Accident And Health Insurance - Basics

This section will present different classes of health insurance policies, as well as concepts that generally apply to health insurance. You will begin by learning about the principal types of losses and benefits, common exclusions from coverage, and producer's responsibilities and liabilities for errors. This section will take an in-depth look at health insurance underwriting. This type of underwriting is particularly prone to unfair discrimination because of the presence of certain health conditions and the use of genetic information. Finally, you will learn about the concept of policy replacement and factors to consider in determining the best course of action.

TERMS TO KNOW

Comprehensive coverage — health insurance that provides coverage for most types of medical expenses
Copayment — an arrangement in which an insured must pay a specified amount for services "up front" and the provider pays the remainder of the cost
Deductible — the portion of the loss that is to be paid by the insured before any claim may be paid by the insurer
Dependent — someone relying on the insured for support
Enrollee — a person enrolled in a health insurance plan, an insured (doesn't include dependents of the insured)
Insolvent — unable to meet financial obligations
Pre-existing conditions — conditions for which the insured has received diagnosis, advice, care, or treatment during a specific time period prior to the application for health coverage
Riders — added to the basic insurance policy to add, modify or delete policy provisions
Solicitation — an attempt to persuade a person to buy an insurance policy; it can be done orally or in writing
Waiting period — a period of time that must pass after a loss occurs before the insurer starts paying policy benefits

A. Basic Health And Disability Insurance Principles, Concepts, And Marketplace

Health insurance is a generic term encompassing several types of insurance contracts which, though related, are designed to protect against different risks.

There are two separate types of insurance included in the generic term *health insurance*. One type provides coverage for expenses related to health care, and the second is designed to provide payments for loss of income. The terminology used to reference health insurance varies from state to state as well as from company to company. The health insurance policy that is designed to provide periodic payments when an insured is unable to work because of sickness or injury is referred to as **disability income insurance**.

Educational Objective:

II.A.1. Be able to identify and/or apply your understanding of the following terms:

a. *Accidental means vs. accidental bodily injury, accident vs. sickness, coinsurance, copayment, deductible, elimination period, extension of benefits, gatekeeper concept, managed care, master policyowner, pre-existing condition, probationary period, stop-loss provision, waiver of premium, waiting period*
b. *Cancellation and renewability features (e.g., cancellable, optionally renewable, conditionally renewable,guaranteed renewable, noncancellable)*

1. Important Terms

Accident vs. Sickness

There are two major causes of loss (perils) under a health insurance policy. Policies may cover both accident and sickness or accident only.

Accidental bodily injury is an unforeseen and unintended injury that resulted from an accident rather than a sickness.

Sickness is normally defined as an illness that first manifests itself while the policy is in force. The majority of health insurance claims result from sickness rather than accidental injury. An emergency medical condition is one which is so severe in pain or symptoms that if not treated quickly and properly could cause serious bodily harm, or possibly death.

Know This! The two major perils covered in health insurance policies are accidental bodily injury and sickness.

Accidental Means vs. Accidental Results

Like many disability policies, Accidental Death and Dismemberment (AD&D) policies also distinguish between injuries due to **accidental means** and **accidental results**.

With policies that base payment on accident means, the injury and its cause must be unexpected and unintended (*for example,* a man loses a leg in a car accident. Both the accident and the loss are unexpected.).

With policies that base payment on accidental results, only the injury must be unexpected and unintended (*for example*, a man is cliff-diving and breaks his neck. The man intentionally jumped off the cliff, but not with the intention of breaking his neck.).

Coinsurance

Most major medical policies include a **coinsurance** provision that provides for the sharing of expenses between the insured and the insurance company. After the

insured satisfies the policy deductible, the insurance company will usually pay the majority of the expenses, typically **80%,** with the insured paying the remaining **20%.** Other coinsurance arrangements exist such as 90/10; 75/25; or 50/50. The larger the percentage that is paid by the insured, the lower the required premium will be. The purpose of the coinsurance provision is for the insurance company to control costs and discourage overutilization of the policy.

Deductible

A **deductible** is a specified dollar amount that the insured must pay first before the insurance company will pay the policy benefits. The purpose of a deductible is to have the insured absorb the smaller claims, while the coverage provided under the policy will absorb the larger claims. Consequently, the larger the deductible, the lower the premium that is required to be paid.

