INSURANCE CONTINUING EDUCATION
Earn your credit in 3 EASY STEPS:

1 – READ this book.
2 – COMPLETE the open book exam.
3 – SUBMIT for scoring via Fax, Mail, or Online!

Principles for Insurance Professionals

10 Credit Hours, Approved For All Licensees
California Approved Course License Number 290771

STATE-APPROVED
CONTINUING EDUCATION
for
CALIFORNIA INSURANCE LICENSEES

BOOKMARKEDUCATION

www.BookmarkEducation.com
(800) 716-4113

PRINCIPLES FOR INSURANCE PROFESSIONALS

Printed in the United States of America.
▪P1▪

All inquiries should be addressed to:

Bookmark Education
6203 W. Howard Street
Niles, IL 60714
(800) 716-4113
www.BookmarkEducation.com

INTRODUCTION

Many continuing education courses are very narrow in their focus. They might limit themselves to only a few major topics or stick to explaining just one type of insurance. There's certainly nothing wrong with insurance professionals choosing courses that deal exclusively with their areas of expertise. But it's sometimes helpful to step back and see how a particular kind of coverage fits into the broader world of insurance and risk management. While it's important to disclose important policy exclusions to insurance applicants, full service isn't possible unless a producer can go a step further and explain how other kinds of coverage might fill those gaps.

"Principles for Insurance Professionals" is intended to help financial professionals create comprehensive insurance strategies for the common household. It explores nearly every major form of personal insurance that a person might consider purchasing during his or her lifetime. Early chapters summarize the insurance most people buy in their early or mid-adult life. Later sections address the insurance-related concerns of senior citizens and retirees. More specifically, the order of major topics in the course material is as follows:

- Chapter 1 covers consumer-related fraud in all lines of insurance and points out the red flags of possible misconduct.
- Chapter 2 is about auto insurance, including optional coverage and the kinds mandated by law.
- Chapter 3 explains the important health care reforms resulting from the Patient Protection and Affordable Care Act, including new consumer protections and the requirement to have health insurance. (In-depth explanations of various health insurance options are found in our companion course, "Insurance Policies: An Essential Resource.")
- Chapter 4 looks at disability insurance, including policies for short-term needs and plans for long-term needs.
- Chapter 5 goes into detail regarding major topics in homeowners insurance, including coinsurance requirements, common policy forms and the differences between replacement costs and actual cash values.
- Chapter 6 summarizes the importance and versatility of life insurance, including term life and permanent life.
- Chapter 7 explores the options for people interested in annuities, including fixed annuities, variable annuities and indexed annuities.
- Chapter 8 briefs readers on the common elements in a long-term care policy, including elimination periods, benefit periods and benefit triggers.
- Chapter 9 provides a primer on Medicare, including classic health coverage, prescription drug plans and supplementary insurance options.

To those students who are already experts on these topics, we hope you will benefit from a review and will be reminded of how important your role as an insurance professional can be. For those for whom these topics are new, our goals are to help you identify the risks faced by consumers and to give you enough background information

so that you can figure which issues might be worthy of further study. And who knows? You might even learn something that ends up taking your career in a new, exciting direction.

CHAPTER 1: INSURANCE FRAUD

When advocacy groups such as the Coalition Against Insurance Fraud (CAIF) claim that instances of insurance fraud add up to roughly $80 billion each year, you might reply instinctively with the same dismissive line a comedian once used in response to a government report that said a certain percentage of Americans do not fill out their census forms: “How do they know that?”

Fraud, after all, differs from crimes like theft, battery and assault, in that those crimes are usually noticed by a victim. If someone breaks into your home, you will likely find damage to a door or a window, along with the empty spaces where your prized possessions once stood. You will probably file a police report, and an officer will give you the old “We’ll let you know if we hear anything” speech. Law enforcement officials might never even come close to snatching your burglar, but they will at least document the fact that a crime has been committed.

With fraud, there are no broken locks, shattered windows or empty spaces to make the misdeed obvious. Instead, at its core, there is a psychological trespass, an attempt by one person to take advantage of another’s trust. Sometimes our instincts and our detective skills allow us to uncover a lie. But our judgment is bound to fail us occasionally, and other people’s lies will be able to hide themselves within our trusting nature.

