

Traditional Medical Expense Insurance

Traditional medical expense insurance products provide *indemnity benefits*, or *reimbursement benefits*, which are contractual benefits that are provided based on the actual amount of the insured's financial loss. Under traditional medical expense insurance policies, insureds are reimbursed for the covered medical expenses they incur up to a stated maximum dollar amount. After an insured receives medical treatment for an illness or injury from a licensed provider of recognized medical services, the insured or the medical care provider files a claim with the insurance company for policy benefits. If the insurer determines that the charges are covered under the policy, the insurer reimburses the insured or the provider for the expenses according to the terms of the insurance policy. The insured is responsible for paying any amount that remains after the insurer pays its share of the claim.

Traditional medical expense insurance provides three types of coverage: (1) basic medical expense coverage, (2) major medical expense coverage, and (3) other medical expense coverage. These coverage options can be offered under separate policies or combined under a single policy, and the coverage can be offered on a group or individual basis.

Basic Medical Expense Coverage

Basic medical expense coverage provides separate benefits for each of the following types of medical expenses:

- **Hospital expenses**, which include charges for specific inpatient and outpatient hospital services, such as room and board, medications, laboratory services, and other fees associated with a hospital stay
- **Surgical expenses**, which include charges for inpatient and outpatient surgical procedures
- **Physicians' expenses**, which include charges associated with physicians' visits both in and out of the hospital

Basic medical expense coverage typically provides *first-dollar coverage*—that is, the insurer begins to reimburse the insured for eligible medical expenses without first requiring an out-of-pocket contribution from the insured. However, benefits provided under basic medical expense policies typically are limited, and many types of medical expenses are not covered.

Major Medical Expense Coverage

Today, rather than offering basic medical expense coverage, most health insurers offer **major medical expense coverage**, which provides substantial benefits for (1) basic hospital, surgical, and physicians' expenses, (2) additional medical services related to illness or injuries, and (3) preventive care.

Two types of major medical coverage are commonly available.

- A **supplemental major medical policy** is a policy issued in conjunction with an underlying basic medical expense insurance policy. The supplemental policy is designed to provide benefit payments for expenses that exceed the benefit levels of the underlying basic plan and, often, for expenses that are not covered by the underlying plan.

- A **comprehensive major medical policy** is a single policy that combines the coverages provided by both a supplemental major medical policy and an underlying basic medical expense policy. A comprehensive major medical policy provides substantial medical expense coverage under one policy, and that policy covers most of the medical expenses the insured may incur. Today, the majority of medical expense insurance policies are issued as comprehensive major medical policies.

Covered Expenses. The benefits that major medical expense coverage provides include payment for many different types of medical treatments, supplies, and services. Major medical expense policies usually cover a wider range of medical expenses than do basic medical expense policies. The covered services and treatments typically include all or some of the following medical expenses:

- Hospital charges for room and board in a semiprivate room
- Miscellaneous inpatient hospital charges, such as laboratory fees, X-rays, medications, and the use of an operating room
- Surgical supplies and services
- Anesthesia and oxygen
- Physical, occupational, and speech therapy
- Surgeons' and physicians' services
- Registered nurses' services
- Specified outpatient expenses, such as laboratory fees, X-rays, and prescription drugs
- Preventive services, such as childhood immunizations and periodic screening and diagnostic tests

Major medical policies allow the insured to seek medically necessary treatment from any licensed provider of recognized medical services.

Benefit Amounts. Major medical expense policies, like all health insurance policies, pay benefits only for *allowable expenses*—that is, those expenses the insured incurs that are covered under the policy. Most policies specify a maximum benefit amount that the insurer will reimburse for any allowable expense. In most cases, the maximum benefit amount payable for a particular service is based on the usual, customary, and reasonable fee for that service. The **usual, customary, and reasonable (UCR) fee** is the amount that medical care providers within a particular geographic region commonly charge for a particular medical service. For example, an insurer might set its maximum benefit amount for an appendectomy in a given state at 90 percent of the UCR fee for the procedure in that state. If an insured files a claim for an amount that is equal to or less than the maximum benefit for the treatment received, then the insurer will allow the entire amount of the claim. If the amount of the claim is greater than the maximum benefit, then the insurer will allow expenses up to the maximum, and the insured is responsible for paying expenses that exceed the maximum benefit amount.

Expense Participation Requirements. Under most major medical expense policies, allowable expenses are subject to expense participation, or cost-sharing, requirements that are designed to encourage insureds to control the amount of their medical expenses. The two most common forms of expense participation requirements are deductibles and coinsurance, and most major medical expense policies include both a deductible and a coinsurance feature.

A **deductible** is usually a flat dollar amount of eligible medical expenses, such as \$200 or \$500, that the insured must pay before the insurer begins making any benefit payments under a medical expense insurance policy. Most major medical expense policies contain a **calendar-year deductible**, which is a deductible that applies to the total of all allowable expenses an insured incurs during a given calendar year. In other words, an insured is required to pay the deductible specified in the policy each calendar year in which he submits claims.

Example. Elizabeth Cater is covered by a comprehensive major medical expense policy that specifies a \$500 calendar-year deductible. During 2009, Elizabeth incurred a total of \$400 in allowable expenses. In 2010, she incurred a total of \$800 in allowable expenses.

Analysis. Because Elizabeth's allowable expenses for 2009 did not meet the \$500 calendar-year deductible specified in her policy, she was required to pay the entire \$400 in expenses she incurred that year. In 2010, she was required to pay \$500 of the \$800 in allowable expenses she incurred to satisfy the policy deductible, but she was eligible to receive reimbursement from the insurer for at least a portion of the remaining \$300.

Coinsurance is an expense participation requirement imposed by many medical expense plans; the requirement generally is a specified percentage of all allowable expenses that remain after the insured has paid the deductible and that must be paid by the insured. Most major medical expense policies set the coinsurance amount at 10, 20, or 30 percent of allowable expenses that remain after the insured has paid the deductible amount.

