity of a person or entity whom it has reason to believe committed a fraudulent act relating to a workers' compensation insurance claim or insurance policy, including any application, the insurer, or agent authorized by an insurer to act on its behalf, or rating organization shall notify the local district attorney's office and the Fraud Division of the Department of Insurance.

D. Insurance Claims Analysis Bureau

An insurance claims analysis bureau performs the following functions:

- Collect and compile information and data from members or subscribers concerning insurance claims.
- Disseminate information to members or subscribers relating to insurance claims for the purpose of preventing and suppressing insurance fraud.
- Promote training and education to further insurer investigation, suppression, and prosecution of insurance fraud.
- Provide, without fee or charge, to the Commissioner, all California data and information contained in the records of the insurance claims analysis bureau in furtherance of the prevention and prosecution of insurance fraud.

6. Post Claims and Pre-Selection Activities

No insurer in California who issues policies that cover hospital, medical, or surgical expenses, can engage in what is known as "postclaims" or "post-selection" underwriting activities. Postclaims underwriting means the rescinding, canceling, or limiting of a policy due to the insurer's failure to complete medical underwriting and resolve all reasonable questions from written information submitted on or with an application before issuing the policy. ***Example:*** An insurer cannot ask very broad questions on an application, then after an insured files a claim, cancel the policy because the insured failed to be specific on a particular health issue.

Likewise, there are pre-selection limitations placed on insurers such as HIV testing. Testing for the **HIV** virus can only be done with the written consent of the potential insured party. This consent includes the party to which the results of the test

are to be reported to: a physician, the county health department in which the insured resides, or the insured directly. This consent is valid for **6** months and is obtained by the insurance company during the underwriting process, so long as it is prior to any testing for the virus. It must be made known to the potential insured that the test for HIV will be used in the determination of the individual's insurability.

Insurance Licensing

Objectives

This unit discusses how to obtain and maintain an insurance license, the importance of keeping accurate financial records, and which actions could result in suspension or revocation of a license. As future licensees, it is important to know that all of your actions as an insurance Producer will be checked through the Commissioner's office and honesty is critical to the longevity of your business.

1. People Required to have an Insurance License

California requires the following people to obtain an insurance license:

A. Producers

Insurance Agents (also known as producers) is a person authorized, by and on behalf of the insurer, to transact all classes of insurance other than life, disability or health insurance.

A **Life Licensee** is a person authorized to act as a life agent on behalf of a life insurer or disability insurer to transact life insurance, accident and health insurance, or life and accident health insurance.

An **Insurance Broker** means a person who, for compensation and on behalf of another person, transacts insurance other than life, disability or health with, but not on behalf of an insurer.

A **Life-Only Agent** is a person authorized by and on behalf of a life insurer to transact the following types of life insurance: permanent (whole life) life, temporary (term), group life, universal life, credit life, deferred and variable annuities (variables require registration with the NASD),funeral and burial life and long term care.

An **Accident and Health Agent** is a person authorized to sell the following forms of insurance: health, disability, workers compensation, credit disability, twenty-four hour coverage and long term care.

A ***Certified Insurance Agent*** are accident and health agents that have had special training in order to sell ***Covered California (Obamacare in California)*** to help individuals, as well as small businesses select appropriate health insurance plans to fit their needs.

A **Fire and Casualty** agent is a person authorized by and on behalf of a Fire and Casualty insurer to transact Fire and Casualty.

A **Personal Lines Agent** is a person authorized to sell the following insurance: Personal automobile, dwelling and homeowners insurance.

A **Limited-Lines Automobile Agent** is a person authorized to sell automobile liability coverage, automobile physical damage and automobile collision insurance.

That's plenty obvious, so let's move on.

Here are a few other insurance job categories:

- The **Broker** helps put together the insured's policy (any line of insurance except Life).
- The **Solicitor** brings in prospective clients for the Producers or Brokers (any line of insurance except Life).
- The **Consultant** makes recommendations to the insured for a fee.
- The **Life and Disability Insurance Analyst** advises (for a fee) an insured or a person named as a beneficiary by a Life or Disability policy.
- The **Administrator** works with Life insurance, Health insurance, and Annuities. Their duties include, collecting premiums and adjusting or settling claims.

Agent vs. Broker vs. Solicitor

California law defines and insurance agent as someone authorized by an insurer to transact all forms of insurance except life insurance . . . that would be a task reserved for a life-only agent. "Insurance broker" means a person who, for compensation and on behalf of another ***person***, transacts insurance other than life with, but not on behalf of, an insurer. Know that there is ***NO life broker or NO health broker***. An **Insurance Solicitor** is a person employed to aid an insurance agent or insurance broker in transacting insurance other than life. There is ***no life solicitor*** license.

Life Agent vs Life Analyst

Life agents acts on behalf of a life insurer and is paid by the insurer. Life analysts (private consultant) acts on behalf and is paid by someone ***other than an insurer.***

Note: Legally, none of these people can sell, solicit, or negotiate insurance unless they're licensed or authorized to work under a Producer. If someone does transact insurance without a license, they can be fined up to **$50,000** and/or put in jail for up to **1** year.

Any person who ***transacts insurance without a valid license*** is guilty of a misdemeanor and could be fined up to **$50,000**, or imprisoned for a year, or both.

Future producers have to pass a written exam that tests knowledge of the different classes of insurance, the duties and responsibilities of Producers, and the state's statutes and rules.

People who want to be involved in certain kinds of insurance aren't required to take the final licensure exam—though they may still end up taking some form of test of knowledge. For example:

- Livestock
- Mortgage
- Travel and transportation
- Credit Life
- Credit Health
- Baggage, Trip Cancellation, and Interruption
- Lender's Property
- Motor Vehicle Physical Damage

- Mechanical Breakdown
- Credit Involuntary Employment

Note: The ***CIC defines "Transact"*** when applied to insurance as any of the following:

- Solicitation
- Negotiations preliminary to execution
- Execution of a contract of insurance
- Any dealings before/after the execution of a contract, or any matters arising from the contract

2. Licensing Examination

Future producers have to pass a written exam that tests knowledge of the different classes of insurance, the duties and responsibilities of producers, and the state's statutes and rules.

People who want to be involved in certain kinds of insurance aren't required to take the final licensure exam—though they may still end up taking some form of test of knowledge. For example:

- Livestock
- Mortgage
- Travel and transportation
- Credit Life
- Credit Health
- Baggage, Trip Cancellation, and Interruption
- Lender's Property
- Motor Vehicle Physical Damage
- Mechanical Breakdown
- Credit Involuntary Employment

Applicants can take the state's examination after completing one or more of the following requirements:

- Attend a class taught by an authorized instructor (*yawn*)
- Watch a video on prelicensing, licensing, and insurance (*double yawn*)
- Complete a valid and verifiable online prelicensing course, preferably through an association as knowledgeable and fun-loving as ***Affordable Educators***

Pre-examination Licensing Training includes:

- **40** hours of instruction in **Fire and Casualty Insurance**
- **20** hours of instruction in **Life Only**
- **20** hours of instruction in **Accident and Health**
- **12** hours of instruction in **Code and Ethics**
- **20** hours of instruction in **Personal Lines**
- **20** hours of instruction in **Limited Lines Automobile**

3. Resident and Nonresident

A **resident** producer lives in the state they transact insurance for, whereas, a **non-resident** producer doesn't live in the state that they transact insurance for. If you get that one wrong on the final exam, we're coming to your house to slap you in person.

