

## INTRODUCTION TO INDIVIDUAL HEALTH INSURANCE (313-1)

Obj 1-1. **HEALTH INSURANCE** provides benefits for injuries and illnesses.

**Health insurance includes** disability income *and* medical expense *and* long-term care (**LTC**) insurance. Adequate health insurance promotes financial stability by protecting the insured from the financial consequences of illness and injury.

A 2005 study found that adverse health-related events trigger over 45% of personal and family bankruptcies.

**When filing for bankruptcy, debtors often state one of the following situations:**

1. illness or injury,
2. uncovered medical bills,
3. lost income, *and/or*
4. having to mortgage their homes to pay medical bills.

Obj 1-2. **INDIVIDUAL HEALTH INSURANCE** is health insurance bought by a person to provide benefits in the event of an insured's illness or injury.

### THE THREE COMPONENTS OF INDIVIDUAL HEALTH INSURANCE:

1. **Medical expense insurance**--pays for covered medical services as required by the beneficiary's illness, injury, or health maintenance.
2. **Disability income insurance**--replaces income lost as a result of illness or injury.
3. **Long-term care insurance**--pays for custodial and skilled-nursing care services required on a long-term basis by chronically ill and/or mentally or physically disabled people.

Obj 1-3. **THE THREE 'BUILDING BLOCKS' OF HEALTH INSURANCE:**

1. **Government programs--fall into two broad categories:**

- a. **Public assistance**--consists primarily of **Medicaid**, which covers the medical expenses of certain low-income, limited-assets persons who meet stringent needs tests.  
*[Medicaid will be discussed in Chapters 7 and 17.]*
- b. **Social insurance programs**--provide benefits prescribed by law and offered as a matter of right with an emphasis on social adequacy rather than on individual equity. Benefits are designed to provide a base layer of protection for losses caused by injury, death, retirement, *and/or* unemployment.  
**Social insurance programs include**
  - 1) workers' compensation insurance,
  - 2) state temporary disability income programs (in a few states),
  - 3) **Social Security** (retirement, disability, and survivor benefits), *and*
  - 4) **Medicare** (health insurance for the elderly and some disabled workers).

2. **Employer-provided coverage**--is the major source of health insurance for most Americans. **Group insurance plans** cover employees and their dependents with broader coverage and at a lower cost than can be provided by individual policies.

**Voluntary benefits** are group or individual insurance products that are available to employees who are willing to pay 100% of the premiums. Coverage is portable.

3. **Individual health insurance**--is needed if a person is not adequately covered by government programs and/or employer-provided benefits.

Health insurance planning requires an understanding of the existing coverage under government programs and employer plans.

**Three examples of situations when people buy individual insurance:**

- a. **Medicare supplement**--Most people need supplemental medical coverage under Medicare because benefits are usually less than most persons had before Medicare eligibility. Medicare beneficiaries must also decide whether to buy prescription drug coverage.

- b. **Disability insurance--Social Security disability benefits may be insufficient because** Social Security has a six-month waiting period, benefits might not be adequate for higher-income workers, *and* the requirements to receive benefits are stricter than those for private disability insurance.  
Even workers covered under employer-provided plans might need to supplement their coverage with individual disability income policies.
- c. **Dependent coverage--**Many small employers provide few, if any, health insurance benefits. Even those employers that subsidize employee coverage often pay a smaller portion of the cost of dependent coverage.  
Employees pay 100% of the cost of voluntary benefits.  
An employee might find cheaper protection in the individual health insurance marketplace.

Obj 1-4. **HEALTH INSURANCE PLANNING** creates a foundation for life insurance and investment planning.

Health insurance planning is necessary because clients often fail to recognize the potentially financially devastating effects of medical bills, lost income, and disability.

**A health insurance agent**

- 1. gathers information about the client's needs, goals, and finances,
- 2. evaluates the client's needs,
- 3. recommends the policies and benefit levels needed for financial security, *and*
- 4. helps the client implement the plan.

Agents typically advise clients to buy protection before it is needed *and* at a younger age while coverage is available and more affordable.

EO 5. **THE CHANGING ENVIRONMENT FOR INDIVIDUAL HEALTH INSURANCE:**

- 1. **Declining availability of employer health benefits--**Only 60% of employers offer medical expense insurance.  
Even fewer employers offer short-term disability income insurance (39%) or long-term disability income insurance (31%).  
Only 12% of full time employees have access to long-term care insurance.  
As employers continue to reduce benefits, more employees will turn to the individual health insurance market for individual health insurance.
- 2. **Longer post-retirement life expectancy--**The individual health insurance component of a financial plan must address the potential effect of increased longevity on health-related expenses.
- 3. **Medicare reductions--**The number of Medicare beneficiaries who buy individual Medicare supplement policies should continue to increase as employers cut retiree benefits and Medicare increases cost sharing provisions.
- 4. **Increased personal responsibility--**Consumer-directed health plans let insureds control their selection and use of medical expense insurance.