Example. Wendell Ford is covered by a comprehensive major medical expense policy that specifies a \$400 calendar-year deductible and a 20 percent coinsurance requirement. In 2010, Wendell incurred \$1,000 in allowable expenses.

Analysis. Wendell was responsible for paying the \$400 deductible. In addition, he was responsible for paying coinsurance in the amount of 20 percent of the remaining \$600, or \$120 ($0.20 \times \$600$). Wendell's total out-of-pocket costs, therefore, were \$520 (\$400 + \$120). The insurer paid the remaining \$480 (\$1,000 - \$520).

Most major medical expense policies limit the amount of money the insured must pay under the coinsurance provision by including a maximum out-of-pocket provision. The **maximum out-of-pocket provision**, also known as the **stop-loss provision**, specifies that the policy will cover 100 percent of allowable medical expenses after the insured has paid a specified amount out-of-pocket to satisfy deductible and coinsurance requirements.

Example. Susan Young is covered by a comprehensive major medical expense policy that specifies a \$500 calendar-year deductible, a 20 percent coinsurance requirement, and a \$5,000 maximum out-of-pocket provision. Susan incurred a total of \$2,500 in allowable expenses in January when she was hospitalized for treatment of an illness. In May of that same year, Susan incurred an additional \$30,000 in allowable expenses when she underwent surgery.

Analysis. Of the \$2,500 in allowable expenses Susan incurred in January, she was required to pay \$500 to meet the policy's calendar-year deductible and an additional \$400 ($0.20 \times \$2,000$) in coinsurance. The insurer paid the remaining \$1,600. Because she had satisfied her deductible in January, Susan was required to pay only coinsurance on the allowable expenses she incurred in May. The amount of this coinsurance was \$6,000 ($0.20 \times \$30,000$). However, the maximum out-of-pocket provision in her policy requires Susan to pay only \$5,000 of her expenses for the year. Because she had already paid \$900 in deductible and coinsurance amounts in January, Susan paid only \$4,100 of her May expenses (\$5,000 – \$900). The insurer paid the remaining \$25,900.

Exclusions. Although major medical expense policies cover most medical expenses, they commonly exclude from coverage any medical expenses that result from the following treatments:

- Cosmetic surgery other than corrective surgery required as a result of an accidental injury or other medical reasons
- Treatment of an illness or injury that occurs while the insured is in military service or that results from an act of war
- Treatment of intentionally self-inflicted injuries
- Treatment that is provided free of charge in a government facility or that is paid for by other organizations
- Routine dental treatments, routine eye examinations, and corrective lenses

An insured who incurs expenses for excluded services or for services not covered under the policy is required to pay the full amount of those expenses. In addition, excluded or nonallowable expenses are not counted toward the insured's deductible.

Other Medical Expense Coverages

Insurance companies offer a range of other medical expense coverages to provide benefits for expenses that exceed the benefit levels covered by major medical expense policies or for expenses that are not covered under those policies. Other medical expense coverages that are commonly offered include

- ***Dental expense coverage***, which provides benefits for routine dental examinations, preventive dental work, and dental procedures needed to treat tooth decay and diseases of the teeth and jaw. Dental expense coverage typically is provided under a stand-alone dental expense policy.

- **Prescription drug coverage**, which provides benefits for the purchase of drugs and medicines that are prescribed by a physician and are not available over-the-counter. Prescription drug coverage usually requires the insured to pay part of the cost of the prescription out-of-pocket at the time of purchase. Benefit levels and expense participation requirements for prescription drug coverage usually vary according to the type of drugs. For example, some policies require insureds to pay one out-of-pocket amount for generic drugs and a higher amount for brand-name drugs. Prescription drug costs are a covered expense under many major medical expense policies, but prescription drug coverage can also be provided under a stand-alone policy.
- **Vision care coverage**, which provides the insured with benefits for expenses incurred in obtaining eye examinations and corrective lenses. Vision care coverage generally provides benefits to cover one routine eye examination per year for each insured. Policies also specify the maximum benefit amount the insurer will pay for eyeglass lenses and frames or contact lenses.

Managed Care Plans

Today, most insureds in the United States are covered by some type of managed care plan. **Managed care** is a method of integrating the financing and delivery of health care services within a system that manages the access to health care services and the cost of those services. A **managed care plan** is an arrangement that integrates the financing and management of health care with the delivery of health care services to a group of individuals who have enrolled in the plan. Figure 13.1 describes some common types of managed care plans.

Managing Access to Health Care Services

Managed care plans manage access to health care services through the use of provider networks. A **network** is a group of physicians, hospitals, and ancillary services providers that a specific managed care plan has contracted with to deliver health care services to plan members. Ancillary, or supplemental, services providers include laboratories, radiologists, home health care providers, and physical, speech, and occupational therapists. Provider contracts specify how the managed care plan will pay the providers.

Managed care plans typically require plan members to choose providers from within the network or offer financial incentives to members who choose network providers. Some managed care plans also encourage plan members to use a **primary care provider (PCP)**, also referred to as a **primary care physician**, who is a network member who coordinates members' medical care and treatment. In a PCP-based system, a plan member selects a PCP from among the network of providers and receives basic medical care, preventive care, and wellness care directly from the PCP, without obtaining authorization from the plan. To receive specialized care, however, the plan member usually must obtain authorization or a referral from the PCP. The PCP thus serves as a plan member's point of entry into the

Figure 13.1. Types of Managed Care Plans

A **health maintenance organization (HMO)** is a health care financing and delivery system that provides comprehensive health care services to plan members—often referred to as *subscribers*—in a particular geographic area. HMOs typically require subscribers to gain access to services through a primary care provider, and subscribers must use in-network providers; benefits generally are not provided for services rendered by non-network providers. Subscribers are required to pay a small copayment at the time of service, but they do not pay deductibles or coinsurance, and they are not required to file claims for benefits.