If someone wants to transact in another state, they have to obtain a license in their home state before becoming a nonresident producer.

All **non-resident** producers have to apply to the NAIC. The Commissioner acts as the Attorney-in-fact after the application is accepted. This means the Commissioner handles any legal actions brought against the non-resident producer.

The Commissioner can also arrange a reciprocal agreement, exempting certain people from taking the prelicensing examination. This agreement means that if someone from another state is allowed to transact insurance in California, then a California insurer will be allowed to transact insurance in that other state.

4. Temporary License

The Commissioner can issue a temporary license to someone before they've completed the final examination. The temporary license is valid for a maximum of **180** days.

A temporary license is granted if:

- A producer dies or is physically/mentally unable to follow through on their duties, a spouse or legal representative can obtain a temporary license to either give the producer time to recover or train their replacement.
- A producer enters into active military duty, a temporary license can be issued to allow the replacement producer time to train and obtain a license.
- The Commissioner revokes a producer's license and a temporary license needs to be issued, in order to give the

replacement time to train and obtain their own permanent license.

The Commissioner can limit the temporary licensee's authority or revoke the license at any time.

5. Responsible Producers

California requires all producers to engage in honest and responsible insurance transactions. A producer has to meet certain qualifications before becoming licensed, such as:

- Be **18** years or older
- Establish a residence and business in the state of California
- Not committed a felony involving dishonesty or breach of trust (A violation of Title 18, United States Code, Section 1033-1034)
- Completes Pre-licensing Training from a school like Affordable Educators, college, or university registered with the Department of Insurance and received a Completion Certificate verifying educational hours (valid for up to **3** years)
- Passes the state examination with a score of **70% or above**
- Pays the required fees
- Apply to the National Association of Insurance Commissioners (NAIC) Uniform Application. The Commissioner will send an Examination Eligibility Notice, which is valid for 180 days once approved

Title 18

Title 18, Section 1033-1034 legislation (1994) says that certain **prohibited persons cannot participate in the business of insurance** (selling, reinsuring or the role as an officer, director or employer of an insurer) unless they have received written consent of the Insurance Commissioner. A **prohibited person** means any person who has been convicted of a felony, dishonesty or breach of trust. **Conviction** means a finding of guilty or plea of guilty or no contest in a criminal court of the U.S. **Felony** means a crime for which the maximum punishment exceeds one year incarceration. **Dishonesty** includes perjury, bribery, forgery, counterfeiting, making false statements, deception, fraud, schemes, material misrepresentation and failure to disclose material facts. **Breach of trust** means crimes of misuse, misapplication or misappropriation. The **penalty** for violating the above section is a fine of **not more than $50,000 for each violation** OR the amount of compensation the person received for the prohibited conduct (whichever is greater) or **imprisonment for not more than 10 years or both**. **Failure to inform** the Department of Insurance of a prior felony conviction on a license application could result in a violation of this statute and /or constitute grounds for denial of an insurance license.

Note: Prohibited persons, such as felons, must request written consent from the Commissioner, pay a fee, provide all documentation, and receive consent prior to engaging in any business. It is a criminal offense, punishable by civil penalty up to **$50,000** for each violation, and imprisonment for up to **5** years, to employ or permit prohibited persons to participate in the business of insurance without consent. The Commissioner may require additional information in some cases.

Businesses applying for Producer status must pay all applicable fees; plus, they are required to designate one person as the business' state rules and regulations compliance specialist.

6. Producer Appointment

Producers have to become affiliated with an insurer before they can transact insurance. Once someone is an affiliated producer, they represent the insurer, not the insured.

Being affiliated or appointed by a company basically means they hire a producer to sell their insurance. Just because you're licensed, doesn't mean you can immediately start selling your own brand of insurance: you need to represent an established insurance company.

Licensed insurance producers only represent the insurer that appointed them. They can't write policies or represent other insurers if they haven't been appointed. That being said, it's possible for a producer to be appointed by more than one company, and then they can transact insurance for each company.

Note: If a producer hasn't been appointed or affiliated, they can't legally transact insurance, even if they're licensed.

7. Termination of Appointment

An insurer may Terminate, or cancel, a Producer's Appointment or Affiliation at any time; however, the insurer must notify the Commissioner within **15** days of the termination. The Termination Notice needs to specify the reason(s) for termination and either be delivered in person or mailed to the Producer's last known address. Whoever initiates the termination (either the insurer or Producer) is responsible to notify the Commissioner within **15** days of the effective termination date.

The insurer is exempt from notifying the Producer of an Appointment termination if the insurer ceases to sell insurance or if the termination is a mutual agreement.

The insurer can also terminate a Producer without written notice if any of the following occur:

- The license is denied, restricted, revoked, suspended, or cancelled
- The business is sold, transferred, or merged
- Bankruptcy is filed
- Fraud or intentional misconduct takes place

A licensee may surrender a license for cancellation by delivery to the Commissioner, or by written notice of the intent to cancel. A license terminates upon the death of the licensee, or when an licensed entity ceases to exist or is otherwise terminated or dissolved.

A co-partnership however may continue to transact insurance if it files an application notify the Commissioner of the change in membership within **30** days.

A Producer may terminate an Agency Appointment at any time as long as the Commissioner and insurer are notified.

If a policy of insurance is issued regarding that application, the insurer is considered to have authorized the agent to act on its behalf, and the insurer is responsible for all actions of the agent

that relates to the application and policy, as if the agent had been appointed. This has to happen no more than **14** days after the life agent submits an application for insurance to the insurer for which the insurer issues a policy. The insurer shall forward to the commissioner a notice of appointment of the life agent as the insurer's agent. However, nothing obliges an insurer to accept an application for underwriting from a life agent.

At the same time, a licensed life agent who is NOT specifically appointed for a particular life insurer can't:

- Present a proposal to a prospective policyholder for insurance with that insurer
- Transmit an application for insurance to that insurer if the insurer requires all its life agents to represent only that insurer or a group of affiliated insurers of which that insurer is a member

Except when performed by a surplus line broker, the following acts are misdemeanors in California:

- Acting as agent for a non-admitted insurer to transact insurance
- Advertising a non-admitted insurer to transact insurance
- Aiding a non-admitted insurer to transact insurance

In addition to any other penalties, the person might have to pay **$500** to the state, as well as **$100** per each month the person continues the violation.

8. Obtaining a License

Here are the necessary requirements that must be completed if someone wants to obtain an insurance license in California:

A. Qualifications

Individuals in pursuit of a California insurance license must prove their qualifications to the Commissioner of the Department of Insurance.