Whether by failing to cover their tracks or by leaking their plans to the wrong individual, every single person who has ever been exposed as part of a fraud was a sloppy liar. And because we can only base fraud statistics on the people who have been caught, those statistics can never accurately account for the good liars who go undetected as they bilk insurers out of big bucks.

That said, the inevitable softness of the $80 billion estimate should in no way give our society an excuse to brush off the need to lobby for increased fraud awareness. For those readers who are inclined to ignore the prevalence of insurance schemes, let’s assume for a moment that the $80 billion figure from the CAIF is a great exaggeration. For argument’s sake, let’s chop the estimate down by more than one-half to roughly $30 billion, a more conservative number that many other insurance experts have cited. To put that number in perspective, losses from Hurricane Andrew totaled somewhere between $15 billion and $26 billion, and insured losses from the September 11 terrorists attacks came to roughly $38 billion. As all insurance professionals who lived through those events know, the catastrophic level of destruction greatly affected the availability of affordable coverage in the damaged areas for several years.

If anything good can be said about fraud, it is only that it is less physically dangerous than a hurricane or a terrorist attack. But even if we decide that the $30 billion price tag for fraud is the more accurate estimate, we are still acknowledging that, from a financial perspective, the insurance industry is suffering financial losses on par with an Andrew-like hurricane or a terrorist attack every year, all because of lies. And, of course, the

asterisk that must follow the $80 billion could just as easily mean that fraud costs insurers even more than the CAIF suggests.

Consumer Views on Fraud

For emotional reasons, we might avoid thinking about the prevalence of fraud. If we allow ourselves to believe that our fellow human beings, the people we put our trust in every day, are capable of stealing $80 billion or more, we may risk having to deal with sad, cynical thoughts that conflict with our desire to feel safe and happy. We may become upset when, for example, we are forced to think about an innocent motorist who died when a driver from behind intentionally crashed into her so he could pocket some cash through his no-fault auto policy.

But professional insurance producers should not relegate their sadness solely to those sorts of situations. Instead, they should realize the enormity of a societal problem and feel upset because most Americans admit to tolerating insurance fraud and because that tolerance is often directly linked to a poor opinion of the insurance industry.

The aforementioned CAIF conducted a phone survey, quizzing 602 respondents about their attitudes toward insurance and fraud. The results of this study seem to prove that people can have divisive attitudes about ethics even when a given issue has undeniably negative connotations attached to it.

Insurance companies, who have an obvious incentive to take strict stances against fraud, would probably like all of their customers to be what the study called “moralists.” These people believe there is absolutely no excuse for committing fraud and that anyone who engages in it deserves punishment.

Moralists made up the largest group in the survey, but that should not necessarily reassure insurers and make them think the average person sees eye-to-eye with the industry. In fact, the moralists were merely the victors of a tight four-group race, accounting for roughly 31 percent of respondents.

Twenty-two percent of people fit into a category called “realists.” These respondents generally agree with moralists that committing insurance fraud is wrong, but they do not believe in prosecuting fraud with an iron fist. They even recognize some situations in which fraud is acceptable.

About a quarter of the participants had a more passive take on insurance fraud. These people, termed “conformists,” reason that insurance fraud is so common that it is an acceptable crime, if not an encouraged one.

If insurers can view moralists as their allies in a war against fraudsters, people who the study called “critics” might be viewed as their enemies. Critics do not just tolerate fraud. They often justify it by accusing insurers of mistreating consumers and having excessively greedy agendas. Critics belonged to the smallest group in the CAIF study but still accounted for a significant 21 percent of respondents.

The big picture developed by this study is clear: Insurance fraud occurs on such a frequent basis because only one-third of our society refuses to tolerate it. If the industry wants to live to see a day when only amoral creatures engage in fraud, its prevention strategy must be aggressive and aim to change a lot of people’s minds.

Defining Fraud

Before you can convince someone to think differently about anything, you need to step away from your own situation, block out as many personal biases as possible and try to understand the other person's opinion, as well as the reasoning that nurtures that opinion. You want to know not only what the person thinks but also why the person thinks that way.