Most major medical policies feature an **annual deductible** (also called a calendar year deductible) that, as the name implies, is paid once in any year, regardless of the amount of claims in that year. The policy may contain an **individual deductible,** in which each insured is personally responsible for a specified deductible amount each year, or a **family deductible** (usually 2 to 3 times the individual deductible) whereby the annual deductible is satisfied if two or more family members pay a deductible in a given year, regardless of the amount of claims incurred by additional family members. Some policies contain what is known as a **per occurrence deductible** or **flat deductible** which the insured is required to pay for each claim, possibly resulting in more than one deductible being paid in a given year.

The policy may also contain a provision which applies when more than one family member is injured in a single accident, also called the **common accident provision**. In this case, only one deductible applies for all family members involved in the same accident.

Some supplemental major medical plans also include an **integrated deductible** in which case the amount of the deductible may be satisfied by the amount paid under basic medical expense coverage. For example, if the supplemental coverage included a $1,000 integrated deductible, and the insured incurs $1,000 in basic medical expenses, the deductible will be satisfied. If the basic policy only covered $800 of the basic expenses, the insured would have to satisfy the remaining $200 difference.

Some policies also include a **carry-over provision** that states that if the insured did not incur enough expenses during the year to meet the deductible, any expenses incurred during the last 3 months may be carried over to the next policy year to satisfy the new annual deductible.

For example, if an insured has a $500 deductible and incurs $100 in the first half of the year, and another $250 during the last quarter, thus not reaching the total deductible for the year, the $250 could be carried forward to the next year, and the insured would be eligible for claim payments when/if he incurred an additional $250 in the new year.

Disability income and long-term care policies usually have a **time deductible** in the form of elimination period.

Copayment

Copayments are arrangements where the insured pays a specified dollar amount for a claim, typically at the time of receiving the service, and the insurance company pays the remaining amount. Copayments differ from coinsurance because copayments are typically expressed in dollar amounts, while coinsurance is usually expressed as a percentage of the cost.

Gatekeeper Concept

Initially the member chooses a *primary care physician* or *gatekeeper*. If the member needs the attention of a specialist, the *primary care physician* must refer the member. This helps keep the member away from the higher priced specialists unless it is truly necessary.

Managed Care

Any medical expense plan that attempts to contain costs by controlling the behavior of participants is considered a **managed care** program. A true managed care plan should have 5 basic characteristics:

1. Controlled access of providers;
2. Comprehensive case management;
3. Preventive care;
4. Risk sharing; and
5. High quality care.

Extension of Benefits

Extension of benefits means continuation of coverage under a specified benefit after discontinuance of original coverage to an employee or dependent. This provision protects a disabled person from becoming uninsured due to a loss of coverage for any reason. Basic medical expense benefits will usually be extended for 3 months, while major medical expense benefits will usually be extended for a period of 12 months. In order for extension of benefits to be provided, the insured must have been disabled before the policy was discontinued and must continue to be disabled.

Stop-Loss Provision

Most policies also limit the amount of *out-of-pocket* expenses the insured can incur during a policy year. A **stop-loss limit** is a specified dollar amount beyond which the insured no longer participates in the sharing of expenses. The insurance company pays 100% of the expenses that are above the specified stop-loss limit.

Waiting Period

The **waiting period** or **elimination period** stipulates how long a person must wait to receive benefits for a period of disability. The elimination period begins on the effective date of the policy and lasts for 5 months. Benefits can be received at the

beginning of the 6th month. Benefits cannot be offered retroactively for a period of disability that began during the elimination period.

Waiver of Premium

The **waiver of premium** provision or rider is usually included with guaranteed renewable and noncancellable disability income policies. It provides that in the event of permanent and total disability, premiums will be waived for the duration of the disability. To qualify, the insured must be totally disabled for a specified period of time, usually 3 to 6 months. During this waiting period, the insured must continue to pay the policy premium, but usually the waiver is retroactive to the date the disability began and any premiums paid during the waiting period will be refunded. This rider generally expires when the insured attains age 65; however, as long as the insured becomes disabled prior to age 65, the premiums will continue to be waived for the duration of the disability.

Master Policy

In group insurance, the policy is called the **master policy**, and is issued to the policyowner, which could be the employer, an association, a union, or a trust.

Pre-existing Conditions

Pre-existing conditions are conditions for which the insured has received diagnosis, advice, care, or treatment during a specific time period prior to the application for health coverage. Up to January 2014, an individual health insurance policy could have these conditions excluded from coverage; however, the recently enacted health care reform eliminated pre-existing conditions restrictions in health insurance plans.