EO 1-6. **THREE MAJOR FACTORS CAUSED THE ESTABLISHMENT OF MEDICAL EXPENSE INSURANCE IN THE 1930s:**

- 1. **Unemployment--**Widespread unemployment during the depression years made individuals and families consider the financial consequences of job loss.
- 2. **Rising medical costs--**Medical advances increased medical costs, causing individuals and families to worry about paying for health care costs.
- 3. **Employer-employee relationships--**Employers began to see health insurance as a necessary step in developing and maintaining sound relationships with employees.

### **THREE ORGANIZATIONS PROVIDED EARLY FORMS OF MEDICAL EXPENSE INSURANCE:**

1. **Blue Cross-Blue Shield (BCBS) Plans**--Baylor University Hospital established the first prepaid hospital service plan for its teachers in 1929.  
Medical societies adopted that model in the 1930s, and the Blue Cross plans were born.  
**Prominent characteristics of BC-BS plans:** BC-BS plans have
  - a. not-for-profit (and thus tax exempt) status,
  - b. service agreements with health care providers in the community,
  - c. preferred-pricing discount arrangements with health care providers,
  - d. community rating (with a single average premium rate),
  - e. service benefits (often with first-dollar benefits and no out-of-pocket costs),
  - f. claims from health care providers filed directly with the plan, *and*
  - g. governance by health care providers, who accept partial payments in deficit situations.
2. **Health Maintenance Organizations (HMOs)**--The first HMO, the Ross-Loos Clinic, was formed in 1929.  
Others were formed in the 1930s.  
**HMOs** are prepaid service plans that use community rating *and also* provide the actual medical care, emphasizing preventive medicine.
3. **Insurers**--entered the hospital insurance market in the 1930s to compete against BC-BS plans.

### **THE HISTORICAL DEVELOPMENT OF MEDICAL INSURANCE:**

1. **1930s**--Early medical expense insurance concentrated on hospital care and physicians' services.
2. **1940s**--By 1940, over 9% of the US population had some form of health insurance.
3. **1950s**--By the early 1950s, insurers protected more people against hospital expenses than BC-BS, and the volume of group insurance premiums exceeded the volume of individual premiums.  
By the end of the 1950s, over 66% of the US population had some form of medical expense coverage.
4. **1960s**--In the mid-1960s, the federal government established national health insurance programs for the elderly (**Medicare**) and the poor (**Medicaid**).  
Medicare eliminated the 65-and-older population from the primary medical benefits market, but opened up a new market for supplemental and ancillary benefit programs.  
The introduction of those two programs created a surge in the number of people seeking medical treatment.  
Health care costs skyrocketed.  
Health care providers began **cost shifting** (recovering the cost for care of patients who did not pay their bills by increasing the charges to insured and self-pay patients).
5. **1970s--Employers and insurers modified their traditional benefit plans and medical expense policies in four ways to save money:**
  - a. **Employee cost sharing**--increases deductibles, coinsurance, and copayments to shift more of the burden of increased costs onto employees.
  - b. **Coordination of benefits (COB)**--makes sure households with two benefits plans don't receive total benefits payments in excess of the actual medical costs.
  - c. **Service alternatives**--add benefits to the medical expenses policy to encourage policyholders to choose less expensive health care alternatives, such as coverage for outpatient surgery, ambulatory care, and hospice care.
  - d. **Utilization controls**--make sure policyholders truly need treatment before authorizing payment.  
**Utilization controls include** second opinions and preadmission testing.
6. **1980s and 1990s**--Insurers continued to look for ways to control costs.
  - a. **Managed care plans**--control medical costs through negotiated provider agreements and enrollee financial incentives.

- b. **Specialty benefit and service organizations**--are independent businesses that provide specialized health care services in a limited benefit area.  
Historically, insurers used these services as carve-out programs for specialized care to get cost savings and/or better outcomes.
  - c. **Legislative action**--included state and federal programs to increase the availability of insurance.  
On the federal level, the **Health Insurance Portability and Accountability Act of 1996 (HIPAA)** made health insurance more portable to people who change or lose their jobs.
  - d. **Consolidation**--resulted, as in any mature market, from competition when the medical expense insurance market peaked in the 1980s and '90s.  
Blue Cross-Blue Shield plans and not-for-profit HMOs abandoned their nonprofit status to compete more effectively.  
Several major mutual insurers converted to stock insurers to raise capital to compete with managed care companies.
7. **Early 2000s**--Significant inflation in medical expense insurance premiums led to increased attention on developing consumer-directed health plans to contain benefit costs.  
These plans typically combine a high-deductible insurance arrangement with an annual credit of funds to an account used to pay unreimbursed medical expenses.