If insurance professionals step far enough out of their work environments, they might learn, much to their surprise, that what is obviously fraud to them is something else to the average consumer. Many people who work for insurance companies have a broad definition of fraud that encompasses any embellishment or lie affecting a person's insurance coverage. Many consumers, though, use a less inclusive definition. They agree with insurers that outright lying constitutes fraud, but they also believe that embellishing facts on an application or claim form is worthy of a lesser charge.

To illustrate the different definitions, let's use a medical example. Pretend you are given blood tests by your doctor that cost about $100 combined and are not covered by your health insurance. After your appointment, your physician prepares a bill for your insurance company and lists different tests. These tests are very similar to the ones he actually performed, but they cost $150 and are covered in full by your insurer.

If we use the first definition (the one more common among insurers), your doctor has committed insurance fraud by exaggerating his performed services to the insurance company and affecting your coverage. People who use the second definition might view the situation differently. You went to the doctor for blood tests, and he provided them to you. Though his billing of similar tests involved some deception, it was not as if he claimed to have performed a clearly unrelated procedure such as some form of cosmetic surgery. He knowingly stretched the truth. But did he really commit fraud?

In order to avoid overblown semantic arguments, we will use the first, broad definition from this point forward whenever referring to insurance fraud. Now that we have addressed the fact that many people put conditions on what can be considered fraud, we can move forward and examine why consumers allow themselves to set those conditions in the first place.

To insurance professionals whose self-concepts are grounded in their work, someone who commits insurance fraud is merely a thief who has no ethical principles. Sometimes the details of an exposed scam sadly support such a harsh judgment of fraudsters. At other times, however, people deceive and steal from insurers for what they believe to be matters of principle rather than greed.

In these cases, insurance professionals certainly need not excuse fraud, but they should note the criminal's motives. If enough principled people justify insurance fraud in a given circumstance, it might be a sign that the public has a major problem with the industry and that one way to prevent fraud might be to provide better service at a more economical price.

Learning About Fraud and Becoming Proactive

If the insurance community is to ever truly unite to combat fraud, it must do away with the notion that fraud is something to detect only after a policyholder files a claim.

Besides unnecessarily burdening claims departments with nearly all of the physical tasks related to fraud detection, this notion ignores the ethical responsibilities all agents and brokers have to insurance companies.

Whether they are employed by an insurer or hired by a policyholder, ethical insurance professionals must bring consumers and insurers together only in good faith and should not transfer high risks to an insurer without informing the carrier of the risks. This obligation applies to health insurance agents who work with chronically ill customers, auto insurance agents who work with inexperienced drivers and, yes, all agents and brokers who work with any consumer who seems likely to have fraud-related motives.

In the rest of this chapter, agents and brokers will learn about fraud in various lines of insurance and how to spot it. Insurance producers will also be alerted to situations in which people within their industry have hurt the anti-fraud cause through their own fraudulent activity.

Stopping Fraud Before It Starts

While the individual agent or broker is not expected to take on the role of a police inspector, he or she is expected to keep an eye out for red flags of fraud, document any of those flags as they pertain to a particular consumer and share the documented concerns with those in his or her organization. Although many insurance companies hire professional investigators to observe, interview and analyze prospective and current policyholders who seem intent on committing fraud, any informed agent or broker with analytical thinking skills can contribute greatly to fraud prevention.

Early Red Flags

Fraud schemes differ from one line of insurance to the next, but some general red flags seem to apply to all types of insurance at the application stage. Some possible signs of fraud are concretely visible on an application, while others become noticeable only once insurance producers look more closely and observe how an applicant acts and how the pieces of information provided by the applicant fit together to form a bigger picture of the person's credibility.

Still, in keeping with this "bigger picture" idea, it is important to note that the existence of a single red flag or even several red flags does not necessarily prove a consumer has committed insurance fraud or is even considering it. Insurance professionals must analyze each customer's circumstances within a reasonable framework and not put every consumer in a needlessly defensive position. Ideally, by sharing suspicions of fraud with other professionals and analyzing these situations together, insurance producers can increase their chances of exposing fraud and minimize the number of false accusations that penalize innocent people.