2. Cancellation and Renewability Features

Cancellable

In some cases, an individual may need health insurance for a specified period of time. Coverage is then considered a term health policy, which is not renewable. When the term expires, the insured must purchase another policy. These policies are also called **period of time** policies as they are only effective for a specific period of time, and will be cancelled by the company at the end of the term.

Examples of term health policies are travel accident policies, short term health plans, or accident only policies. Policies which cover specific events, such as school functions, summer camp, or athletic events, are other examples. Once the event is over, coverage is no longer in place.

Noncancellable

The insurance company cannot cancel a noncancellable policy, nor can the premium be increased beyond what is stated in the policy (note that the policy may call for an increase in a certain year, such as "age 65," but that must be stated in the original contract). The insured has the right to renew the policy for the life of the contract; the insurer cannot increase the premium above the amount for which the policy was originally issued. However, the guarantee to renew coverage

usually only applies until the insured reaches age 65, at which time the insured is usually eligible for Medicare. For disability income insurance, the policy will be renewed beyond the insured's age 65 only if the insured can provide evidence of continuing to work in a full-time job.

Know This! The insured may cancel an insurance policy at any time.

Guaranteed Renewable

The **guaranteed renewable** provision is similar to the noncancellable provision, with the exception that the insurer can increase the policy premium on the policy anniversary date. The insured, however, has the unilateral right to renew the policy for the life of the contract. The insurer may increase premiums on a **class basis only** and not on an individual policy. As with the noncancellable policy, coverage generally is not renewable beyond the insured's age 65. **Medicare Supplements and long-term care policies must be written as guaranteed renewable** contracts, and cannot be cancelled by the company at the insured's age 65.

Know This! A guaranteed renewable policy requires the insurer to continue coverage, as long as premiums are paid.

Conditionally Renewable

With a conditionally renewable policy, the insurer may terminate the contract only at renewal for certain conditions that are stipulated in the contract. *For example,* one condition may be that the insured must be employed to collect disability payments. In addition, the policy premiums may be increased. The company **may not** deny renewal due to claims experience.

Optionally Renewable

Optional renewability is similar to conditional renewability, except that the insurer may cancel the policy for any reason, on certain homogeneous classes (not individuals within a class). Renewability is at the option of the insurer. The insurer can only decide not to renew a policy on the policy anniversary or premium due date (renewal date). If the insurer elects to renew coverage, it may also increase the policy premium.

3. Major Kinds of Insurance Mechanisms

Service Type
Blue Cross & Blue Shield

Blue Cross and Blue Shield organizations have a contractual agreement with physicians and hospitals. The physicians and hospitals are the producers in the cooperative. Blue Plans are voluntary not-for-profit health care organizations (although recently in some states they have been amending their structure to become for-profit organizations); they are not insurance companies.

Blue Plans started out as separate associations with Blue Cross providing payments to hospitals and Blue Shield covering physician charges. Although today hospital charges are still paid by Blue Cross, and Blue Shield pays physician charges, the two associations are merged as one.

Blue Cross and Blue Shield are operated as local facilities throughout each state and are managed by a governing board in each locality. They are considered **prepaid plans** because each subscriber pays a set fee (usually monthly) in order to receive the services that are provided under the plan. It is also considered a **service plan** because benefits are paid to the hospitals and physicians (health care providers) instead of to the subscriber (insured).

When dealing with group plans, both the Blues and insurance companies use **experience rating** to determine rates to be charged. The rates are thus based on the overall experience of the group. The Blues, however, still use **community rating** in pricing products for smaller employers and individuals. Community rating involves a pooling of the experience of all groups in all areas and then the setting of an average rate that will be sufficient to support this experience. This rate then applies to all groups insured under a particular plan. Most Blue Shield plans now offers surgical benefits on a reasonable and customary basis.

HMOs

Increasing health care costs during the 1970s and 1980s helped stimulate the rapid growth of **Health Maintenance Organizations (HMOs**). HMOs were established to manage health care and the associated costs by providing prepaid care that emphasizes preventive care. This is quite a departure from traditional health insurance policies that typically did not cover preventive care, covering illness only after it has manifested.