The Commissioner will deny an application for any license if:

- The applicant isn't qualified
- Granting the license isn't in the public's best interest
- The applicant doesn't intend to actually engage in business
- The applicant doesn't have a good business reputation
- The applicant lacks integrity
- The applicant has been refused a professional, occupational or vocational license or had such a license suspended or revoked
- The applicant wants the license in order to avoid enforcement of insurance laws in California
- The applicant has knowingly or willfully made a misstatement in a document or application for a license, or a false statement in testimony given under oath before the Commissioner
- The applicant has previously engaged in a fraudulent practice or a dishonest manner
- The applicant is incompetent and untrustworthy

- The applicant has knowingly misrepresented the terms or effect of an insurance policy or contract
- The applicant has failed to perform a duty or has committed an act expressly forbidden
- The applicant has been convicted of:
    - A felony
    - A misdemeanor by this code or other laws regulating insurance
    - A public offense involving a fraudulent act or dishonesty in acceptance, custody or payment of money or property
- The applicant helped someone else do something which could result in the suspension, revocation or refusal of a license
- The applicant has permitted any person in his employ to violate any provision of this code
- The applicant has violated any provision of law under authority conferred by license
- The applicant submits a fake certificate to the Commissioner

Note: A judgment, plea or verdict of guilty or a conviction following a plea of “nolo contendere” is considered to be a conviction, so it’s best not to set even one toe in a courtroom.

In addition, the following acts could result in suspension or revocation of a license:

- The licensee makes the client cosign, or make a loan, investment, or gift of their policy

- The licensee talks the client into making them the beneficiary under the terms of any intervivos or testamentary trust, or the owner or beneficiary of a life insurance policy or an annuity
- The licensee talks the client into making them or any of their buddies a trustee under the terms of any intervivos or testamentary trust
- The licensee, acting as power of attorney for the client, used their position in order to buy insurance for the client that would give the licensee a commission

Note: All of the above no-no's are so obvious, we're surprised they didn't include:

- Don't shove people into traffic
- Don't steal food stamps from poor people
- Don't incite mass riots

But just in case any of those rules surprised you, we mean it, *don't*.

Producer applicants may eventually be qualified to receive a license in one of the following areas:

- Life Only Insurance
- Accident and Health Insurance
- Variable Life Insurance
- Fire and Casualty Insurance
- Personal Lines Insurance
- Limited Lines Automobile Insurance

B. Written Consent

If a person who has been convicted of a felony or engaged in dishonest activity deemed inappropriate by the Commissioner, he/she may ask for Written Consent to transact insurance. The Commissioner will review each individual situation and, if applicable, establish rules or procedures for the individual to follow. If the person does not follow the Commissioner's mandates or commits other dishonest acts, he/she may not be able to transact insurance in the state of California.

C. Exemptions and Exceptions

The following people don't have to be licensed:

- An insurance company and its employees that are indirectly involved in insurance transactions. This includes an underwriter, loss control, inspection, processing, or claims settling employees
- Administrative, clerical, customer service, those in the position of receiving insurance premium, taking claims and requesting change
- A Producer or representative of a Fraternal Benefit Society, which is a non-profit group that provides Life and Health Insurance to its members. The Producer must not devote more than **50%** of his/her time to selling insurance, plus not sell more than **$50,000** of Life insurance coverage in a year.
- People who train others to become Producers and do not actually sell, solicit, or transact insurance
- An Attorney-in-fact who represents a Reciprocal Insurer, or an employee of the insurer or attorney

- A Real Estate Licensee who sells Home Protection or Warranty Insurance
- People who advise others regarding insurance, but do not solicit its sale

9. Maintaining a License

An individual is required to do the following in order to maintain their California insurance license:

A. Continuing Education

The Continuing Education Requirement promotes trustworthy and competent insurance agents for benefit of the public. All resident licensees must fulfill California's Continuing Education Requirement. An insurance license remains in effect (unless revoked or suspended) as long as applicable fees are paid and the Continuing Education Requirement is fulfilled.

This requirement does not apply to those persons holding resident licenses for any kind or kinds of insurance for which an examination is not required, nor shall it apply to any limited or restricted license the commissioner may exempt, or licensed nonresident agents who comply with the continuing education requirements or brokers of their state of residence.

Note: A licensee is exempt who submits proof satisfactory to the commissioner that he or she has been a licensee in good standing for **30** continuous years in this state and is **70** years of age or older.

Each new licensee is responsible for obtaining educational credit hours through approved instructional methods.

Upon renewal, these licensees must comply with the following requirement:

- Life-Only Agents -- A minimum of **24** hours per license period (every two years) following the date of the original license issuance.
- Accident and Health Agents -- A minimum of **24** hours per license period (every two years) following the date of the original license issuance. Accident and Health agents who ***also hold a property and casualty broker-agent license and/or a life license*** are only required to complete 24 hours of continuing education for either license type; Three of the 24 hours must be ethics education. *Example: Jenny Smith has an Accident a Health License and a P& C License, every two years Jenny has to complete only 24* ***TOTAL*** *hours for licenses. Bill is dually licensed with an accident and health license and a life-only license. Bill's total CE requirement is 24 hours every two years.*
- Life-Only and/or Accident & Health PLUS Property and Casualty Agents. A minimum of **24** hours per license period (every two years) following the date of the original license issuance.

The courses or programs of instruction that meet the standards for continuing educational requirements, and the number of classroom hours for which they are equivalent, are as follows:

- Any part of the Life Underwriter Training Council (**LUTC**) Course Curriculum totaling **50** hours, including the health course totaling **26** hours
- Any part of the American College **CLU** diploma curriculum totaling **30** hours
- Any part of the Insurance Institute of America's Accredited Advisor in Insurance (**AAI**) program totaling **25** hours
- Any part of the American Institute of Property and Liability Underwriters' Chartered Property Casualty Underwriter (**CPCU**) professional designation program totaling **30** hours
- Any part of the Certified Insurance Counselor (**CIC**) program totaling **25** hours
- Any insurance-related course approved by the curriculum board and the commissioner taught by an accredited college or university per credit hour granted totaling **15** hours
- Any course or program of instruction or seminar developed or sponsored by an authorized insurer, recognized agents' association, or insurance trade association, or any independent program of instruction, if approved by the curriculum board and commissioner, qualify for the number of hours assigned
- Any correspondence course approved by the curriculum board and commissioner qualify for the number of classroom hours assigned

B. Special CE Requirements

- **Ethics:** Every licensed agent must complete a minimum of four hours in specially-approved courses in ethics

every renewal period. Personal Lines and Limited Auto agents need only complete two hours. NOTE: This requirement is PART OF not in addition to the continuing education hours required and discussed above.