A **preferred provider organization (PPO)** is a health care benefit arrangement that provides incentives for plan members to use network providers, but also provides at least some coverage for services rendered by non-network providers. PPOs do not provide health care directly to plan members; instead, they act as brokers or middlemen by contracting with health care providers to deliver medical services at discounted fees to a specific group of covered individuals. PPOs resemble traditional indemnity plans in that they typically reimburse in-network health care providers on a fee-for-service basis, though network providers agree to discount those fees for plan participants.

A **point-of-service (POS) plan** is a managed care plan that combines features of HMOs and PPOs. A plan member generally must select a primary care provider who is responsible for coordinating the member's medical care within the plan's network of providers. Plan members who need medical care choose, at the point of service, whether to seek care in-network or out-of-network. The plan, however, provides a much lower level of coverage for services received from non-network providers.

managed care system and as a gatekeeper to additional services. Plans typically encourage members to obtain services through PCPs by requiring lower out-of-pocket costs for PCP-based care.

Managing the Cost of Health Care Services

Managed care plans seek to manage health care costs by requiring plan members and medical care providers to share the cost of health care services. In most managed care plans, plan members receive comprehensive health care in exchange for payment of a fixed, periodic—usually monthly—premium. This premium covers the cost of most health care services, no matter how often the member uses those services. In addition, when a plan member receives services from a network provider, the plan member generally pays a specified, fixed amount, known as a **copayment**, to the provider.

Example. Stephen Burdette is a member of a managed care plan that requires a \$25 copayment for physician office visits and a \$20 copayment for prescription drugs. On February 1, Stephen visited his PCP for treatment of a sprained ankle. During the office visit, X-rays were taken of Stephen's ankle. The PCP also wrote Stephen a prescription for pain medication.

Analysis. Before leaving the PCP's office, Stephen paid a \$25 copayment to cover the office visit. The remaining charges for the office visit, including the X-rays, were covered by the managed care plan. When Stephen took his prescription to the pharmacy, he paid a \$20 prescription copayment. The pharmacy billed the managed care plan for the remaining cost of the prescription.

Although copayments are significantly lower than deductibles and coinsurance requirements included in traditional medical expense insurance policies, they provide an incentive for plan members to manage the utilization, and therefore the cost, of health care services.

Managed care plans also encourage medical care providers to deliver necessary care in a cost-effective way by requiring them to share in the financial risk of providing medical care. Managed care plans achieve risk sharing by negotiating fee arrangements with medical care providers and making other contractual arrangements that encourage cost-effective care. Negotiated fee arrangements for in-network providers can include plan member copayments, fee schedules, and fee caps. If the costs of medical services exceed the provider's negotiated fee, the provider must absorb the loss. Out-of-network providers typically are reimbursed on a fee-for-service basis.

Managed care plans also manage health care costs by providing a variety of additional services designed to reduce the amount of medical care that plan members will require. Managed care plans typically offer

- Extensive preventive care programs, including prenatal and well-baby care, routine physical examinations, screening programs, 24-hour telephone line access to a nurse, and childhood immunizations
- Access to wellness programs, including smoking cessation, weight management, and stress management programs
- Patient education programs, including seminars, newsletters, and medical self-help booklets

Government-Sponsored Medical Expense Coverage

In many countries, governments or public agencies provide citizens with comprehensive medical expense coverage of core health care services, including hospital care and physician services. The scope of such government-sponsored coverage varies greatly from country to country.

In Canada, for example, the provincial governments each have established medical expense insurance plans that meet the conditions set out in the federal *Canada Health Act* to qualify to receive federal funding for their plans. Each province and territory provides a medical expense insurance plan that provides basic health care benefits to qualified residents. These benefits vary somewhat from province to

specific expenses—other than loss of income—that may result from an insured's disability. Businesses are subject to certain financial risks if an owner, partner, or key person dies. Likewise, such businesses could suffer a financial loss if an owner, partner, or key person becomes unable to work because of a disability.

Key Person Disability Coverage

Just as businesses that rely on the work of a key person may need to purchase key person life insurance, businesses also may need **key person disability coverage**, which provides benefit payments to the business if an insured key person becomes disabled. When a key person is unable to work because of disability, the business loses the person's services and, thus, loses money. Such losses can be offset by key person disability benefits.

Disability Buyout Coverage

In Chapter 5, we described buy-sell agreements and how they can be funded by life insurance policy death benefits. A buy-sell agreement also may include provisions concerning the purchase of a partner's or owner's interest in the business should the partner or owner become disabled. **Disability buyout coverage** provides benefits designed to fund the buyout of a partner's or owner's interest in a business should he become disabled.

Long-Term Care Coverage

Long-term care (LTC) coverage provides benefits for medical and other services to insureds who need care for an extended period in their own homes or in a qualified facility. With the increased life expectancy and better medical treatment in many parts of the world, increasing numbers of people may require long-term care. Because the costs of long-term care can deplete savings quickly, many people are turning to long-term care insurance to provide for that care. Insurance companies issue both individual and group long-term care policies. In addition, some insurers offer long-term care coverage as a rider to life insurance policies, disability income policies, or annuities.

Benefit Triggers

Long-term care insurance policies typically contain **benefit triggers**, which are requirements specifying the conditions that establish an insured's eligibility to receive long-term care benefits. Long-term care benefits generally are payable if an insured either loses his physical functional capacity to perform at least a specified number of the activities of daily living without assistance or has a severe cognitive impairment.

- The **activities of daily living (ADLs)** are the activities of eating, bathing, dressing, continence, toileting, and transferring into or out of a bed, chair, or wheelchair. A licensed health care practitioner must certify that the insured requires assistance with at least the specified number of ADLs.

- A **cognitive impairment** is a reduction in a person's ability to think, reason, or remember. Alzheimer's disease and dementia are common types of cognitive impairment. Cognitive impairment severe enough to require regular supervision or assistance to protect the insured and others around the insured triggers LTC benefits. LTC policies generally treat severe cognitive impairments as a benefit trigger even if the insured can perform all of the ADLs without assistance.

