



## ACCIDENT & HEALTH 2009 Supplement

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The California Department of Insurance introduced substantial changes to its prelicense course objectives on November 3, 2008. This supplement highlights these changes.

**IMPORTANT: EXPECT NEW QUESTIONS ON THE STATE LICENSE EXAM STARTING JANUARY 2009. THIS SUPPLEMENT WILL HELP PREPARE YOU. STUDY THIS INFORMATION WITH CARE.**

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# **INSURANCE LAW**

## **Elements of an Insurance Contract 8-14**

The 4 major elements of a contract are:

Competent Parties  
Legal purpose  
Offer and acceptance  
Consideration

An easy way to remember is **CLOC**

## **Fair Credit Reporting Act requirements: 7-23**

Applications for life 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

## **Medical Information Bureau 7-22**

There 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. To protect privacy, MIB requirements are:

- 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.

### **Certificate of Authority 9-15**

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.

### **PRIVACY LEGISLATION** 10-15

**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

## **LICENSING**

### **Life Agent vs Life Analyst 9-23**

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.*

### **Title 18 8-27**

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.

### **Agent vs. Broker vs. Solicitor 9-23**

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.

### **Continuing Education 9-40**

Life only agents require 24 hours of continuing education every renewal period (2 years). Special CE rules apply if an agent has BOTH a life and casualty licenses:

- Life-Only and/or Accident & Health PLUS Fire and Casualty Agents (less than 4 years in business) -- A minimum of **25** hours per year following the date of the original license issuance.
- Life-Only and/or Accident & Health PLUS Fire and Casualty Agents 4 or more ears in business) -- A minimum of **24** hours per license period (every two years) following the date of the original license issuance.

Agents writing **California Partnership** coverage must meet California long term care requirements

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.

### **STATE GUARANTY FUNDS 5-17**

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** doesn't 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

## **HEALTH POLICIES**

**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. 13-1

### **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 13-9

## Health Terms You Should Know . . .

**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 13-9

## Other Health Insurance Policies 2-18

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 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**.

## **GROUP COVERAGES**

**Individual v. Group Coverage:** In general, individual health plans are **less expensive** than group plans because state laws typically require group plans to accept everyone, regardless of health. Also, group rates are based on claims history of the insured group (a possible small pool of individuals) while individual rates are based on a much larger pool of individuals buying from the same insurer. 13-2

**Group Eligibility:** With Group Health coverage, there may be eligibility requirements (e.g., 1,000 hours in a 12-month period or a waiting period (e.g., you must be employed 90 days before you can be covered). If someone joins the group after the insurance has gone into effect, they will probably have to wait until the end of this probationary period for coverage to begin. 13-4

### ***Contributory vs. Noncontributory Plans***

Contributory plans require that employees pay part of the premium for their insurance benefits. This is the familiar paycheck 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 non-contributory plan means the employer pays all premiums. The employee pays no part of the premium. 14-14

A **blanket policy** is health insurance covering groups of people such as a group of employees for a certain employer or members of a religious, charitable or civic organization, or members of a union, etc. 14-14

**Occupational vs. Non-occupational** triggers in a policy may determine the degree of exposure and premiums a group health plan pays. For

example, a worker at an automobile refinishing shop is exposed to occupational risk when sanding, stripping, buffing or painting a car while at work. A non-occupational risk might be to the owner of the car from the inhalation of paint fumes and other particulates resulting from the work on the car. 13-8

**Third party administration:** A group health plan can be administered by a third party. An example might be the Mayo Clinic providing third party services for a company's group health plan to aid in its design, claims processing, medical management, pharmacy benefit management, customer service, etc. 14-13

**Coordination of benefits:** If a husband and wife both have health plans at their own work, required provisions in the plan must determine who pays for a claim so the employee receives the maximum benefit without a duplication of payment. 14-16

**Types of Providers and Contracts:** Group plans may have medical services provided through various types of providers such as private and HMO physicians, hospitals, urgent care centers, home health care, etc. Some providers may be on contract to provide services in a PPO (referred provider organization), HMO (health maintenance organization) or EPO (exclusive provider organization) or POS (point of service) type environment. Typically these contracts are agreements whereby the health care provider offers services at a discount.