- **Annuities**: Every life agent who sells annuities shall complete an **annuity eight hour certification** course BEFORE soliciting or selling clients. Thereafter, **four hour certification refresher annuity training** must be taken **every two years** prior to license renewal. NOTE: This requirement is PART OF not in addition to the continuing education hours required and discussed above.
- **Long Term Care:** Every agent show sells long term care insurance must complete an long term care **eight-hour certification course** BEFORE soliciting or selling long term care insurance. Thereafter, an **eight-hour certification long term care course** must be taken each renewal period. However, if the agent has been in business **less than 4 years, he must take** an eight-hour long term certification care course every year for the first 4 years in business in order to be certified to solicit and/or sell long term care. This does not increase the total continuing education hours required and discussed above.
- **California Partnership for Long-Term Care (PR):** Fire and casualty broker-agents and life-only and accident and health agents who wish to solicit individual consumers for the California Partnership product must (prior to being authorized); complete one specifically

designated LTC training course (2004 LTC) and one specifically designated PR course.

Maintaining authority to solicit individual consumers for the Partnership Product requires:

- An **8**-hour specifically designated LTC training course (2004LTC) each year and must be accompanied by either a **4**-hour PR course every **12**-month period or an **8**-hour PR course every **2**-year license term.

- **Worker's Compensation:** Any life agent who wishes to sell **24-hour coverage** shall complete a course, or seminar of an approved continuing education provider on workers' compensation and general principles of employer liability. Satisfactory completion of this requirement is by proctored examination, administered or approved by the department.

Any person **failing to meet the requirements** and who has not been granted an extension of time within which to comply by the commissioner shall have his or her **license automatically terminated** until the time that the person demonstrates to the satisfaction of the commissioner that he or she has complied with all requirements.

Where a **person cannot perform the requirements** due to a **disability or inactivity** due to special circumstances, the commissioner will provide a procedure for the person to place his or her **license on inactive status** until the time that the

person demonstrates to the satisfaction of the commissioner that he or she has complied with all of the requirements.

C. Change of Address or Place of Business

Every licensee and every applicant for a license shall **immediately notify the Commissioner** in writing (or online) of any change in his address.

10. License Renewal, Nonrenewal and Fees

Not less than 60 days before a license will expire, the commissioner will mail, to the latest address of record, an application to renew the license for the succeeding license term. **It is the licensee's responsibility to renew** whether or not a renewal notice is received. (The commissioner may accept a late renewal. Application for renewal of a license may be **filed on or before the expiration date**. The application for **renewal of an expired license** may be filed up to one year later. The regular fee and a **delinquent fee** of **50%** of the regular renewal fee apply. Unless a license is suspended or revoked, a licensee **who has applied to renew** a license is entitled to continue operating under the existing license for **60 days after its specified expiration date**, or until notified the renewal application is deficient, whichever comes first, if the applicant has satisfied all license renewal requirements, including:

- The submission of the applicable renewal application and fee on or before the expiration date of the license.
- The satisfaction of all required continuing education or training requirements.

A. Military Service

If a licensed person enters the military service of the United States and is in the service at a time of a Renewal application, the filing of such application is waived, and the license held shall remain in force during the period of such military service and until the end of the license year in which he is released from such service but not for less than **6** months after such release. During this period a person can file an application and pay the fee without taking an examination or paying any penalty.

11. Suspension and Revocation of License

The Commissioner may suspend or revoke any license for any of the grounds on which he may deny an application. A suspension or revocation may be with or without notice or hearing based upon the reason for action.

The following are grounds for suspension or revocation:

- Providing false or misleading information in the license application
- Violating any insurance laws or rules
- A violation committed by a partner or associate that was known or should have been known by the Producer
- Fraudulently obtaining or trying to obtain a license
- Mishandling money received through insurance transactions
- Intentionally misrepresenting the terms of a policy

- Having been convicted of a felony or misdemeanor where the Producer (or license applicant) was dishonest or breached the trust of others
- Fraudulently transacted insurance
- Demonstrated dishonesty in a business's financial matters
- Had a license revoked or suspended in another state (U.S. or Mexican) or Canadian Province
- Forged another person's name on an insurance document
- Cheated on the license examination
- Knowingly transacted business with an unlicensed individual
- Failure to pay a civil penalty or any fees to the Commissioner
- Failure to comply with the Continuing Education Requirement
- Refusal to renew a license by the Commissioner

An accused Producer can request a hearing from the Commissioner. The Producer will have an opportunity to defend him/herself and will receive any decisions in writing.

12. Records Maintenance

It is the obligation of each life, life and disability, and disability insurance agent and any other agent and insurer to preserve and maintain all applicable records in his or her possession, in addition to those records transmitted to the insurer, at his or her principal place of business. Records must be kept in an orderly manner, readily available, and open to inspection or examination by the commissioner at all times.

Specific records to maintain for ***5 years*** include the following:

- Name of the insured and insurer;
- Policy number;
- Effective, termination and cancellation dates of coverage;
- Amount of gross premium, net premium and commission;
- Names of persons who receive or are promised any commissions or other consideration related to the transaction;
- Amount of premium received;
- Date the premium is received by the agent or broker;
- Date the premium is deposited into a trust account;
- Name, address of bank and account number in which the premium is deposited;
- Date the premium is paid by the agent or broker to a person entitled thereto with identification of how the premium was transferred;
- Amount of net and gross premium returned;
- Date the returned premium is received from the insurer by the agent or broker, or the date credited to such account; and
- Date the gross return premium is remitted to the person entitled thereto.

In additions, agents are required to keep records of the following for up to ***eighteen months*** after the transaction:

- Identity of each person who transacted the insurance;
- Records of all binders, whether written or oral, showing the names of the insured and insurer, the nature of the coverage, the effective and termination dates, and premium for the binder or policy to be issued;
- A copy of the application; and

- Correspondence received and sent, including notes of conversations or any other records necessary to describe the transaction.

The Department of Insurance also mandates that these records be kept in a neat and orderly fashion and easily attainable in case of an inspection.

A. Reporting of Actions

If any administrative action has been taken against a Producer, he/she must report it to the Commissioner no later than **30** days after the final disposition or no later than **30** days of the initial pretrial hearing date in the case of criminal prosecution. The Producer must include all relevant documentation, including a copy of the court order, any complaints filed, plus the results of any hearings.

B. Assumed Business Name

Every individual and organization licensee and every applicant for such a License, shall file with the commissioner in writing the true name of the individual or organization and also all fictitious names under which he conducts or intends to conduct his business and after licensing shall file with the commissioner any change in or discontinuance of such names. The commissioner may disapprove the use of any true or fictitious name.

13. Fiduciary Responsibilities

All funds received by an insurance agent, broker, or solicitor, life agent, life analyst, surplus line broker, special lines surplus line broker, motor club agent, bail agent, permittee, administrator, or solicitor, as premium or return premium for any policy of insurance, are held in a fiduciary capacity. Any person who diverts or appropriates those fiduciary funds to his or her own use is guilty of theft and punishable for theft as provided by law.

Producers accept payment for insurance premiums, plus handle money from business and personal use. It is extremely important that these premium funds are placed in a separate trust account and do not end up being mixed with other funds, except money used for the following:

- Advancing premiums
- Keeping reserves to refund premiums
- Paying bank charges and fees
- Paying for any other costs arising out of the process of receiving and returning premiums

A Producer must keep a **Client Trust Account** in the form of a checking account, demand, or savings account and fiduciary funds deposited into this account. If the insured makes the payment payable the insurer, the Producer must forward it directly to the insurer.