Long-Term Care Benefits

Long-term care insurance provides coverage for medical or other health-related services required in a qualified facility or, for most policies, in an insured's home. Qualified facilities may include nursing homes, rehabilitation facilities, inpatient behavioral health facilities, hospices, assisted living facilities, and adult day care centers. Care paid for by LTC coverage may include diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services. LTC policies vary as to the facilities and services covered. For example, some group LTC policies provide home health care and adult day care as options, rather than as standard features of the policy. The benefit period for LTC insurance can be set for any length of time—from one year to a maximum of lifetime coverage.

Long-term care insurance policies generally state a **daily benefit amount**, which is the maximum amount of benefits payable for each day of an insured's long-term care at a care facility or in the patient's home.¹ Daily benefit amounts typically range from \$50 to \$500. Many LTC policies provide a lower daily benefit amount for certain types of facilities. For example, an LTC policy may provide a daily benefit amount of \$200 a day for care in a nursing home, \$150 a day for care in an assisted living facility, and \$100 a day for home care.

Long-term care policies generally determine the amount of benefits payable according to either the indemnity method or the reimbursement method.

- Under the **indemnity method**, the insurer pays the insured the daily benefit amount regardless of the actual expenses for long-term care of the insured. For example, if an insured enters a nursing home costing \$150 per day and the policy provides a daily benefit amount of \$200, then the insured will receive the daily benefit amount of \$200, even though the benefit is \$50 greater than the actual cost of nursing home care.
- Under the **reimbursement method**, the insurer pays the insured the amount of covered LTC expenses per day up to the stated maximum daily benefit amount. Under the reimbursement method, if an insured enters a nursing home costing \$150 per day and the policy provides a daily benefit amount of \$200, then the insured will receive a benefit of \$150 per day, the actual cost for nursing home care. However, if an insured enters a nursing home costing \$250 per day, and the policy provides a daily benefit amount of \$200, the insured will receive a benefit of \$200 per day, which is the maximum daily benefit amount for care in a nursing home.

Some LTC insurance policies contain an **inflation protection provision**, which either automatically increases the benefit amount each year by a specified percentage or allows the insured to opt for a higher daily benefit amount at specified intervals during the lifetime of the policy without having to show evidence of

Outline

Individual Health Insurance Policies

- Individual Health Insurance Policy Provisions
- Individual Health Insurance Underwriting
- Financial Design of Individual Health Insurance Products

Group Health Insurance Policies

- Group Health Insurance Policy Provisions
- Group Health Insurance Underwriting
- Funding Mechanisms

Individual and group health insurance policies both provide the health insurance coverages—including medical expense, disability income, and long-term care coverages—we described in the previous chapter. In this chapter, we describe the features of individual and group health insurance policies issued by commercial insurance companies. Remember that the term health insurance includes medical expense, disability income, and long-term care coverage. Throughout the chapter, we point out ways in which medical expense insurance policies, disability income policies, and long-term care policies differ.

Individual Health Insurance Policies

An individual health insurance policy is an enforceable contract between an insurance company and the policyowner. The policy describes the coverages provided, the benefits payable, and the premium amounts and their due dates. A copy of the insurance application the policyowner completed typically is attached to the policy when it is issued. The policyowner and the insured usually are the same person, although individual health insurance policies can provide coverage for the policyowner's family as well. The insurer typically pays benefits directly to the policyowner or to a health care provider on behalf of the insured.

To create a valid health insurance contract, the applicant must submit an application for insurance and pay the initial premium for the contract. The policyowner then must pay periodic renewal premiums to keep the policy in force.

Individual Health Insurance Policy Provisions

Individual health insurance policies include a number of provisions that are the same as provisions included in individual life insurance policies. For example, both types of policies include an *entire contract provision* that specifies the documents that constitute the insurance contract. With the exception of open contracts issued by fraternal insurers, the entire contract consists of the policy and any policy riders or other documents attached to the policy, including the attached application for insurance.

Some provisions are included in both individual life and individual health insurance policies, but the provisions contain some differences. In addition, individual health insurance policies contain some provisions that are not found in individual life insurance policies. In this section, we describe some of the provisions typically included in individual health insurance policies.

Grace Period Provision

Like individual life insurance policies, individual health insurance policies contain a *grace period provision* that allows the policyowner to pay a renewal premium within a stated grace period following the premium due date. Coverage remains in force during the grace period. If the premium is not paid by the end of the grace period, the policy lapses and all coverage ends.

The length of the grace period included in individual health insurance policies varies, depending on how frequently renewal premiums are payable. For example, policies for which renewal premiums are paid monthly typically contain a 10-day grace period. The grace period is usually 30 or 31 days if premiums are payable less often than monthly, although many insurers provide a 30- or 31-day grace period even when premiums are payable monthly.

Incontestability Provision

Individual health insurance policies include an incontestability provision that, like the incontestability provision included in individual life insurance policies, limits the time during which the insurer has the right to avoid the contract based on material misrepresentations made in the application. However, the policy provisions included in individual medical expense policies, individual disability income policies, and individual long-term care policies are not identical.

The incontestability provision included in most individual medical expense policies states that after the policy has been in force for a stated period of time—usually two or three years—the insurer cannot use a material misrepresentation in the application to contest the policy, *unless* the misrepresentation is fraudulent. In the United States, once an individual medical expense insurance policy is in force, insurers are prohibited from denying any claim on the basis of a material misrepresentation in the application, *unless* the misrepresentation is fraudulent or intentional. The incontestability provision specifically notes that the insurer retains the right to deny a claim on the basis of another policy provision. For example, the insurer may deny a claim on the basis that the expenses are specifically excluded from coverage.