- **PPO** members choose from a list of doctors and health providers.
- **HMO's** specify the provider you need to use.
- **EPO's** are similar to HMO in that members must stay in the network but they have a choice as to who is their primary doctor.
- **POS** is also similar to the HMO but members are allowed to see doctors outside the network (with certain limitations) at an additional charge. 13-10

### **Group Insurance and The Law:**

Specific California Insurance Code (CIC) Sections apply to group health policies. You need to know the following:

**CIC 10202** – A "group" is considered two or more employees; employers act as fiduciaries where premiums and coverage is concerned.

**CIC 10203.4** – Group policies may extend coverage to dependents of an employee (spouses, children through age 20 (age 24 if a student)).

**CIC 10200** – Group policies may be issued at "less than usual" or wholesale rates.

**CIC 10206** – 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** – insurers are not responsible or have limited liability for losses due to war, military service or aviation accidents.

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

**CIC 10209** – 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** – 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 policies may be issued for a term not exceeding one year

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.

**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.

## **OTHER HEALTH POLICIES**

Within the insurance industry 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.
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- **Blanket** – allows a single policy to cover more than one type of property at the same location, or multiple properties at different location owned by the same insured.
- **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.
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- **Supplemental Accident** – pays for out-of-pocket expenses related to accidental injury 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**. 18-6

## **OTHER WAYS TO FUND HEALTH INSURANCE**

In addition to the traditional forms of coverage health and disability care policies and providers, individuals, employees and the self-employed have options to fund routine or supplemental health expenses using the following plans:

***Medical and Health Savings Account (HSA, MSA)*** – tax advantaged savings accounts can be combined with high deductible health insurance to pay for uncovered or supplemental health expenses.

***Flexible Spending Account (FSA)*** – tax-advantaged payments from an employee are administered by an employer to provide a health care fund to pay for medical expenses not covered by the employee's traditional health policy.

***Health Reimbursement Account (HRA)*** – tax-advantaged programs that allow an employer to reimburse and deduct medical expenses incurred by his employees.

***High Deductible Health Plan (HDHP) & HSA*** – health plans for individuals, employees and self-employed with higher than normal deductibles. The strategy is to team the HDHP with an HSA. The money saved by choosing a high deductible plan can go into the HSA and pay for some of the deductible costs as well as routine medical expenses.

***Consumer Driven Health Plan (CDHP)*** – consumers use some form of HSA, HRA or FSA to pay for routine medical care while a HDHP protects them from catastrophic expenses they might incur in a hospital stay or accident.

## **HEALTH POLICY ELIGIBILITY**

As an agent, it is your responsibility to identify how your client's circumstances, eligibility and/or ratings affect his ability to obtain health insurance as well as available options. Following are factors to consider:

***Demographics*** (gender, age, occupation) – while employers cannot discriminate by sex or age, insurers can. For example, women and older individuals / employees, who statistically use more health care, may cost more to insure.

***Industry*** – health care costs and benefits may vary based on the associated industry risk, e.g., a health care worker is at a higher risk of illness than a secretary.

***Location*** – areas of higher density are likely to incur higher accidents and health care costs than rural locations.

***Carrier history*** – certain carriers accept certain health risks and reject others. Knowing their standards and history can save the time and

frustration that comes when a client is rejected, especially if he was not acceptable from the start.

**Medical history** – knowing your clients chronic or ongoing conditions, catastrophic illnesses, pregnancies, disabilities, dependents and extended benefits from a former carrier are essential to him obtaining correct coverage, affording needed coverage or even being eligible for coverage at all.

**Contribution** – some policies, like workers compensation, are non-contributing (the insured does not need to contribute or pay in order to be covered).

**Participation** – coverage may only be available if the insured is an employee, member, officer or a dependent of same. 14-21

## **DISABILITY INCOME INSURANCE**

### **Need For**

A disability income policy provides an insured with a portion of their earnings if they become disabled. A lot of people tend to overlook this type of policy, but statistics show that today's working force has a 50% chance (or higher) of being disabled for more than three months before they reach retirement. 15-1

### **Partial vs Total Disability 2-8**

**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".

### **Occupational vs. Non-Occupational Policies 2-4**

Disability income policies may be occupational or non-occupational.