Producers/agents must establish and maintain records in an appropriate accounting system for all client payments received. The **Commissioner** may request to see these records at any time

during the **Producer's** business hours. If the **Producer** does not make these records available or maintain client premium fund records for **3** years following the policy cancellation date, serious consequences can result.

When receiving cash from a client for premium payments, the **Producer** must take the following steps:

- Give the person a receipt showing the amount of money paid, the date and time, the policy number, plus the policy holder's name
- Deposit the money into a **Client Trust Account**
- If the **Producer** does not have such an account, he/she must convert it into a money order, certified check, or cashier's check made out to the insurer
- Keep records of all money received and forwarded

END SECTION

When you have studied ALL required minutes for this section, click the blue button at right to record your time and access your quiz. Answer all questions correctly on the Quiz to move to the next Study Section. Re-Take Quiz as needed.

√ **Search this section using CTRL+F**
√ **Please study required minutes before taking Section Quiz**
√ **CAUTION: 20-Minutes or more idle time (no study activity) will cause disconnection and loss of study session minutes**

Section AH 10

ETHICS & TRADE PRACTICES

Objectives

This section will prepare you for examination questions regarding basic code and ethics knowledge. If you take our 12-Hour Code and Ethics training, you will study this subject in even greater depth.

Introduction to Code and Ethics

1. Historical Background

The following timeline illustrates and explains important court decisions and events in the history of **Insurance Regulation** in the United States. You will come across many of these events again in your study of insurance and further down the road when you are a licensed agent.

A. Early 19th Century

There were no specific laws or regulations in place other than the individual state laws that governed corporations and private businesses. There were no state insurance laws on the books and

no federal regulation of the industry. Resulting improprieties and abuses lead to a demand among the industry for regulation.

B. 1850

New Hampshire is the first state to establish a state **Insurance Commissioner**—still a very important office now. The states of Massachusetts, California, Connecticut, Indiana, Missouri, New York and Vermont soon appoint state Insurance Commissioners.

C. 1868

A Supreme Court decision in the case of **Paul vs. Virginia** rules that insurance is not interstate commerce. This establishes that states actually have the right to regulate insurance and not the federal government.

D. 1871

The **National Association of Insurance Commissioners** is formed. The **NAIC** seeks some uniformity with regards to state insurance regulation and reporting requirements. The organization also develops regulations concerning the solvency of insurance companies and methods for the exchanging of information between states.

E. 1905

In New York, the **Armstrong Investigation** of insurance is conducted to improve regulation and lessen abuses.

F. 1910

Again in New York, the **Merritt Committee Investigation** of fire insurers leads to greatly improved state regulation and a new state insurance code.

G. 1939

The state of New York adopts a rule that states all insurance companies doing business in New York *must* comply with the insurance laws of New York with regards to any state they do business in.

H. 1944

Another very important Supreme Court decision concerning ***Paul* vs. Virginia.** The **South-Eastern Underwriters Case** causes the U.S. Supreme Court to overturn **Paul vs. Virginia**, and rules that insurance was indeed interstate commerce when conducted over state lines and that federal anti-trust laws applied to the industry. The effect of this ruling left the industry virtually unregulated.

I. 1945

The **McCarran-Ferguson Act (Public Law 15)** is passed by Congress due to strong opposition against federal regulation of insurance. **This law gave back to individual states the right to regulate and tax insurance to the extent that it is not regulated by the federal government.** This is a landmark moment in the history of insurance regulation, and the **McCarran-Ferguson Act** is still an important law today.

2. Federal versus State Regulation

Current federal influence of the industry includes regulation by the Security and Exchange Commission (SEC) and the National Association of Securities Dealers (NASD) for securities regulation of certain insurance products; and the Internal Revenue Service (IRS) for tax code provisions regarding products and companies. Pension legislation with regulations from the Labor department such as ERISA, protects plan participants and their beneficiaries. Health insurance legislation, such as the standardization of Medicare supplement policies, as well as long term care insurance, are areas of overlapping regulation by states and the federal government. The sale of insurance products in the banking industry will involve their regulatory organizations, The Federal Reserve and the Office of the Comptroller of the Currency.

Like any other industry, there is debate concerning the influences of federal versus state regulation.

Proponents of **Federal** regulation argue that:

- State regulation is not uniform which, leads to inefficiencies and other tangles. Despite improvement led by the NAIC's model legislation, this situation is unlikely to change.
- State regulation is ineffective in controlling insurance companies that operate on a nationwide basis.
- Federal regulation would be more effective as well as cheaper.

Proponents of continued **State** regulation argue that:

- State regulation is satisfactory, more flexible and capable of meeting individual state insurance needs. There is no real proof that federal regulation would improve conditions or be more efficient.
- The voluntary cooperation of state insurance departments has already made great strides in achieving uniform provisions.
- If federal regulation were imposed, it would lead to two regulatory systems instead of one cohesive system.

The future is likely to see more federal influence of the industry, however it is unlikely to become the sole regulator in all matters relating to insurance.

In state legislatures, and in Congress in recent years, there has been proposed legislation and passed legislation regarding current Life and Health insurance issues including; a tax on the cash value build-up in a life policy, certain mandated benefits such as Family or Maternity leave, privacy and authorization with HIPAA.

3. Ethics and History

The overall purpose of regulation is to **protect the public good** and the insurance consumer.

The state insurance department seeks to provide protection by regulation regarding three primary areas:

1) Company authorization and financial stability or solvency

2) Agent licensing and education

3) Sales practices

These regulations set minimum standards and form the basis of **ethical guidelines** by making certain actions unlawful. There remains a difference however between law and ethics. Witness the business scandals such as **Enron** and **World Com**, breaches in ethical behavior in the securities industry in spite of penalties that include prison as well as fines or civil penalties. An action may be lawful, but unethical.

Today, higher legal standards for the benefit of consumer protection will likely find an agent or company liable for their actions. Public perception of the industry has been affected by scandal, insolvency, class action lawsuits, and their own personal experiences.

How then, do insurance agents live up to higher expectations and responsibilities? To tell someone “Do the right thing”, may be too simplistic. A personal ethical or moral code is required to answer the question of what one should do in a given situation.

Ethical or moral codes have long existed, a universal norm being “The Golden Rule”, a version of it expressed by most religions including Christianity, Judaism, Islam, Hinduism, Buddhism, and Confucianism.

Ethics is the basis for trust, promises, and reliability in our business. Accepting ethics at the philosophical level is one thing, living the practicality of it in business daily is another. The evolution from insurance agent to insurance professional, and the responsibility of that role may help.