An HMO is regarded as an organized system of health care that provides a comprehensive array of medical services on a prepaid basis to voluntarily enrolled persons living within a specified geographic area (called **service area**). Insureds (called **subscribers**) pay a premium to the HMO and are provided with a broad range of health care services, including routine doctor visits and emergency room care. The service is provided by physicians and hospitals that have an agreement with the HMO to provide care.

Indemnity Type

An **indemnity** plan pays health insurance benefits to the insured based on a predetermined rate set for medical services. The amount of actual expense for those services does not matter. The policy will pay the fixed amount stated in the contract. Usually an indemnity plan will pay a stated amount for each day the insured is hospitalized as an inpatient; it does not usually pay the cost of medical expenses, specific hospital bills, or specific doctor bills.

Insurers

Commercial insurers such as stock, mutual, and life insurers also write health and disability insurance on an indemnity basis. These policies can be written as either individual or group policies and include benefits for hospital, medical, surgical, and major medical expenses.

MET

A **Multiple-Employer Trust (MET)** is made up of two or more employers in *similar or related businesses* who do not qualify for group insurance on their own. Before HIPAA defined small employers, many small companies were unable to get health insurance at a reasonable cost due to the fact that there weren't enough people in the company to insure. In situations like this, several small companies banded together to create a large pool of people so that the insurance company will provide coverage. This group of employers jointly purchase a single benefits plan to cover employees of each separate employer.

A noninsured plan may operate without the services and funds of an insurance company. Once the trust fund is established, it can pay for employees' health care expenses directly (self-funding). The trustee has charge of the funds and all financial activities occur through it. As with any self-funded program, the employer assumes legal responsibility for providing coverage, and the employee has no conversion right upon leaving the group coverage.

PPO

The Preferred Provider Organizations (PPOs) could be seen as the traditional medical systems' answer to HMOs. In the PPO system, the physicians are paid fees for their services rather than a salary, but the member is encouraged to visit approved member physicians that have previously agreed upon the fees to be charged. This encouragement comes in the form of benefits. While the members can utilize any physician they choose, the PPO may provide 90% of the cost of a physician on their approved list while possibly only providing for 70% of the cost if the member chooses to utilize a physician not included on the PPO's approved list.

EPO

An **Exclusive Provider Organization** (EPO) is a type of PPO. The members of an EPO, however, do not choose health care providers from a list of preferred providers. Instead, insureds under an EPO plan use specific providers who are paid on a fee-for-service basis.

Self-Funding

Self-funded plans are funded by the insured (usually the employer) and administered by a third party. A successful self-funded program will have the following characteristics:

- A group large enough to reasonably predict future loss experience;
- Sound statistical data to support the self-funding concept;
- A stop-loss contract to assume losses beyond the insured's retention;
- A third party administrator who services claims; and
- Flexibility in plan design and administrative procedures.

4. Limited Insurance Policies

Educational Objective:

II.A.2. Be able to identify a definition of the following limited insurance policies:

a. Travel accident
b. Specified or dread disease and critical illness
c. Hospital income and hospital confinement indemnity
d. Accident only
e. Credit disability

There are a variety of health insurance policies providing limited coverage for specific accidents or sickness. These contracts must specify the type of accident or sickness covered, limited perils and amounts of coverage. Benefits may be paid on an **expense-paid** (reimbursement) basis or **indemnity** basis.

Know This! Limited policies cover a specific sickness or accident only.

Travel Accident

A **travel accident** policy provides coverage for death or injury resulting from accidents occurring while a fare-paying passenger is on a common carrier. The benefits are *only paid if the loss occurs* during the time of travel.

Specified and Dread Disease and Critical Illness

A **dread disease**, or limited risk, policy provides a variety of benefits for a specific disease such as cancer policy or heart disease policy. Benefits are usually paid as a *scheduled, fixed-dollar amount* of indemnity for specified events or medical procedures, such as hospital confinement or chemotherapy.

A **critical illness** policy covers multiple illnesses, such as heart attack, stroke, renal failure, and pays a lump-sum benefit to the insured upon the diagnosis (and survival) of any of the illnesses covered by the policy. The policy usually specified a minimum number of days the insured must survive after the illness was first diagnosed.

Hospital Income or Hospital Confinement Indemnity

A **hospital indemnity** policy provides a specific amount on a daily, weekly or monthly basis while the insured is confined to a hospital. Payment under this type of policy is unrelated to the medical expense incurred, but *based only on the number of days confined in a hospital.* This can also be called a hospital fixed-rate policy.