The incontestability provision included in individual disability income policies is the same as the provision included in individual life insurance policies. The insurer cannot contest the disability income policy's validity on the ground of material misrepresentation in the application after a stated period—typically one or two years from the date the policy was issued. Note that, unlike the provision included in individual medical expense policies, the incontestability provision included in individual disability income policies does not include a reference to fraudulent misrepresentations.

According to the incontestability provision included in long-term care policies an insurer's right to avoid the insurance contract on the basis of a material misrepresentation in the application typically varies depending on the length of time the policy has been in force.

- If the individual long-term care policy has been in force for a period of at least six months but less than two years, the insurer cannot use a material misrepresentation in the application to contest the policy or deny a claim, unless the misrepresentation pertains to the condition for which benefits are sought. For example, suppose Nathan Morrison, a person with a history of heart disease,

indicated on his application for long-term care insurance that he had not been treated for heart disease. One year after the policy's effective date, Nathan was severely injured as a passenger in an automobile accident and, as a result, required long-term care. Although the insurer would have declined Nathan's application initially if it had known of his heart condition, the misrepresentation contained in the application did not pertain to the condition for which benefits were sought, namely, the injuries Nathan suffered in the automobile accident. Therefore, the insurer could not deny Nathan's claim for long-term care benefits on the basis of the misrepresentation in the application.

- If the individual long-term care policy has been in effect for more than two years, the insurer cannot contest the policy or deny a claim on the basis of misrepresentation in the application unless the insured knowingly and intentionally misrepresented relevant facts relating to his health.

Claims Provisions

Individual health insurance policies typically include provisions that define both the insured's obligation to provide timely notification of loss to the insurer and the insurer's obligation to make prompt benefit payments to the insured. For example, the policy may require the insured to notify the insurer of a claim in writing within 30 days from the date the claim arose and to furnish the insurer with proof of the loss within 90 days from the date the claim arose. Similarly, the policy may require the insurer to pay benefits within 60 days of receipt of proof of loss for a medical expense claim and within 30 days of receipt of proof of loss for a disability income or long-term care claim.

Legal Actions Provision

Individual health insurance policies typically include a **legal actions provision**, which limits the time during which a claimant who disagrees with the insurer's claim decision has the right to sue the insurer to collect the amount the claimant believes she is owed under the policy. The length of this time period varies from jurisdiction to jurisdiction, but it typically ranges from one to three years after the claimant provides the insurer with proof of the loss.

Overinsurance Provision

To prevent an insured from profiting from an illness or injury, many individual health insurance policies contain an **overinsurance provision**, which states that the benefits payable under the policy will be reduced if the insured is overinsured. An **overinsured person** is one who is entitled to receive either (1) more in medical expense benefits than the actual costs incurred for treatment or (2) a greater income amount during disability than the amount that would have been earned from working.

An overinsurance provision takes effect *only* if the insurer was not notified of the other existing coverage at the time of application. In cases of overinsurance, the insurer reduces the amount of the benefits that would otherwise be payable under the policy and refunds any premium amount paid for the excess coverage.

Physical Examination Provision

Individual disability income insurance policies usually include a **physical examination provision**, which states that the insurer has the right to have an insured who has submitted a claim examined by a physician of the insurer's choice, at the insurer's expense. Such an examination allows the insurer to verify the validity of disability income claims. The provision also gives the insurer the right to require that a disabled insured undergo medical examinations at regular intervals so that the insurer can verify that the insured is still disabled.

Individual Health Insurance Underwriting

Underwriting of applications for individual health insurance focuses on determining the degree of morbidity risk that a proposed insured represents. As noted in Chapter 1, morbidity risk refers to the risk of illnesses and injuries. Various factors affect the degree of morbidity risk a proposed insured presents. The primary factors that affect the degree of morbidity risk a proposed insured presents include the following:

- **Age.** Morbidity rates generally increase with age. As people grow older, they are more likely to become ill, and the average duration of each illness generally increases.
- **Health.** An individual's health history and current health are both important factors in determining morbidity risk. Many illnesses have a tendency to recur, and an individual's future health is strongly affected by her past and current illnesses and injuries.
- **Sex.** Because females generally experience a higher morbidity rate than males of the same age, the cost of providing health insurance coverage to females generally is higher than the cost of providing coverage to males.
- **Occupation.** A person's occupation may affect his morbidity risk. Occupational factors that affect the degree of morbidity risk include the hazards inherent in the occupation, the stability of the occupation, and the amount of recovery time people usually need to resume their normal job duties.
- **Avocations.** Engaging in certain sports or hobbies may expose an individual to an increased chance of injury or disease.
- **Work history.** A proposed insured's work history is especially important for disability income coverage. A person with a number of gaps in his work record or who has a history of only temporary jobs may be a poor risk for disability income coverage because he may lack the incentive to recover from a disability or the incentive to return to work.
- **Habits and lifestyle.** A person's habits and lifestyle can lead to a higher risk of accidental injury or illness. For example, a person who has a recent criminal record may present a higher degree of risk than does a person with no criminal record. Individuals who smoke or have alcohol or drug-related problems also are more likely to present health insurance claims than are people who do not use those substances.

In many jurisdictions, various laws limit the factors an insurer can consider in determining the degree of morbidity risk that a proposed insured represents. Laws in some jurisdictions place limits on the extent to which an insurer may consider an individual's health history or current health in determining morbidity risk for medical expense coverage. In addition, many jurisdictions have enacted antidiscrimination legislation to prevent health insurers from considering certain aspects of an applicant's lifestyle, such as the applicant's sexual orientation, during the underwriting process.

Financial Design of Individual Health Insurance Products

The fundamental principles underlying the financial design of health insurance products are the same as those underlying the financial design of life insurance products. Health insurance premiums must be adequate to provide the promised benefits and must be equitable to all policyowners. Nevertheless, life insurance and health insurance products have significant differences, and most of these differences affect how insurance companies create the financial design of these two products.

First, let's look at some of these differences between life insurance and health insurance.