There are **7** requirements for recognition as a professional:

1) Specialized knowledge not understood by a lay person

2) Academic study of the subject

3) Licensing examination is required

4) Professional organization or society

5) Independence in their recommendations

6) Public recognition as professionals

7) A code of conduct (ethics)

Professional organizations include the National Association of Insurance and Financial Advisors (NAIFA), Society of Financial Service Professionals, the Million Dollar Round Table (MDRT), the American College, sponsor of the professional designations; Chartered Life Underwriter (CLU), Chartered Financial Consultant (ChFC) and Life Underwriting Training Council Fellow (LUTCF). Other designations in the industry are the Charted Property Casualty Underwriter (CPCU), and Certified Financial Planner (CFP).

All of these organizations have a code of conduct, code of ethics, or pledge, that have as it's common theme, a recognition of obligations and responsibilities to those they serve:

- The best interests of the client come first
- Obey the law
- Loyalty to the company
- Professional conduct, truthfulness, confidentiality
- Duties to other professions, family, and self

Many of the regulations in our industry have to do with sales practices. Suitability, disclosure, sales illustrations, and replacement, the particulars of which you will learn later in units that follow, are the issues that concern regulators, companies, and ourselves as professionals.

The solicitation, selling, and servicing of insurance properly, may be accomplished by following some basic principles:

- Identify yourself as you are without misleading titles
- Use illustrations and sales materials properly
- Provide options or choices in recommendations
- Record all information requested on the application
- Protect client confidentiality
- Deliver the policy and explain things to your client

- Service with a regular review

Ethics and Seniors
Agents should always practice being ethically sound individuals, especially when dealing with sensitive matters such as helping the elderly population with their financial needs. Seniors are at greater risk of scams and financial exploitation simply because they are older, frail, hard of hearing or lack the comprehension they had in younger years. Let's look at an example: As seen in Grace vs Interstate Life, an accident and health agent sold his client a health policy while she was in her 50's After the client reached 65 he continued to collect premiums despite the fact that Medicare would have replaced most of the benefits of her policy. The court did not look favorably on the agent's lack of duty to notify his senior client that he no longer needed a private health policy.

When agents cross the line, they can be subject to fines or a an expensive lawsuit. That is why most agents carry **Errors and Omissions (E&O) coverage.** While they typically do not cover instances where the agent was negligent, they can cover mistakes or even a baseless lawsuit. If you are sued and the other party wins, E&O coverage will pay the loss, subject to policy limits and a deductible, in addition to defense costs.

An agent's exposure may be in one or more of several areas:

- Alleged misrepresentation of policy terms and coverages
- Misuse of policy illustrations
- Improper licensing for product
- Misunderstanding of tax ramifications
- Downside risk that is not explained

- Premiums or premium offset arrangements
- Incorrect information on an application
- Failure to provide proper coverage
- Inappropriate or unsuitable product recommendations

Agents can protect themselves with documentation of client files with copies of; checklists, questionnaires, factfinds, agendas, notes, illustrations, disclosures, and phone logs. Maintaining client contact is important in the relationship also, and many agents use birthday or greeting cards, client newsletters, and periodic reviews to stay in touch.

Marketing and Trade Practices

Objectives
This unit will cover the Code and Ethics concerning the selling of insurance products in California. The purpose of Regulation concerning the Marketing of Insurance products is to ensure that all insurance companies act in good faith, abstain from deception and that they treat all members of the public with honesty and fairness in all insurance matters. While this is common sense in all business practices, there are several concepts and regulations that are particular to the insurance business.

1. Illegal and Unfair Practices

Insurance products are regulated to make sure that all members of the public are treated with honesty and fairness. Obviously, that's business ethics 101, but there are regulations

specific to the insurance industry that could end up on the final exam.

With regard to the marketing or claims handling of insurance products, the following are defined as unfair methods of competition and unfair and deceptive acts or practices:

A. Misrepresentation

Misrepresentation means any of the following:

- Misrepresenting the terms of a policy, its dividends, the financial condition of an insurer, or making any misrepresentation to any policyholder insured in any company in order to induce them to lapse, forfeit, or surrender their insurance
- Making untrue or misleading statements
- Entering into any agreement to commit any act resulting in unreasonable restraint, or monopoly in the business of insurance
- Publishing or circulating false statements of financial condition in order to deceive
- Making false entries or willfully omitting any material facts in order to deceive
- Making or allowing any unfair discrimination
- Stating that the named insurer is a member of the California Insurance Guarantee Association, or stating that the insurer is insured against insolvency

- Canceling or refusing to renew a policy in violation of the code

B. Premiums

There are **3** main illegal practices regarding premiums:

1) **Commingling** means company money is mixed with the customer's money or the agent's money.

2) **Overcharging premiums** involves overcharging the insured and then keeping the excess.

3) **Charging premiums for unapplied coverage** means a producer accepts premium payments for coverage that isn't in effect.

C. The insurance License

It's illegal to transact insurance without a license, and it's illegal to obtain a license fraudulently. It's also illegal to sell insurance that's outside the scope of the license you have. If a producer is licensed to sell Property and Casualty insurance, they can't transact a Life insurance policy. So, just to reiterate:

- It's illegal to transact insurance without a license
- It's illegal to obtain a license fraudulently
- It's illegal to sell insurance outside the scope of your license

D. Rebating

Rebating means you use a sales inducement to get a prospective customer to buy an insurance policy. This could involve guaranteeing a dividend, splitting commissions with the client, or paying premiums for the client.

E. Illegal Inducement

This is a nice way of saying bribing somebody. It could mean giving gifts to prospective clients, offering them money, or even buying them nice dinners. Offering special contracts or changes to a contract or policy is also illegal, as well as offering prospective clients foot massages or a free phrenological assessment. Illegal, illegal, illegal.

F. Concealment

Concealment involves intentionally withholding facts or information to gain an advantage in an insurance transaction.

G. Twisting

Twisting means any situation where the truth is twisted or bent to get someone to drop an existing policy for a new policy. For example, if a producer could get a commission by convincing a client to drop their existing life policy, which takes care of all their needs, for a new policy they might not necessary need, the producer is engaging in twisting.

H. Defamation

The official definition of defamation is the malicious discrediting or slandering of an insurance company or its agents. Basically, it's

saying/writing/implying something mean that could hurt a company/individual's reputation or cost them money. For example: "Buy from us, because unlike our competitors, we don't reek of day old cheese!" Usually it's harsher than that, but you get the general idea.

I. Controlled Business

You can't get a license just to write controlled business, which means you're only selling to friends and family. You can write some controlled business, but there are guidelines regarding controlled business:

- In a **2**-year period no more than twice the amount of a producer's premiums can be from controlled business
- A producer can't have twice the amount of controlled Life and Health policies, than they have for noncontrolled premiums

J. Free Insurance

This would fall under "inducement," but the CIC specifies that Free Insurance is a no-no. Basically, someone would offer free insurance as a benefit of buying an annuity or a property. Agents/producers/insurers aren't allowed to do this.

Free Insurance

The prohibitions of free insurance doesn't include insurance written in connection with newspaper subscriptions or general circulation. It also doesn't include insurance issued to credit unions or members of credit unions.