Accident Only

Accident-only policies are limited policies that provide coverage for death, dismemberment, disability or hospital and medical care resulting from an accident. Because it is a limited medical expense policy, it will *only pay for losses resulting from accidents* and not sickness.

Credit Disability

A credit disability policy is issued only to those in debt to a specific creditor. In case of the borrower's disability, payments to the creditor will be made on the loan until the disabled borrower is able to return to work.

Key points to remember about limited policies:

- **Accidental injury** — pays benefits for injuries from accidents only (not from sickness);
- **Specified disease** — pays a fixed-dollar amount benefit for a specified disease only;
- **Indemnity policies** — pays based on a number of days the service was provided, usually a fixed dollar amount per day.

B. Underwriting

Educational Objectives:
II.I.1. Be able to identify the purpose of underwriting: prevention of adverse selection, properly classifying risks (be able to differentiate between *preferred, standard*, and *substandard* risk classifications), and underwriting responses to substandard risks.

II.I.2. Be able to identify the process of underwriting:

a. The responsibility of the agent as a field underwriter
b. Completing the application
c. Know that additional information may be required if an application reveals certain health conditions or other risk exposures

Underwriting is the first step in the total process of insuring health risks. The basic purpose of health insurance underwriting is to **minimize the problem of adverse selection**. Adverse selection involves the fact that those most likely to have claims are those who are most likely to seek insurance. An insurance company that has sound underwriting guidelines will avoid adverse selection more often than not.

1. Field Underwriting

In health insurance, **field underwriting** is far more important than in life insurance. The basic purpose of health insurance underwriting is to minimize the problem of adverse selection. Adverse selection involves the fact that those most likely to have claims are those who are most likely to seek insurance. An insurance company that has sound underwriting guidelines will avoid adverse selection more often than not. Note that the **specific underwriting requirements will vary by insurer.**

Moral hazard is a significant factor in health insurance underwriting because of the possibility of malingering, and it is the agent, not the home office underwriter, who actually has personal contact with the applicant. It is the responsibility of the agent to ask the applicant questions clearly and precisely and to record the answers accurately.

A producer's function as the field underwriter is to gather credible information from an applicant that would assist the underwriter in screening marginal or unacceptable risks before taking an application for an insurance policy.

Know This! A producer is the company's field underwriter.

Application Procedures

An application for insurance begins with a form provided by the company and completed by the agent as questions are asked of the applicant, and the applicant's responses are recorded. This form – often called the "app" – is then submitted to the insurance company for its approval or rejection. The application is the applicant's written request to the insurance company to issue a policy or contract based upon the information contained in the application. If the policy is issued, a copy of this application is stapled in the back of the policy and it becomes part of the **entire contract.**

A **notice to the applicant** must be issued to all applicants for health insurance coverage. This notice informs the applicant that a credit report will be ordered concerning their past history and any other health insurance for which the applicant has previously applied. The agent must leave this notice with the applicant.

Completeness and Accuracy

The agent must take special care with the accuracy of the application in the interest of both the company and the insured. Because the application is often the main source of underwriting information, it is the agent's responsibility to make certain that the application is filled out completely, correctly, and to the best of the applicant's knowledge.

Know This! It is the agent's responsibility to make sure that an application for insurance is complete and accurate to the best knowledge of the applicant.

Signatures

Every health insurance application requires the signature of the proposed insured, the policyowner (if different than the insured), and the agent who solicits the insurance.

Changes in the Application

Because the application is so important, most companies require that it be filled out in ink. The agent might make a mistake when filling out the app or the applicant might answer a question incorrectly and want to change it. There are two ways to correct an application. The first and best is to simply start over with a fresh application. If that is not practical, draw a line through the incorrect answer and insert the correct one. **The applicant must initial the correct answer.**

Know This! Any changes on the application must be initialed by the applicant or insured.

Premiums with the Application

Under the terms of the insurability conditional receipt, the insurance coverage becomes effective as of the date of the receipt, provided the application is approved. This receipt is generally provided to the applicant when the initial premium is paid at the time of application.