- The amount payable for a life insurance claim is specifically defined by the policy, but the amount payable for a health insurance claim often is much less definite. For example, medical expense claims range from fairly small to very large amounts, depending on the severity and duration of the covered illness or injury.
- An insurer is likely to pay a number of covered claims for each person insured by a health insurance policy, but it will pay only one death claim for each person insured by a life insurance policy.
- Inflation, changes in the economy, and changes in medical practice affect the amount of benefits paid for health insurance claims much more dramatically than such factors affect life insurance claims.
- Medical costs may vary considerably in different geographic areas; as a result, the amount of benefits payable for a particular claim can vary by geographic location. By contrast, the amount of a life insurance policy death benefit does not vary by geographic location.

In creating the financial design of a health insurance product, an insurance company uses information about morbidity rates to calculate the product's **claim costs**—the costs the insurer predicts that it will incur to provide the policy benefits promised. For example, medical expense insurance typically provides benefits to pay various types of medical and hospital expenses. The insurer estimates the claim costs for each type of benefit provided.

The premium amount a customer pays for an individual health insurance policy varies depending on the choices the applicant makes concerning the coverage the policy provides. For example, an applicant is permitted to make some choices concerning the benefit levels that an individual health insurance policy includes.

Also, insurers usually offer an applicant for an individual medical expense policy several choices concerning the amount of the policy's deductible; the larger the deductible, the lower the amount of premium required. Insurers generally offer an applicant for an individual disability income policy or long-term care policy several possible combinations of elimination periods and maximum benefit periods.

A number of jurisdictions require an insurer's loss ratio to be at least a minimum stated percentage. The **loss ratio** is the ratio of benefits an insurer paid out for a block of policies to the premiums the insurer received for those policies. The loss ratio generally is stated as the percentage of premiums paid out in benefits for a block of policies. The loss ratio is calculated by dividing the total amount the insurer paid out in policy benefits for a block of policies by the total premiums the insurer received for that block of policies. For example, if an insurer received \$1,000,000 in premiums for a block of policies and paid out \$900,000 in policy benefits for those policies, then that block of policies has a loss ratio of 90 percent (\$900,000 benefits paid ÷ \$1,000,000 premiums received). Note that even if the loss ratio for a block of policies remains level over a period of time, the amount of premiums required for those policies will increase if policy benefit costs increase.

Group Health Insurance Policies

Most health insurance policies that commercial insurers issue are group health insurance policies. A group health insurance policy is an enforceable contract between an insurer and the group policyholder that purchased the group insurance coverage. The insured members of the group are not parties to the insurance contract and are not given individual policies. Instead, each insured group member is given a certificate of insurance or benefit booklet that provides information about the terms of the group health insurance coverage and the insured's rights under the policy.

If a group policyholder purchases different types of group health insurance, an insurer generally issues separate master policies to the group policyholder for each type of coverage provided. For example, an insurer could issue both a group medical expense policy and a group disability income policy to the group policyholder. In addition, a group policyholder can choose to purchase various types of health insurance coverage from one or more providers.

Group Health Insurance Policy Provisions

Many policy provisions are substantially the same in all group life and group health insurance policies. For example, every group health and group life insurance policy contains an eligibility provision that describes the eligibility requirements for coverage under the policy.

Similarly, group life and group health insurance policies both contain grace period provisions, providing a 30- or 31-day grace period following the premium due date during which insurance coverage remains in force even if the premium is not paid. If the required premium is not paid by the end of the grace period, the group life insurance or group health insurance policy terminates, and the group policyholder is legally obligated to pay the premium for the coverage provided during the grace period.

Some group health insurance policy provisions vary depending on the type of health insurance coverage the policy provides.

- Group medical expense insurance policies specify the types of medical expenses they cover, the benefit maximums (if any), the deductible amount, and the coinsurance features.
- Group disability income policies specify the definition of total disability, the length of the elimination period, the method of determining the amount of the disability income benefit payable, and the length of the maximum benefit period.
- Group long-term care policies specify the types of care covered, the benefit triggers, the daily benefit amount, the length of the maximum benefit period, and the length of the elimination period.

Many employer-employee group health insurance policies provide dependent coverage, but the availability of dependent coverage varies depending on the type of health insurance coverage a group policy provides.

- Most group medical expense policies provide that an insured employee's family and dependents are eligible for group insurance coverage. Such dependent coverage is generally available at the option of the insured group member, who usually must pay an additional premium amount for dependent coverage.
- Most group disability income policies do not provide coverage for dependents of group members.
- Many group long-term care policies provide optional coverage for certain dependents and family members of the insured employee. Depending on the policy, dependent coverage may be available for the insured employee's spouse, parents, or grandparents. Group long-term care policies typically do not provide dependent coverage for the insured employee's children.

Many of the provisions that typically are included in individual health insurance policies also are included in group health insurance policies. For example, both individual and group health insurance policies include a claims provision, an incontestability provision, and a legal actions provision. Individual disability income policies and group disability income policies both include a physical examination provision.

Coordination of Benefits Provision

People often are eligible for coverage under more than one group medical expense plan. For example, spouses who both work often are eligible for coverage under their own employers' group policy and under their spouses' group policy. If an insured receives full benefits from both policies, he might receive benefit amounts that are greater than the amount of medical expenses actually incurred and, consequently, would profit from an illness or injury. The ***coordination of benefits (COB) provision*** is designed to prevent a group insured who is covered under more than one group medical expense policy from receiving benefit amounts that are greater than the amount of medical expenses the insured actually incurred. The COB provision prevents duplicate benefit payments by defining the group health plan that

is the primary provider of benefits and the plan that is the secondary provider of benefits for group insureds who have duplicate group medical expense coverage.

A plan defined in the COB provision as the primary provider of benefits is the plan that is responsible for paying the full benefit amounts promised under the plan. When the plan designated as the primary plan has paid the full benefit amounts promised, then the provider of the secondary plan determines the amount payable for the claim in accordance with the terms of the secondary plan.

