

FINANCING HEALTH CARE--EMPLOYMENT-RELATED COVERAGE (351-1)

[Seniors are likely to have higher health insurance costs because

1. *health problems and recovery periods increase with age,*
2. *seniors typically have longer and more frequent hospital stays,*
3. *seniors are more likely to be injured in accidents, **and***
4. *seniors are more likely to have chronic health conditions.]*

[Seniors who plan for post-retirement health care costs

1. *improve their quality of life,*
2. *reduce worry about paying for health care, **and***
3. *increase the likelihood of meeting their future financial goals.]*

EO 1. THE THREE COMPONENTS OF HEALTH CARE:

1. **Health maintenance--Wellness** is the state of being in good health. Wellness is an important component of health care because it reduces future health care costs. **Wellness care consists of** lifestyle decisions (regular exercise, healthy diet) **and** preventive medicine (physical exams, medical screenings, immunizations). Although insurance policies historically have **not** paid for wellness care, many of today's policies now **do** pay for them.
2. **Medical care--Medical care expenses include** fees for hospital stays, outpatient surgery, diagnostic tests, physician appointments, prescription drugs, dental problems, prescription glasses, hearing aids, orthopedic shoes, **and** home health care.
3. **Long-term convalescent care**--There is an increasing need for long-term care as people age because chronic medical conditions and frailty worsen with age, making the need for long-term care increasingly likely.

EO 2. THE CONTINUUM OF HEALTH CARE SETTINGS ranges from least to most intensive. **At the less intensive end**, there is self-care and care received in physicians' offices and diagnostic facilities. **At the more intensive end**, there is hospitalization, in which the patient's every need is attended to. **In the middle of the continuum** are skilled nursing facilities and hospices, which provide more intensive care than the patient can receive in his own home but less intensive care than he would receive in a hospital. Seniors use different care settings as the circumstances of their lives change, sometimes needing more intensive care, sometimes needing less intensive care.

EO 3. THE CONTINUUM OF HEALTH CARE PROVIDERS ranges from trained and licensed providers (physicians, nurses, dietitians, therapists) to untrained providers (family, friends, volunteers). **Medical expense policies usually** require insureds to receive care from licensed care providers. **Long-term care policies usually** allow a broader range of health care providers.

[Health insurance is heavily regulated because

1. *in the past, some insurers and insurance agents used unethical sales practices to sell policies to vulnerable older clients **and***
2. *health insurance protects a highly valued and irreplaceable aspect of human life.*

In some cases, federal regulations preempt state regulations of health insurance.]

[The three sources of health insurance regulations:

1. ***legislatures**--which pass laws regulating insurance,*
2. ***regulators**--which enforce those insurance laws and regulations, **and***
3. ***courts**--which may declare insurance laws unconstitutional and which resolve disputes between insurers and insureds.]*

EO 4. **STATE REGULATION THAT AFFECTS HEALTH INSURANCE: The National Association of Insurance Commissioners (NAIC)** is a voluntary association of all insurance commissioners that promotes uniform legislation and regulations for insurance.

The NAIC develops model laws and regulations, which states may, but are *not* required to, adopt.

The nine categories of state regulation:

1. **Licensing**--Insurer licensing evaluates the insurer's ability to provide the coverage it promises to its insureds, based on its financial strength, management, and business practices. **An unauthorized insurer** is *not* licensed to sell insurance in the state where it is selling insurance.
2. **Financial standards**--Insurers must meet standards for investment practices and maintenance of reserves. State-licensed insurers typically pay funds into a state-run **guaranty fund**, which pays the claims of any insolvent insurer(s).
3. **Policy forms**--A **policy form** is a standardized contract between an insurer and an insured. **Most states require** insurers to file their forms with the insurance commissioner. **Almost all states require** insurers to follow specific policy formats (eg, exclusions must be clearly labeled and printed in a readable type) and to define specified terms (eg, hospital, accident, illness, preexisting condition). **Most states require these seven mandatory provisions:**
 - a. **Entire contract provision**--states that only those items attached to or written into the policy are part of the policy. Policy changes are *not* valid *until* an executive officer of the insurer has approved the endorsement and attached it to the policy.
 - b. **Incontestable clause**--limits the insurer's right to contest the policy to *two* years and makes the policy incontestable with respect to the insured's misstatements on the application.
 - c. **Grace period**--gives the insured a specified number of days beyond the due date (usually *31* days) to pay each premium and still maintain full coverage.
 - d. **Reinstatement provision**--explains how the insured can apply for reinstatement of his cancelled policy. Reinstated medical expense policies usually cover only accidental injuries for the first *ten* days, and then restore coverage for sickness.
 - e. **Claims provisions**--explain the rules for giving notice of claims, providing claims forms, providing proof of loss, and paying claims (timing and recipient). The insured usually has from 90 days to one year to file proof of loss.
 - f. **Physical examinations and autopsy provision**--lets the insurer examine or perform an autopsy on the insured at its own expense while a claim is pending.
 - g. **Legal actions provision**--requires the insured to wait for *60* days after submitting proof of loss before starting legal action against the insurer. The insured also may *not* bring legal action against the insurer more than *three* years after submitting proof of loss.

These three optional provisions must follow prescribed formats:

 - a. **Misstatement of age provision**--changes benefits payable under the policy to the level at which they would have been paid, had the insured's age been recorded correctly.
 - b. **Insurance with other insurers provision**--lets two or more insurers with valid coverages share the cost of a claim, rather than paying the insured twice.
 - c. **Conformity with state statute provision**--makes any policy provision that, on its effective date, conflicts with the statutes of the insured's state of residence conform to the minimum requirements of those statutes.
4. **Mandated benefits**--**Mandated benefits** are state laws that set coverage requirements for medical expense policies. State-mandated benefits increase the price of insurance. **Mandated option laws** require insurers to *offer* mandated benefits to each insured, with the insured choosing and paying for the coverages he wants. Mandated option laws lower insurance premiums *but* increase the chance of adverse selection. **Mandated benefits can be organized into these seven categories:**
 - a. **Populations**--The insured's children are covered up to a specified age limit. Disabled children who are unable to earn their own livings are covered with no age limit.

- b. **Provider recognition**--Some states require insurers to recognize the services of licensed care providers *if* those providers are acting within the scopes of their licenses *and* the services provided are covered by the contract.
 - c. **Alternative care settings**--Some states require insurers to recognize services provided through home health care and in surgicenters and other nontraditional health care facilities.
 - d. **Conditions**--Some states require coverage for certain medical conditions, such as alcoholism, Lyme disease, and mental illness.
 - e. **Diagnostic tests and exams**--Some states require coverage for certain tests and exams, such as colon cancer exams and mammograms.
 - f. **Treatments**--Some states require coverage for certain treatments, such as acupuncture.
 - g. **Services and products**--Some states require coverage for certain services and products, such as marital counseling and diabetes self-management training.
5. **Market conduct--Market conduct standards can be organized into seven categories:**
- a. **Advertising**--Advertising standards provide insurance customers with accurate, clear descriptions of insurance products. Insurers must present required information prominently *and* give accurate descriptions of benefits and premiums. Insurers may *not* use deceptive or exaggerated words and phrases *or* disparage other insurers and their products. **Advertisements that are invitations to contract must disclose** exceptions, reductions, and limitations that affect the basic policy provisions; any deductible or coinsurance factor; any pre-existing conditions clause; *and* provisions for policy renewal, cancellation, and termination.
 - b. **Claim settlement practices--Standards prohibit unfair claim settlement practices, such as** failing to explain the basis for denying a claim, settling a claim on the basis of a policy altered without the insured's knowledge or consent, *and* refusing to pay a claim without conducting a reasonable investigation.
 - c. **Unfair discrimination**--Most states prohibit unfair discrimination. **Common state regulations prohibit** unfair sex discrimination (although insurers *can* use sex-distinct rates for individual insurance products), unfair discrimination against blind and partially sighted people, *and* (in life and health insurance) unfair discrimination against people with physical or mental impairments.
 - d. **Agent conduct**--Standards prohibit agents from acting fraudulently or unethically. **Prohibited activities include** rebating (returning some of the premium or commission to the insured as a sales inducement), twisting (convincing an insured to cancel, disadvantageously, another insurer's contract to take out a new contract), *and* misappropriation (keeping funds that belong to others).
 - e. **Free-look period--A free-look period** is a period of time (usually **30** days) during which a new insured can return a health insurance policy for a full premium refund.
 - f. **Policy replacement**--If an insured's new policy is meant to replace an existing policy, the insured must be warned if the new policy does *not* cover preexisting conditions.
 - g. **Privacy protection**--Most standards restrict and prescribe the use of personal information, include a mechanism by which insureds can find out what information has been collected about them, and require notification of adverse underwriting decisions.
6. **Access and affordability**--Most states have regulations that help people with previous health problems to find and to afford health insurance.
7. **Premium rates**--Most states require insurers to file their rates with the state insurance department. Certain types of medical insurance must demonstrate an acceptable loss ratio.
8. **Renewability--A guaranteed renewable policy** gives the insured the right to renew the policy, although the insurer may change the premium rate for the entire class of insureds.
9. **Policyowner complaints**--Most states provide for an independent, external review of benefit decisions, especially those decisions that denied benefits due to medically unnecessary or experimental treatments.