Disclosure of Information about Individuals

An insurance company or an agent cannot disclose any personal or privileged information about an individual unless any of the following occurs:

- A written authorization by the individual dated and signed within the past 12 months has been provided;
- The information is being provided to all of the following:
  - An insurance regulatory authority or law enforcement agency, pursuant to the law;
  - An affiliate for an audit, but no further disclosure is to be made;
  - A group policyholder for the purpose of reporting claims experience;
  - To an insurance company or self-insured plan for coordination of benefits; and
  - A lien holder, mortgagee, assignee or other persons having a legal or beneficial interest in a policy of insurance.

Common Situations for Errors and Omissions

At any time during the sales process there can be a misunderstanding or misrepresentation that could lead to legal action being taken by the insured. Agents should document everything: interviews, phone conversations, requests for information, etc. The **sales interview and the policy delivery** are the most common occasions for errors and omissions (E&O) situations to occur that may result in providing inadequate coverage or failure to maintain and service coverage.

2. Company Underwriting

The underwriter's function is to select risks that are acceptable to the insurance company. The selection criteria used in this process, by law, must be only those items that are based on sound actuarial principles or expected experience. The underwriter cannot decline a risk based on blindness or deafness, genetic characteristics, marital status, or sexual orientation.

When underwriting health insurance policies, the prime considerations are age, gender, occupation, physical condition, avocations, moral and morale hazards, and financial status of the applicant.

Sources of Underwriting Information
Application

An accurate and thorough application is imperative to the insurance company.

Producer Report

Only the agent/producer is involved in completing the agent's (producer's) report. It asks questions about the length of time that the applicant has been known to the agent, an estimate of the applicant's income and net worth and whether the agent knows of any reason that the contract should not be issued. The agent's statement **does not** become part of the *entire contract*.

Attending Physician's Statement

If the underwriter deems it necessary, an attending physician's statement (APS) will be sent to the applicant's doctor to be completed. This source of information is best for accurate information on the applicant's medical history. The physician can explain exactly what the applicant was treated for, the treatment required, the length of treatment and recovery, and the prognosis.

When an attending physician's report reveals a condition that requires more information for underwriting purposes, and if this information is not available from that physician, then the insurer can require that the applicant be examined by a physician of the insurer's choice and at the insurer's expense.

Investigative Consumer (Inspection) Report

An investigative consumer report includes information on an applicant's character, general reputation, personal habits, and mode of living that is obtained through investigation. For example, this report could include interviews with associates, friends, and neighbors of the applicant. Such reports may not be performed unless the applicant is clearly and accurately informed of the report in writing. The consumer report notification is usually part of the application. At the time that the application is completed, the agent will separate the notification and give it to the applicant.

Medical Information Bureau (MIB)

The **Medical Information Bureau (MIB)** is a membership corporation owned by member insurance companies. It is a nonprofit trade organization which receives adverse medical information from insurance companies and maintains confidential medical impairment information on individuals. Reports on previous insurance information can be obtained from the Medical Information Bureau. Members of MIB can request a report on an applicant and receive coded information from any other applications for insurance submitted to other MIB members. MIB information cannot be used in and of itself to decline a risk, but it can give the underwriter important additional information.

Medical Examinations and Lab Tests (Including HIV Consent)

Medical examinations, when required by the insurance company, are conducted by physicians or paramedics at the insurance company's expense. Usually such exams are not required with regard to health insurance, thus stressing the importance of the agent in recording medical information on the application. The medical exam requirement is more common with life insurance underwriting. If an insurer requests a medical examination, the insurer is responsible for the costs of the exam.

If an insurer requires an applicant to take an HIV test, the insurer must first obtain the applicant's written consent for the test. The consent form must explain the purpose of the test, and inform the applicant about the confidentiality of the results, and procedures for notifying the applicant about the results. Underwriting for HIV or AIDS is permitted as long as it is not unfairly discriminatory. An adverse underwriting decision is not permitted if based solely upon the presence of symptoms, but only if HIV is confirmed in relation to the symptoms. Insurance

companies must maintain strict confidentiality regarding HIV-related test results or diagnoses.

The following are guidelines to help insurers avoid unfair underwriting for the risk of HIV/AIDS:

- If tests were performed correctly, insurers may decline a potential insured for coverage if his/her medical sample comes back "positive for HIV/AIDS" after 2 different tests have been performed. The applicant can also be declined if he/she has already been diagnosed with AIDS/HIV by another medical professional.
- These tests must be paid for by insurer, not insured.
- If an insurer tests for HIV, it must first obtain from the insured informed, written consent. This often entails a separate disclosure form signed by all insureds and the agent. A copy of this duplicate form should then be left with the client. The information includes written details on the tests performed, their purposes and uses, and how results will be returned to the insured. The form often asks for a physician's name and address so that the client's doctor can get involved should a positive result come back. If the client has no physician, the insurer should urge the client to consult a physician or government health agency.
- Informed consent also includes supplying the client with information concerning AIDS/HIV counseling from third-party sources.
- The information that is gathered must be handled correctly and in compliance with confidentially requirements by authorized personnel.
- If an insured correctly obtains coverage, but later dies due to AIDS or AIDS-related conditions, coverage cannot be limited or denied.