#### **THE HISTORICAL DEVELOPMENT OF DISABILITY INCOME INSURANCE:**

1. **Early history**--In the early 20<sup>th</sup> century, insurance companies began to sell separate disability insurance policies.  
Insurers developed the first disability income **guaranteed-renewable contract** (which could *not* be terminated during the policy term) and **noncancelable contract** (which could *not* be terminated during the policy term *and* guaranteed a level premium for the life of the policy).
2. **The 1930s and the 1940s**--The high unemployment rates during the Depression led to an increase in both the number of disability insurance claims and the average length of claims.  
**Disability income insurers that survived the Depression learned to** define 'disability' carefully, base benefits on the insured's earned income, motivate insureds to return to work rather than remain disabled, and adapt disability income policies to changing socio-economic conditions.
3. **The early 1950s--Disability income policies**
  - a. instituted a benefit period that can be restored after a disability,
  - b. experimented with longer accident benefit periods, *and*
  - c. extended the maximum contract age to 65 (or older) with full benefits.
4. **The 1960s and the 1970s**--The sources of disability income insurance became concentrated in a few specialty providers.  
Several years of profitable experience caused disability income insurers to increase their monthly benefit limits and maximum benefit periods, making the product more popular with the professional and white-collar markets.  
In 1965, Congress extended its social security disability benefits to all program participants.  
Disability income insurers responded to increasing federal and state disability benefits by reducing the amount of coverage they would write for insureds with high levels of governmental coverage.  
Low-income and middle-income markets dried up for private insurers because government disability income provided adequate protection.  
During the recession in the mid-1970s, disability income insurers suffered significant losses caused by overinsurance by the social security program and private insurers' own liberal policy language, underwriting, and claims practices.  
As a result, insurers raised their premiums, lengthened their elimination periods, and reduced their presence in the blue-collar market even further.

8. **The 1980s to the present**--In the early 1980s, the disability income industry expanded, mainly in the professional and white-collar market.  
 Disability income insurers began to compete to insure physicians, whose high earnings and high motivation to return to work made them safe risks.  
 In the early 1990s, the trend toward managed care plans and HMOs plus the rise in malpractice suits caused many physicians to leave the profession and others to see their incomes reduced. Some physicians used their disability income policies to fund retirement, and the rate of long-term and permanent disabilities among physicians began to climb.  
 Insurers responded with large-scale restructuring of disability income insurance products, underwriting, and pricing.  
 By the end of the 1990s, premiums for new policies had increased for both noncancelable and guaranteed-renewable policies.  
 Insurers reevaluated their emphasis on professional-type policies and developed new products that targeted the blue-collar and gray-collar markets and the small business market.  
 The 1990s were characterized by mergers and acquisitions in the disability insurance business. By the end of the decade, the three largest individual disability insurers had merged into one.
11. **Ongoing cycles--From the 1930s to the present, disability income insurance has been characterized by a cycle of**
  - a. **growth**--expansion, competition, entry of new competitors into the market, *and* product liberalization *and*
  - b. **retrenchment**--economic downturn, resulting in increased claims which trigger product design restrictions, sales contraction, premium increases, *and* consolidation of competitors.

#### **THE HISTORICAL DEVELOPMENT OF LONG-TERM CARE (LTC) INSURANCE:**

1. **Early policies**--In the early 1980s, long-term care insurance policies were designed to provide care during recovery from acute illness.  
 They had short benefit periods and limited benefit amounts *and* they lacked guaranteed renewability options.  
 Policies tended to provide benefits for care in nursing homes but not in other settings.  
 They *excluded* Alzheimer's and other organic brain diseases.  
 Premiums were *not* deductible *and* benefits were subject to income taxation!
2. **Coverage changes**--In response to negative publicity, many insurers broadened their coverages. The NAIC model legislation and HIPAA (both discussed in Chapter 18) also caused insurers to modify their policies.  
*[HIPAA provides favorable tax treatment to LTC policies that meet specified standards.]*
3. **Policy enhancements**--Insurer practices vary regarding the treatment of existing policyowners who want enhancements.  
 Some insurers let the policyowner add the enhanced benefits by paying the new premium based on the original age of issue.  
 Other insurers require evidence of insurability and use attained-age rates.