EO 5. **FEDERAL LAWS THAT AFFECT HEALTH INSURANCE:**

1. **The Employee Retirement Income Security Act (ERISA)**--protects and regulates retirement plans and employee benefit plans.
ERISA affects seniors who are still covered by employer-provided health insurance plans.
2. **The Health Insurance Portability and Accountability Act (HIPAA)**--deals with the problem of employees losing health insurance coverage when they change or terminate their employment.
3. **Women's Health and Cancer Rights Act**--mandates benefits that health insurance must include. **Specifically, any policy that provides mastectomy benefits must also provide benefits for breast reconstruction, plastic surgery on the other breast, *and* prostheses and physical complications of all stages of the mastectomy.**
4. **Medicare Supplement Legislation**--directed the NAIC to develop standard Medicare supplement policies with several mandated features.
5. **The Internal Revenue Code**--states that benefits received from a health insurance policy are *not* taxable *except* to the extent that they exceed the medical expenses incurred.
Some health insurance and long-term care insurance benefits are also deductible.

EO 6. **HEALTH CARE FINANCING ISSUES:**

1. **Dealing with seniors**--Seniors can be more difficult to deal with than younger people if they have diminished physical and/or mental capacities.
It's easier to deal with seniors if you know their physical and mental capacities and are prepared to accommodate them. *Example:* Speak slowly and clearly to insureds who are hard of hearing and bring large-print documents to meetings with visually impaired insureds.
2. **Suitability--Suitability** refers to how well the insurance meets the insured's needs and wants. Seniors need insurance products that will pay for all of their health care needs *without* emptying their bank accounts or requiring them to abandon physicians they like and trust.
Seniors in similar financial situations should still receive a range of health care options.
3. **Advance medical directives**--A patient's **living will** tells medical personnel what to do when that patient is in a terminal medical condition.
A durable medical power of attorney appoints someone other than the patient to make decisions about the patient's health care, if the patient becomes incapacitated.

EO 7. **TERMINATION OF EMPLOYMENT-RELATED HEALTH INSURANCE:** Without provisions for continuation or conversion, an employee's medical expense coverage ceases when he is no longer employed *or* when he is no longer eligible for coverage (even if he's still working). Coverage for dependents ceases when the employee is no longer employed *or* when the dependent is no longer a dependent.

EO 8. **THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985**

(COBRA) requires group health plans to let employees and some beneficiaries extend their health insurance coverage at group rates for up to 36 months following a qualifying event.

Group health plans subject to COBRA include medical expense plans, dental plans, vision care plans, *and* prescription drug plans, if the employer averaged over **20** employees in the previous year.