PRIVACY LEGISLATION

The Gramm-Leach-Bliley Act (1999) concerns consumer financial privacy and financial safeguards: ***Financial Privacy --*** Requires financial institution to provide each consumer with a privacy notice explaining what information is collected about the consumer, where the information is used and how it is protected. Any changes must be disclosed. Prohibits the sharing of nonpublic information with a non-affiliated third party unless consumers are given an opportunity to opt-out. ***Financial Safeguards --*** Requires financial institutions to develop a written security plan describing how the company is prepared for and plans to protect consumer nonpublic information, even if the consumer is no longer with the financial institution.

The California Financial Information Privacy Act (2003) adds to the financial privacy provisions of Gramm-Leach Bliley by requiring that consumers ***opt-in*** PRIOR to any sharing of nonpublic information among financial institution non-affiliates. Consumers can ***opt-out*** for any sharing of information among affiliates of the financial institution.

Insurance Information and Privacy Protection Act (2003) provides that personally identifiable information supplied to an insurance agent or broker in order to apply for insurance must be protected. Agents must provide consumers with a privacy Notice explaining how and with whom this information will be shared and the consumer right to ***opt-out*** from having personal information shared.

Health Insurance Portability and Accountability Act (HIPPA) assures that an individual's health information (medical records) by establishing national standards for health providers, billing services and health information companies. Requires covered entities to take reasonable steps to ensure confidentiality of communications, notification of record use and document privacy policies and procedures.

HIPPA also establishes protections for certain people – called HIPPA Eligible Individuals" – when they lose group health coverage. Once eligible, they are guaranteed an offer of at least two health insurance policies that do not impose pre-existing condition exclusion periods. HIPPA is silent on the charges for these policies.

To become HIPPA Eligible, one must meet the following criteria:

18 months of continuous credible coverage in a group health plan

Already used up any COBRA or continuation coverage
Not be eligible for Medicare, Medi-Cal or a group health plan.
Must not have health insurance
Must apply for coverage within 63 days of losing prior coverage

2. Misrepresenting Policy Provisions

It's considered a misrepresentation of policy provisions if an insurance company or producer:

- Fails to disclose policy benefits during a claim
- Denies a claim because the insured fails to exhibit property without proof of demand
- Denies a claim because the insured didn't act within time frames that weren't in the policy
- Requires a release beyond the scope of claim for the payment of the claim
- Issues payment checks for partial settlement that releases the insurance company of it's total liability
- Makes payments to the insured that requires reimbursement if the company doesn't tell the insured about that policy

3. Unfair Claims Settlement practices

The following are considered specific unfair claim settlement practices. An insurance company can't:

- Misrepresent facts or policy provisions
- Fail to respond promptly to a claim
- Fail to properly investigate a claim
- Refuse to pay a claim without an investigation
- Fail to affirm or deny coverage after Proof of Loss is provided

- Refuse to act in good faith when payment is reasonably clear
- Fail to offer reasonable settlement amounts, forcing the insured to resort to litigation or arbitration
- Delay processing a claim with excessive paperwork
- Delay settlement under one coverage as leverage to effect the settlement under another coverage for that policy
- Deny a claim without providing the insured with a clear explanation
- Discriminate against claimants who are represented by a public adjuster
- Fail to honor checks paid to claimants
- Fail to pay a claim promptly after settlement
- Fail to promptly deliver a release or settlement document to the insured of claimant
- Delay or add to the cost of Property/Casualty appraisals
- Fail to make a good faith effort to settle and force the insured into a Property and Casualty appraisal
- Settle directly with a claimant who's represented by an attorney without the attorney's consent
- Delaying the payment or provision of hospital, medical, or surgical benefits for services provided with respect to acquired immune deficiency syndrome or AIDS-related complex for more than **60** days after the insurer has received a claim for those benefits, where the delay in claim payment is for the purpose of investigating whether the condition preexisted the coverage.

Note: This **60**-day period doesn't include any time during which the insurer is awaiting a response for relevant medical information from a health care provider.

3. Prompt, Fair, and Equitable Settlements Definitions

Claimant

The claimant is any person who asserts a right of recovery under a surety bond, an attorney, any person authorized by operation of law to represent the claimant.

Notice of legal action

means notice of an action commenced against the insurer with respect to a claim, or notice of action against the insured received by the insurer, or notice of action against the principal under a bond, and includes any arbitration proceeding.

Proof of claim

means any evidence or documentation in the possession of the insurer, whether as a result of its having been submitted by the claimant or obtained by the insurer in the course of its investigation, that provides any evidence of the claim and that reasonably supports the magnitude or the amount of the claimed loss.

D. File and Record Documentation

Every licensee's claim files shall be subject to examination by the Commissioner or by his or her duly appointed designees. These files shall contain all documents, notes and work papers (including copies of all correspondence) which reasonably pertain to each claim in such detail that pertinent events and the dates of the

events can be reconstructed and the licensee's actions pertaining to the claim can be determined.

E. Duties upon Receipt of Communications

Upon receiving any written or oral inquiry from the Department of Insurance concerning a claim, every licensee shall immediately, but in no event more than twenty-one (21) calendar days of receipt of that inquiry, furnish the Department of Insurance with a complete written response based on the facts as then known by the licensee. A complete written response addresses all issues raised by the Department of Insurance in its inquiry and includes copies of any documentation and claim files requested.

Upon receiving any communication from a claimant, regarding a claim, that reasonably suggests that a response is expected, every licensee shall immediately, but in no event more than fifteen (15) calendar days after receipt of that communication, furnish the claimant with a complete response based on the facts as then known by the licensee. This subsection shall not apply to require communication with a claimant subsequent to receipt by the licensee of a notice of legal action by that claimant.

4. Standards for Prompt, Fair and Equitable Settlements

These are the standards for prompt, fair, and equitable settlements by insurance companies.

No insurer shall discriminate in its claims settlement practices based upon the claimant's:

- Age
- Race
- Gender
- Income
- Religion
- Language
- Sexual orientation
- Ancestry
- National origin
- Physical disability
- Address or location

After receiving proof of claim, every insurer has to:

- Accept or deny the claim as quickly as possible, and no later than **40** calendar days
- Notify the claimant if more time is required to determine whether a claim is going to be accepted or denied, either partially or wholly. The claimant needs to be notified every 30 days if more time is needed
- Settle the claim by making a reasonable offer—insurers can't make an offer that's unfair or unreasonably low

Note: If someone thinks they have received an offer that's too low, they can file a complaint with the Commissioner. The Commissioner shall consider any admissible evidence offered in determining whether or not a settlement offer is unreasonably low.

- Pay any approved claims no later than **30** calendar days

5. Insurance Information and Privacy Protection Act

An insurance institution or agent has to provide a notice of information practices to all applicants or policyholders in connection with insurance transactions as provided below:

- At the **time of the delivery** of the insurance policy when personal information is collected only from the applicant, an insured under the policy, or from public records
- At the **time of the collection** of personal information is initiated when personal information is collected from a source other than the applicant, an insured under the policy, or public records.