From an ethical and nondiscrimination standpoint, no insurer or its agents may consider the individual's gender, sexual orientation, marital status, living arrangements, occupation, zip code, or other such related demographic characteristic in determining whether to take an application, provide coverage, or perform any medical testing. The insurers cannot ask if the insured has been tested before, unless it was for insurance purposes. None of this information should be either on the application or implied. This is so the underwriter can make a clearly unbiased determination and avoid overt or apparent discrimination. The only allowable criterion that a company may use to determine whether to test for HIV is the amount of insurance the applicant has applied for at certain age ranges.

Negligently disclosing confidential results or underwriting information to unauthorized third parties may result in a civil fine of up to $1,000 plus court costs. The fine may go up to $5,000 plus costs for willful violations. If the violation causes economic, bodily, or psychological harm to the other party, the penalty may include a misdemeanor charge, one year in jail, and/or a fine of up to $10,000.

Additional information that may be required from the applicant for health coverage if the application reveals certain health conditions or other risk exposures is as follows:

- Department of Motor Vehicles — Since statistically half of all accidental deaths in the United States occur as the result of traffic collisions, insurers are very interested in the driving records of their applicants. A poor driving record can result in a rated policy.
- Additional medical testing /Current physical — The insurer can request that the applicant be examined by a physician and the results submitted for consideration. It is also common to require examination by a paramedical company and the use of blood, urine or saliva samples to check for nicotine or other drug use and the

presence of HIV. An EKG (electrocardiogram) or a treadmill examination may also be required.
- **Hazardous activity questionnaire** — The insurer may also ask the applicant to fill out a separate hazardous activity questionnaire to determine the applicant's risk classification. The questionnaire may include questions regarding hobby aviation, scuba diving, and auto, boat, or motorcycle racing.

Genetic Testing

Genetic characteristics means any scientifically or medically identifiable gene or chromosome that is known to be a cause of a disease or disorder, and that is determined to be associated with a statistically increased risk of development of a disease or disorder. Examples of genetic conditions include Tay-Sachs, sickle cell, and X-linked hemophilia.

Insurers cannot require a test of the presence of a genetic characteristic for the purpose of determining insurability (except in policies that are contingent on testing for other diseases or medical conditions). Whenever a genetic characteristic test is conducted, the insurer must first obtain the applicant's written consent. The insurer must also notify the applicant of a test result directly or through a designated physician.

Classification of Risks

Once the underwriters have collected and reviewed all the necessary information on the applicant, they will make a decision to either accept or decline the applicant for insurance. The applicants that have been accepted will fall into one of the 3 categories: preferred, standard or substandard.

Preferred

Preferred risks reflect a reduced risk of loss and are covered at a reduced rate. Nonsmokers would be an example of preferred risks.

Standard

Standard risks reflect average exposures and may be insured at standard rates and premiums.

Substandard

Substandard risks are those that reflect an increased risk of loss. These applicants may be able to obtain health insurance coverage but at an increased premium. An applicant could be rated substandard for a poor health history or a dangerous vocation or avocation.

Alternative options available to the underwriter for substandard risks of applicants include:

- Charging an additional premium to reflect the greater exposure to loss; or
- Modify coverage by requiring a longer probationary period.

C. Rate-Making Components

Educational Objective:

IV.A.4. Be able to identify the following rate-makingcomponents: morbidity, insurer expenses,investment return, and benefit duration.

1. Morbidity

Morbidity is the incidence or probability of sicknesses or accidents within a given group of people. Morbidity rates indicate the average number of people who can be expected to become disabled each year due to accident or sickness, and can help insurers project annual claim costs.

2. Insurer Expenses

The insurer collects the mortality charge to pay the policy face amount if an insured dies. Since the insurer earns interest on the premiums it collects, the expected interest is subtracted from the mortality cost to arrive at the *net premium*. Then, the insurer adds its expected operating costs (underwriting, overhead and commissions) to calculate the *gross premium* that the insured pays.