A plan's COB provision may take one of several approaches to determining the amount of benefits payable when the plan is functioning as the secondary provider of benefits. Under the most common approach, the secondary provider first calculates the amount of the insured individual's total allowable expenses and the amount of those expenses that the insurer would pay if it were the primary provider. **Allowable expenses** are those reasonable and customary expenses that the insured incurred and that are covered under the insured's group medical expense plans. The secondary provider then looks at the amount the primary provider paid. If payment of the full benefit amount provided by the secondary plan would result in the insured receiving more in benefit payments from both plans than the total amount of allowable medical expenses, then the secondary plan pays only the difference between the amount of allowable expenses incurred and the benefit amount the insured already received from the primary plan. Under this type of COB provision, the insured individual typically pays no portion of her covered medical expenses; the primary plan pays all allowable expenses in excess of the deductible and coinsurance requirements, and the secondary plan pays the portion of allowable medical expenses not paid by the primary plan, including reimbursing the insured for any deductible and coinsurance amounts paid by the insured.

Example. Brad Metcalf is covered by two group medical expense plans; both plans include a coordination of benefits provision. Each plan also specifies a \$500 deductible and a 20 percent coinsurance requirement. Brad was hospitalized and incurred \$4,500 in allowable medical expenses. He submitted a claim for his expenses to the plan designated as his primary plan. Brad later submitted the claim, along with a description of the benefit paid by the primary plan, to his secondary plan.

Analysis. The plan designated as the primary plan is paying benefits equal to \$3,200. The calculations used to determine this benefit amount are as follows.

\$4,500	Total allowable expenses
<u>- 500</u>	Deductible
\$4,000	
<u>- 800</u>	Coinsurance ($0.20 \times \$4,000$)
\$3,200	Amount payable by the primary plan

Because both plans contain the same deductible and coinsurance features, Brad's secondary plan normally also would pay him \$3,200 in benefits. Under the COB provision, however, the secondary plan will pay Brad only \$1,300; that is, the secondary plan will pay the difference between the total allowable expenses (\$4,500) and the amount the primary plan paid in benefits (\$3,200). Brad incurs no out-of-pocket costs.

Some group medical expense insurance policies contain another type of coordination of benefits provision, generally called a nonduplication of benefits provision, that limits the amount payable if the plan is defined as the secondary plan. A **nonduplication of benefits provision** is a COB provision that, if included in a secondary provider's plan, limits the amount payable by the secondary plan to the difference, if any, between the amount paid by the primary plan and the amount that would have been payable by the secondary plan had that plan been the primary plan. A nonduplication of benefits provision requires the insured individual to pay a portion of the cost of covered medical expenses and, thus, more strictly limits the amount of benefits payable than does the COB provision we discussed previously.

Example. Assume that Brad Metcalf from the previous example is covered under two group medical expense plans that contain the same deductible and coinsurance features as described. In this example, however, assume that Brad's secondary plan contains a nonduplication of benefits provision.

Analysis. As in the earlier example, Brad's primary plan would pay a \$3,200 policy benefit. Under the nonduplication of benefits provision, however, the secondary plan would pay no benefit because the primary plan had already paid the full \$3,200 benefit amount to which Brad was entitled under the secondary plan.

Most COB provisions include rules for determining which plan is the primary provider of benefits. First, most COB provisions state that when an insured also is covered by another group plan that does not include a COB provision, the plan without a COB provision is the primary provider of benefits; the plan with the COB provision is the secondary plan. In addition, if more than one group plan covering an individual includes a COB provision, then the primary plan is usually defined as the plan under which the insured is covered as an employee rather than as a dependent.

Example. Lori and Tom Calloway are married. Both Lori and Tom work full time for employers that provide group medical expense coverage to employees and their spouses and dependents.

Analysis. If only one plan covering the Calloways includes a COB provision, then the plan without the COB provision is considered the primary provider of benefits for both Lori and Tom. Alternatively, if both plans contain a COB provision, then Lori's primary provider is her employer's plan, and her secondary provider is the plan provided by Tom's employer. Tom's primary provider is his employer's plan, and his secondary provider is the plan provided by Lori's employer.

Insurers use a variety of methods to define which plan is the primary provider of benefits if an individual is covered as a dependent under more than one group plan. A common method, known as the *birthday rule* or the *earlier birthday method*, states that the plan covering the employee whose birth date falls earlier in the calendar year will be considered the primary provider of benefits for a dependent.

Note that the employees' actual ages are not a factor in determining the primary provider under the birthday rule.

Example. Assume that Lori and Tom Calloway from the previous example have a son, Jake, who is covered as a dependent under both of their group plans. Lori Calloway was born on March 1, 1980, and Tom Calloway was born on September 1, 1975.

Analysis. According to the birthday rule, the plan provided by Lori's employer would be considered the primary provider of benefits for Jake because Lori's birthday falls *earlier in the year* than Tom's birthday. The actual year in which Lori and Tom were born is not a factor in determining which plan is considered the primary provider of benefits for Jake.

Conversion Provision

Insurers often include a conversion provision in their group medical expense policies. The **conversion provision** gives an insured group member who is leaving the group a limited right to purchase an individual medical expense policy without presenting evidence of insurability. The right is limited in that the insurer can refuse to issue the individual policy if the coverage would result in the insured group member becoming overinsured. For example, an employee who is changing jobs and will be eligible for group medical expense insurance from her new employer would probably be overinsured if she were also issued an individual medical expense policy.

Many individuals who lose their group medical expense coverage cannot afford the cost of an individual medical expense policy. To protect such individuals, laws in some jurisdictions require certain group insurance plans that provide medical expense benefits to allow eligible covered employees the right to continue their group insurance coverage for a limited time in specified situations—such as the termination of employment—in which their group coverage would otherwise terminate. A person who elects to continue group medical expense coverage typically pays the full cost of continuation coverage, including any portion of the premium that the employer had paid.