The written notice has to include the following:

- Whether personal information may be collected from persons other than the individual or individuals proposed for coverage
- The types of personal information that may be collected and the types of sources and investigative techniques that may be used to collect such information

- The types of disclosures and the circumstances under which the disclosures may be made without prior authorization

- A description of the rights established and the manner in which the rights may be exercised.
- That information obtained from a report prepared by an insurance-support organization may be retained by the insurance-support organization and disclosed to other persons

Disclosure forms must be:

- In plain language
- Dated
- Include the nature of information, as well as to whom it may be disclosed
- The name of the agent or insurer
- How long the authorization is valid.

Penalties for violation could include a fine of up to **$50,000** and any court awarded damages.

Marketing To Seniors:

In California, marketing life, annuities, or disability to seniors who are **65** years or older, has specific regulations. Policies have to include a **30**-day free look period, a written comparison of any existing health coverage, and the person has to receive advice

concerning HICAP's free services to seniors (the Health Insurance Counseling and Advocacy Program).

6. The Insurance License

It is illegal to sell any insurance product without an official state-granted license to do so. Also, selling insurance that is outside the scope of one's license is illegal. If an agent is licensed to sell Automobile and Home insurance, they cannot sell or write a Health insurance policy without being licensed for that line. It is also illegal to obtain any insurance license by fraudulent means.

Every licensee shall prominently affix or be printed on business cards, written price quotations for insurance products, and print advertisements distributed exclusively in this state for insurance products, its license number in type, the same size as any indicated telephone number, address, or fax number, as well as the word "insurance".

If someone violates these rules, the person could receive a fine of up to:

- **$200** for the first offense
- **$500** for the second offense
- **$1,000** for the third offense, or any other offenses afterwards

Note: The penalty can't exceed **$1,000** for any one offense.

7. Unfair Discrimination

Insurance companies can't deny insurance coverage based solely on the basis of race, religion, or national origin. Coverage also can't be denied because of a physical or mental disability.
Law and regulations regarding unfair discrimination state that:

- Insurance companies have to treat all applicants equally
- Insurance companies can discriminate as long as the discrimination is based on **Risk Selection and Sound Actuarial Principles**

Risk Selection and Sound Actuarial Principles

Are methods for determining whether a person or a group of people are desirable insurance risks. This takes into account their age, occupation, gender, lifestyle, and history, but it also looks at a statistical model of certain demographics. Actuarial principles help companies deduce how much money in claims they could end up spending on claims based on morbidity rates, mortality rates, etc.

Companies are allowed to use the following characteristics only if those characteristics increase the risk of insurance:

- Age
- Sex
- Marital status
- Race
- Creed
- National origin
- Ancestry
- Lawful occupation
- Change of occupation
- Change of domicile
- Previous insurance rejection
- Cancellations/nonrenewals of insurance

- A previous lack of insurance

8. HIV

California has established mandatory and uniform minimum standards for insurers to avoid making or permitting unfair distinctions between individuals of the same class in the underwriting of life or disability income insurance for the risks of acquired immune deficiency syndrome (AIDS)and AIDS-related conditions (ARC), for assessing AIDS and ARC risks for determining insurability which are deemed to be sufficiently reliable to be used for life and disability income insurance risk classification and underwriting purposes, and to require the maintenance of strict confidentiality of personal information obtained through testing as well as require informed consent before any insurer tests for HIV.

9. Commissions and Fees

Only licensed producers can receive commissions or fees, or any other valuable considerations from insurance transactions. It's illegal for anyone who isn't licensed to accept a commission. Someone can accept renewals and deferred commissions if they were licensed at the time of the sale.

A service fee is a charge the insurance producer makes that isn't part of premium payments.

Note: Service fees aren't allowed in Personal lines of insurance: Auto, Property, and Liability.

Service fees can be charged in Commercial lines of insurance if the producer provided additional services above and beyond customary practice. In these instances, the producer would have to provide a written explanation for the charge.

You can't accept compensation from the insurance company unless you have done the following, prior to the insured's purchase of a policy:

- Obtained the insured's documented acknowledgement
- Disclosed the amount of reimbursement or provided a reasonable estimate of what that reimbursement might be
- Disclosed the nature of the work that will be done on behalf of the insured

10. Advertising

False advertising is illegal. Here are some guidelines concerning advertising:

- Advertising has to be clear and not misleading
- If a company advertises their assets, those assets have to match the last verified statement filed with the Commissioner
- You can't infer or suggest you're an insurer unless you're an insurer
- All advertising has to be true and accurate no matter what form it's in: media, newspapers, magazines, online, and etc.

Advertisements for term life insurance aimed at people who are
55 years or older will:

- Clearly and prominently distinguish basic life insurance benefits from supplemental benefits such as accidental death benefits
- Prominently disclose any limitations, exceptions, or reductions affecting each benefit
- Prominently disclose any condition affecting the policy or certificate holder's continued insurability. If term coverage terminates at a stated age, or at the end of any designated period, that fact and the specified age or designated period shall be disclosed
- Prominently disclose any change in benefits resulting from the aging of the insured, policy duration, or any other factor
- Prominently disclose any change in premium resulting from the aging of the insured, policy duration, or any other factor. If the insurer retains any right to modify premiums in the future, that fact shall be disclosed

A. Internet Advertising

A person licensed in this state as an insurance agent or broker, who advertises on the Internet, and transacts insurance in this state, must identify all of the following information on the Internet:

- Name as it appears on his or her insurance license, and any fictitious name approved by the commissioner
- The state of his or her domicile and principal place of business
- License number

If someone who advertises on the Internet does any of the following, the California Code considers them to be "transacting" insurance:

- Gives an insurance premium quote to a California resident
- Accepts an application for coverage from a California resident
- Communicates with a California resident regarding terms of an agreement to provide insurance or an insurance policy

11. Fiduciary Responsibilities

Producers have certain financial responsibilities. If they receive premium payments on behalf of an insurance company, they have to report the exact amount of the payment and records must be kept on all received/refunded premiums.

Any refunded or returned premium has to be delivered promptly to the insured.

If the producer accepts a premium payment, they have to provide the insured with a receipt for the payment of premium no later than the next business day.

The producer has to deposit premium payments within **7** days of receipt, and if the payment is a check that's made out to the insurance company, the producer has to forward the check directly to the insurance company.

Note: Insurance producers have to keep client records for Property and Casualty insurance for **3** years past the policy's expiration.

If premiums are paid in cash, the insured has to get a receipt, which includes:

- The date
- The name of the agent/producer
- The name of the policyowner/insured
- The amount received
- The insurance company's name
- The policy number

Okay, so some of that is ultra-obvious. Don't roll your eyes at us, we're just being thorough.

Note: Just a quick aside—if there are extra charges relating to someone's policy or application, the insured needs an explanation in writing for those charges.

12. Policy Retention

Policy retention benefits everyone. A producer who keeps an open line of communication with his/her clients will have the opportunity for more sales, as well as be able to provide the maximum protection for that client.

It benefits the client because they always have the insurance protection they need. And, obviously, if a producer has a lot of

happy clients, this is going to benefit the producer and the insurer financially.

END SECTION

When you have studied ALL required minutes for this section, click the blue button at right to record your time and access your quiz.