**Occupational** coverage provides payment for disability arising out of accidents occurring on or off the job. **Non-occupational** coverage pays ONLY for disability that is not work-related. Group health plans typically do not include occupational coverage because that is covered by workers compensation insurance. An occupational policy pays benefits whether or

not the disability is covered under workers' comp. A non-occupational policy does not pay if workers comp pays.

### **Disability Income Subject To Income Tax?**

If the insured pays for premiums (as in an **individual policy**) then the premiums aren't tax-deductible, and any future benefits aren't considered taxable income.

If an employer pays the premiums (as in a **group plan**) and the insured receives benefits from the plan, then the employer can deduct the premium payments from their taxes.

In a **franchise plan**, a disability income insurer is contracted for and negotiated by the employer, association or labor union on behalf of its employees or members, but each employee or member negotiates and contracts for his or her own individual policy, i.e., several policies are issued, one to each employee or member. Rates and benefits vary. If the cost is carried by the employer, the benefits are taxed. 15-11

### **Limitations on Coverage?**

Insurers will limit the amount of disability income benefits a person can apply for based on age, earnings and other policies in force. The reason benefits are designed to be lower than an insured's normal income (say 60% of routine earnings) is to discourage people from abusing coverage and becoming dependent on benefits for long periods of time. 15-6

### **Types of Disability Income Policies**

**Individual Policies** are typically sold to professionals or the self-employed. The benefit amount is intended to replace as much after-tax income as possible when a disability prevents the insured from earning a living.

**Business Overhead Expense Policies** are sold to business owners to cover **business overhead expenses** in case the owner suffers a disability. Rent and utilities might be paid, but NOT loss of income, inventory or cost of capital.

**Business Disability Buyout Insurance** provides funds to purchase the interests of an owner or partial owner of business should they become disabled.

**Group Disability Income Insurance** provides coverage for employees, managers, officers, partners, associates, etc. The purpose is to provide individual disability income benefits within a group contract.

**Key Employee and Partner Policies** are not as common as buyouts. Nonetheless, the loss to a business when a key player or partner becomes disabled and unable to work can be the same as if the person died. This form of disability income protects the business from this loss exposure with benefits of between 40 to 70 percent of the disabled person's income.

## **Eligibility and Rating 2-10**

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.

## **Disability Income Policy Provisions and Riders 2-11**

**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.

**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 Security 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** – 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.

## **MEDICARE**

**Eligibility** - To be eligible for Medicare, an individual must: 16-4

- Be over age 65
- Be a Social Security Disability Insurance (SSDI) beneficiary who has a medical determination of disability by Social Security
- Be under age 65 with EndStage Renal Disease (ESRD).

**MEDICARE SERVICES** are provided through several program products.

**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** – 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 Part A Terms To Know 16-6**

***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**.

***Deductible:*** For 2009, the Part A deductible is \$1,068. 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 \$267 deductible **per day** is paid for days 61 through 90 and \$534 **per day** beyond 90 days.

***Co-payments:*** From the **61<sup>st</sup>** day to the **90<sup>th</sup>** 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.

### **Medicare Part B 16-8**

Medicare Part B is designed as an optional and supplemental insurance to Part A. Anyone enrolled in Part A can enroll in Part B by paying a monthly premium.

**Part B** requires a small annual **deductible** (about \$140) and the following **co-payments**:

- 20% of all reasonable charges for medically necessary services
- The cost of the first three pints of blood used in medical procedures

Enrollment in Part B can be delayed if a person's employer's coverage is still considered "primary".

**Medicare Part B** provides coverage for **3 medical services**:

- 1) Doctors' services
- 2) Home health care not covered by Part A
- 3) Outpatient medical care and supplies

### **Medicare Enrollment 16-14**

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

### **Medicare Claims Under the Original Medicare Plan 16-14**

***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 Supplements, aka Medigap Plans**

Medigap plans are supplemental health insurance plans sold to Medicare eligible beneficiaries. They provide coverage for medical expenses that are not covered or only partially covered by Medicare. There are many Medicare Supplement plans which have been designated A through L. The ***National Association of Insurance Commissioners*** (NAIC) recently adopted a standard model for Medicare Supplements that add **K and L** plans. Their purpose is to reduce the over-utilization of "first dollar" coverage as an

incentive to help beneficiaries control costs, i.e., if individuals know they have to pay a deductible or co-pay, they may forgo seeking medical treatment for minor issues that can typically be self-treated. The NAIC model also suggests a revision to H, I and J plans to eliminate prescription drug coverage for those enrolled in Medicare Part D. 16-12