Self-insured plans *are* subject to COBRA regulations.

The penalty for noncompliance with COBRA is an excise tax of up to \$100 per day per person denied coverage.

Qualified COBRA beneficiaries include employees, their spouses, *and* their dependent children who were covered by the health plan on the day before the qualifying event.

Qualifying COBRA events include the death of an employee, the termination of an employee for any reason *except* gross misconduct, reduced working hours, the divorce or legal separation of the employee and his spouse, the employee's eligibility for Medicare, *and* a child's ceasing to be an eligible dependent.

A qualified beneficiary who suffers a qualifying event has the right to elect to continue identical coverage under the employee's health insurance plan.

COBRA coverage continues for 18 months following termination or reduction of employment and **36 months** for all other events.

COBRA coverage ceases earlier than 18 or 36 months if the health plan terminates for all employees, the insured fails to pay the premium, *or* the insured becomes entitled to Medicare or gets a new insurance policy.

The employer must notify the employee of his COBRA rights twice: first, when the health insurance plan becomes subject to COBRA and second, when the employee experiences a qualifying event.

Qualified beneficiaries must elect COBRA coverage. COBRA coverage is *not* automatic.

Once elected, coverage is effective retroactively to the date coverage would have ceased.

Qualified beneficiaries pay their own premiums, which they may pay in monthly installments.

The maximum premium charge is **102%** of the cost to the plan of a similarly situated employee.

COBRA is often the most cost-effective way of continuing health care coverage, *but* individuals willing to accept high deductibles and copayments can often find less expensive substitutes for COBRA.

A comparison of any program with COBRA should look at benefits as well as costs.

EO 9. METHODS OF CONTINUING MEDICAL EXPENSE COVERAGE AFTER TERMINATION OF EMPLOYMENT:

1. **For retired employees**--Some employers offer continued health coverage to their retirees. New rules from the Financial Accounting Standards Board (**FASB**) regarding the accounting of postretirement benefits, plus the increasing costs of medical expense coverage, has caused many employers to reduce or eliminate retiree benefits.
Typical employer changes to retiree benefits include eliminating all benefits, reducing benefits, increasing retiree premiums, shifting to defined contribution plans, *and* encouraging retirees to elect coverage under a managed care plan.
Coverage before Medicare eligibility is generally provided at pre-retirement levels.
Coverage after Medicare eligibility usually involves a **Medicare carve-out** (which reduces benefits to the extent that they are provided by Medicare) or a **Medicare supplement** (which provides benefits for specified expenses *not* covered by Medicare).
2. **For surviving dependents**--Coverage for survivors of active employees is *not* usually continued beyond the period required by COBRA. Coverage for survivors of retired employees is usually limited to spouses. Coverage is usually identical to that provided before the employee's death.
3. **For disabled employees**--Coverage for employees with short-term disabilities continues without interruption. Coverage for employees with long-term disabilities and/or who have retired due to a disability must satisfy the definition of "total disability" to receive coverage.
4. **For domestic partners**--Although domestic partners are *not* eligible for COBRA coverage, employers increasingly cover domestic partners identically to spouses.

EO 10. THE CONVERSION PROVISION AND MEDICAL EXPENSE COVERAGE: A

conversion provision lets employees whose group health coverage has been terminated buy individual coverage *without* evidence of insurability and *without* benefit limitations for preexisting conditions.

The employee usually must be insured under the group contract for **three** months to be eligible for conversion, *and* must elect conversion within **31** days of termination. Many conversion policies offer **lower** benefits than their group policies. Conversion is often the most cost-effective option for seniors with health problems.

EO 11. HOW MANAGED CARE AFFECTS A SENIOR'S ABILITY TO MAINTAIN MEDICAL EXPENSE COVERAGE:

Most current managed care plans provide full benefits for *only* those services received within the provider network. Retirees under managed care plans who relocate after retirement may find their medical expense coverage will cover few or none of their medical expenses, simply because they have moved outside of their plan's service area.