Another way to view this formula is net premium plus expenses (loading) equals the gross premium.

- **Mortality - Interest = Net Premium**
- **Net Premium + Expense (loading) = Gross Premium**
- **Mortality – Interest + Expense (loading) = Gross Premium**

Calculation Example:

Assume that

$500 Mortality cost $400 Net premium

- $100 Interest + $200 Operating cost

$400 Net Premium therefore, **$600 Gross Premium**

3. Investment Return

Because premiums are paid before claims are incurred, insurance companies invest a large portion of the premiums in an effort to earn interest on these funds (invested in bonds, stocks, or mortgages). The interest earnings help insurers reduce the premium rates for policyowners.

4. Benefit Duration

Probationary Period

The **probationary period** provision states that a period of time must lapse before coverage for specified conditions goes into effect. This provision is most commonly found in disability income policies. In group health insurance, the

probationary period also applies to new employees who must wait a certain period of time before they can enroll in the group plan. The purpose of this provision is to avoid unnecessary administrative expenses in cases of employee turnover.

Elimination Period

The **elimination period** is a type of deductible that is commonly found in disability income policies. It is a period of days which must expire after the onset of an illness or occurrence of an accident before benefits will be payable. The longer the elimination period, the lower the cost of coverage.

D. Duties Of Insured And Insurers In The Event Of Loss

In the event of loss, the following steps must be taken by the parties to the insurance contract:

1. The insured must notify the company of the loss.
2. The insurer's agent will mail claim forms to the insured.
3. The insured completes the forms and returns them with the proof of loss to the insurer.
4. The insurer pays the claims as soon as possible (or within the time limit specified in the policy or by state law).

Upon receipt of a written proof of loss, the insurer must pay death claims immediately. (Most states interpret this to be within 30 days.) If there is no beneficiary named in the policy, the death proceeds are paid to the estate of the insured. (An insurer cannot delay the payment of a death claim until the settlement of the estate of the insured has been completed.)

E. Chapter Recap

This chapter explained the basics of accident and health insurance and underwriting procedures for health insurance policies. Let's recap them:

TYPES OF LOSSES AND EXCLUSIONS

Important Terms

- *Accidental bodily injury*- unintended injury resulting from an accident
- *Sickness* - illness which manifests while a policy is in force
- *Coinsurance* - sharing of expenses between insured and insurer (percentage)
- *Copayment* - sharing of expenses between insured and insurer (dollar amount)
- *Deductible* - dollar amount an insured must pay before benefits begin
- *Gatekeeper* - primary care physician who refers insured to specialist
- *Managed care* - a program designed to contain health care costs
- *Extension of benefits* - continuation of coverage after discontinuance of original coverage to an employee or dependent

- *Waiting period* - amount of time before benefits may be received
- *Master policy* - issued to policyowner (usually the employer) in group insurance

Types of Limited Policies

- *Accident* - coverage for disability, medical care, death or dismemberment resulting from an accident
- *Dread disease policy* - variety of benefits for a specific disease such as cancer policy or heart disease policy
- *Critical illness* - pays a lump sum to the insured upon diagnosis and survival of a critical illness
- *Hospital indemnity* - provides a specific amount on a daily, weekly or monthly basis while the insured is confined to a hospital
- *Credit disability* - covers payments on loans if the insured becomes disabled

UNDERWRITING

Steps in the Underwriting Process

- Field underwriting – by agent
- Company underwriting
- Premium determination
- Policy delivery

Sources of Insurability Information

- *Application* - must be completed and signed
- *Producers/agent's report* - agent's observations about the applicant that can assist in underwriting
- *Attending Physician Report* - best for accurate information on the applicant's medical history
- *Investigative consumer report* - includes information on an applicant's character, general reputation, personal habits, and mode of living that is obtained through investigation
- *MIB report* - helps companies share adverse medical information on insureds

RIGHT OF RENEWABILITY

Noncancellable Insurer cannot cancel or raise premiums beyond the amount stated in the policy

Cancellable Insurer may cancel the policy at any time or at the end of the policy period with proper written notice and a refund of any unearned premium paid

Guaranteed Renewable Insurer may increase the policy premium (on a class basis only) on the policy anniversary date; insured has the unilateral right to renew the policy for the life of the contract