**Medicare Select** is a version of Medigap insurance. The difference is that Medicare Select plans operate on a preferred provider basis where insurance companies list participating doctors and hospitals from which the insured must pick in order to receive benefits. This usually means lower premiums than other Medigap policies. NAIC standard guidelines for Medicare Select plans are met if the service network has been contracted with the insurer; special and urgent services can be met outside the network; there is sufficient access to a network; and the insurer has made some arrangements for quality assurance of the network. 16-12

### **Medicare Supplement - Agent World Rules 16-13**

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** – 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** – 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).

**10192.20** – prohibits 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.

### **MEDI-CAL** 16-16

Medi-Cal (also known as Medicaid in other states) is a welfare health insurance program for individuals who live well below the poverty line. Medi-cal covers most health care costs, including:

- Hospital bills
- Physician bills
- Nursing home care

Although it is a federally created program, it is administered by individual states, and the eligibility requirements vary by state. 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).

Generally, those eligible for **Medic-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

### **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 combining 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.

## **SOCIAL SECURITY**

**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. 5-13

**Partially Insured** – entitles a worker to disability benefits but not to old-age retirement payments. *Example* . . . Bill just began working five years ago so he 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 could receive Social Security benefits. He could also receive disability benefits. 5-13

**3 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: 5-13

- **Dependency period** is the time when the surviving spouse has children (dependents) at home. The family's needs are typically largest at this point.
- **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.
- **Retirement Period** is the period when the surviving spouse is now old enough (age 60) to receive retirement benefits from Social Security.

### **Types of Social Security Benefit Payments: 5-12**

**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 wage 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.

## **UNDERWRITING** 7-19

**The Underwriting Process** - initial, or field underwriting, begins with the agent and *preselection*, whereas *postselection* underwriting is done after the application is submitting for underwriting by the company. The typical progression of events goes like this . . .

- Application
- MIB
- Consumer reports
- Driving records
- Medical exams
- Physicians reports

## **Medical Information Bureau** 7-22

There 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. To protect privacy, MIB requirements are:

- 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. 7-22

**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. 7-23

**HIV and AIDS Discrimination** – Due to medical advances, the longevity of HIV and AIDS 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. 7-23

**Genetic Testing** – insurers cannot indiscriminately test for an applicant's genetic disposition for disease without informed consent. Results must be handled in a strict and confidential manner. 4-15

**The Component's of an Policy's Premium** – Underwriting and ratings are just one part of the process that determines premiums. Other factors include:

**Mortality** – 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. 7-23

**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. 7-23

## **LONG TERM CARE INSURANCE**

### **Why is Long Term Care Insurance Needed? 3-1**

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.

### **Legal Definition 3-2**

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 Contracts**

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.

### **Types of benefits 3-1**

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).

## **Levels of LTC Care 3-2**

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

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

## **Benefit Triggers 3-4**

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

## **Evaluating Policies 3-3**

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), policies 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 or 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 policies 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.

### **Suitability Standards 3-9**

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.

### **Marketing Standards and Responsibilities 3-9**

LTC Agents must know some very specific responsibilities in order sell this valuable insurance:

**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.

### **Consumer Protection 3-10**

**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 3<sup>rd</sup> 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 remuneration of any kind, including, but not limited to bonuses, gifts, prizes, awards and finder’s fees.

### **Qualified vs. Non-Tax Qualified LTC Policies 3-4**

**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.

### **California Partnership for Long Term Care 3-10**

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.

### **HICAP**

In California, HICAP (Health Insurance Counseling and Advocacy Program), through its volunteers, provides unbiased information to help Medicare beneficiaries and their families make the best choices for their health care. Education on Medicare, long-term care and Medicare-related coverage (Medigap, Medicare Advantage, etc) is their primary role, along with legal help at any Medicare appeals and administrative hearings. Services are free and counselors do not sell insurance products. HICAP is sponsored by the California Department of Aging. Counseling is available in every California County by calling (800) 434-0222 or find locations at [www.calmedicare.org](http://www.calmedicare.org).  
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