Group Health Insurance Underwriting

When an insurer evaluates a group for group health insurance coverage, the insurer applies the group underwriting principles we described in Chapter 11. Usually, the group as a whole—rather than the individual members of the group—must meet the insurer's underwriting requirements. Underwriters evaluate a proposed group's expected morbidity rate, which reflects a number of factors such as the industry in which the group members work, the age distribution of the group, and the distribution of males and females in the group.

Funding Mechanisms

The way in which a group insurance plan's claim costs and administrative expenses are paid is known as the plan's **funding mechanism**. A number of funding mechanisms are available for group insurance plans. At one extreme is a **fully insured plan** for which the group policyholder makes periodic premium payments to an

insurance company, and the insurance company bears the responsibility for all claim payments. At the other extreme is a **fully self-insured plan**, also known as a **fully self-funded plan**, for which the group policyholder—usually an employer—takes complete responsibility for all claim payments and related expenses. Between these extremes are a number of alternative funding mechanisms.

Fully Insured Plans

A fully insured plan is the traditional funding arrangement for a group health insurance plan. The insurer issues the group health insurance policy on a one-year renewable term basis, and each year's premium pays for just that year's coverage. New premium rates are charged each year based on the attained ages of the insured members of the group and the group's claim experience. These group health insurance premium rates are typically guaranteed for 12 months. At the end of the policy year, the insurance company may establish new premium rates for the group. Most group long-term disability income and group long-term care insurance plans are fully insured.

Premiums for group health insurance policies usually are payable monthly and can be paid by the group policyholder, the individuals insured under the group policy, or both. As noted in Chapter 11, if the group policyholder pays all of the premiums without requiring the individual insureds to pay anything, the group insurance plan is said to be *noncontributory*. If individual insureds pay any part of the premium, the plan is said to be *contributory*. Individual insureds' contributions generally are paid to the group policyholder, which then makes monthly premium payments to the insurer. For most employer-sponsored group health insurance plans, the employer collects required premium contributions from covered employees through payroll deductions.

The insurer bears all risk under a fully insured plan. If the dollar amount of the claims submitted exceeds the dollar amount of premiums collected, the insurer must absorb the loss. On the other hand, if the group experiences lower claim expenses than anticipated and the dollar amount of the claims submitted is less than the dollar amount of premiums collected, the insurer retains the difference as profit.

Self-Insured Plans

As noted in Chapter 1, individuals and businesses sometimes decide to accept responsibility for a given financial risk rather than purchasing insurance to cover the risk. **Self-insurance** is a risk management technique by which a person or business accepts financial responsibility for losses associated with specific risks. Many employers choose to partially or fully self-insure, or self-fund, the medical expense or disability income coverage they provide for their employees. As a result, the employers bear some or all of the risk of paying claims and the risk that claims may be excessive.

Many employers, for example, fully self-insure short-term disability income coverage for their employees by means of a salary continuation plan. A **salary continuation plan** typically provides 100 percent of the insured employee's salary, beginning on the first day of the employee's absence resulting from illness or injury and continuing for a specified period.

Alternatively, many group medical expense insurance plans are partially self-insured. Under such an arrangement, the employer is financially responsible for

paying a certain level of claims, and the risk for claims above that level is transferred to a traditional health insurance provider. For example, an employer might self-insure the plan's basic medical expense benefits and purchase supplemental major medical insurance coverage from an insurance company.

Many employers believe that self-insuring can help them better control increasing health care costs by allowing them to avoid some of the costs that are built into traditional insurance premium rates. For example, a self-insured employer can avoid paying sales producer commissions and the insurer's operating expenses. Another benefit an employer may receive from self-insuring is an improved cash flow because the employer retains the money it would have paid in premiums and can earn interest on that money.

Stop-Loss Coverage. If a self-insured group experiences several catastrophic medical claims in one year, the employer may not have the financial resources to pay all of the claims. For this reason, many employers that self-insure purchase from an insurance company *stop-loss insurance*, which enables employers to place a maximum dollar limit on their liability for paying health insurance claims. Several forms of stop-loss coverage are available.

- Under *individual stop-loss coverage* or *specific stop-loss coverage*, the stop-loss insurer reimburses the employer for all claims paid for any individual that exceed a stated amount in a stated period of time. The *individual deductible*, or *specific deductible*, is the dollar amount of claims that an employer must pay for any individual in a stated period of time before the stop-loss insurer reimburses the employer for any excess amount. Note that the insurer reimburses the employer whenever the *total amount of claims* paid for any individual in a stated period of time exceeds the individual deductible, not merely when any particular claim exceeds the deductible. For example, suppose an employer has individual stop-loss coverage with an individual deductible of \$10,000 in a specified 12-month period. During that period, the employer pays three separate claims of \$4,000 each for one insured group member. The stop-loss insurer would reimburse the employer \$2,000, the amount by which the claims paid ($\$4,000 \times 3 = \$12,000$) exceed the individual deductible.
- Under *aggregate stop-loss coverage*, the stop-loss insurer begins to reimburse the employer for claims when the employer's total claims exceed a stated dollar amount within a stated period of time. The *attachment point*, sometimes referred to as the *aggregate deductible*, is the total dollar amount of claims that the employer must pay within a stated period of time before the stop-loss insurer begins to reimburse the employer. For example, an employer might purchase aggregate stop-loss coverage with an attachment point of \$250,000 in a specified 12-month period. If the employer paid a total of \$300,000 in claims during that period, the insurer would reimburse the employer \$50,000.

Many employers purchase both individual and aggregate stop-loss coverage. Stop-loss coverage typically is provided under a contract between the stop-loss insurer and the employer. The contract defines the relationship between the insurer and the employer and includes a schedule of benefit payments for which the insurer will reimburse the employer. The agreement is typically for a 12-month period. Note that the stop-loss insurer does not make benefit payments directly to the insured group members; instead, the insurer reimburses the employer, which retains responsibility for making claim payments to insureds.