As you read the following hypothetical example, you will probably realize that some of the presented red flags could be explained innocently on their own terms and would not necessarily justify a fraud investigation. But just as you would in a real-life situation, you will notice how accumulating facts and analyzing those facts can help you form a clearer picture of a prospective insured at the application stage.

Louise works as an insurance agent and has been in the business for a long time. Most of her new customers come to her through referrals, either by co-workers who are

planning their retirement or by her own longtime customers who know she will treat their friends and family members honestly and fairly.

James became one of Louise's potential customers merely by chance. He had cold-called Louise's company in search of a policy, and she just happened to be the agent who picked up the phone. When James visited Louise's office to apply for a policy, Louise noticed almost immediately how restless he seemed, leaning forward on the edge of his chair. She also noted some odd entries on James' application. Apparently James had lived in three different cities in the previous two years and now had his mail sent to a P.O. Box in a small town. Louise had taken the long drive down to the same town once or twice to visit a relative and thought to herself that this guy had come a long way just to apply for insurance.

Louise became more uncomfortable when she got to the spot on the application for a home phone number, and she asked James why he had left this portion blank. James said he did not have a permanent phone at the moment but could be reached at his mother's number for the time being.

Louise next asked for a photo I.D. and noticed James had crossed the line that separates restlessness from genuine annoyance. He sighed in frustration and said he had left his wallet in his car, which was parked several blocks away, and asked Louise if she really needed an I.D. in order to process his application. Louise held firm, and James left the office, returning a minute later with a driver's license that had been issued just five days earlier.

Louise then steered the conversation toward policy specifics. To her, James seemed to want an unusually large amount of coverage. He said over and over again that he wanted to err on the side of caution and claimed to not care how much he had to pay in monthly premiums for comprehensive insurance.

Near the end of their appointment, Louise explained how the company would go about processing James' application and how, if approved, he could pay premiums via checks payable to the insurance company. James said he would prefer to pay in cash and was prepared to make a payment or two on the spot if doing so would mean quicker approval. Louise declined his offer and promised to contact him at his mother's house once his application had been fully processed.

After James left, Louise documented her many suspicions, mentioning that, in her opinion, this applicant appeared likely to commit insurance fraud. An underwriter at her company read her report, performed a credit check on James and discovered that he owed thousands of dollars to various lenders and thousands more to his ex-wife for child support. A few days later, Louise sent a letter to James' P.O. Box and used the phone number James had given her to leave a message on an anonymous answering machine. The insurance company had denied his application.

Granted, our example is absurd because James did absolutely nothing to make himself seem like an honest person. You, the reader, probably stopped giving him the benefit of the doubt long before you reached the part about Louise's company denying the application. But that, of course, is the point. A reasonably intelligent insurance producer who gathers facts and analyzes them can indeed aid insurers by spotting red flags of

potential fraud and certainly has the ability to detect possible fraud in situations that are not nearly as blatant and ridiculous as this example.

Auto Insurance Fraud

For a long time, insurance fraud was thought of as something an individual committed alone or with a few close confidants. But today, it almost seems as though those were the innocent good old days, back when individuals committed fraud but thought it best not to get too many strangers directly involved in their scams. Modern auto insurance fraud is often an example of organized crime and involves many participants.

Auto insurance fraud rings tend to be most common in states with no-fault auto insurance laws. The rings can be extremely complex. In some instances, these operations have included drivers, passengers, witnesses, doctors, lawyers and police officers in their schemes. Each of these participants takes a cut of the billions of dollars that insurers allegedly lose each year because of phony claims.

Organized auto insurance fraud is more than just a serious problem for insurance companies who want to keep their money out of crooks' hands. Perhaps more than any other kind of insurance fraud committed on the consumer's end, auto insurance fraud deserves the attention of all people; those with insurance and those without, those who drive and those who ride in the passenger's seat. Rather than a seemingly victimless crime, this range of deceptions often hurts the innocents among us. To better understand why, let's look at an example of how an auto insurance fraud ring functions.

Organized Crime and Staged Accidents

Rob is part of an auto insurance fraud ring and is one of two passengers, plus a driver, in an inexpensive car. As they ride down some of the quieter roads in an area where reasonably high speed limits are permitted, Rob and the other passenger are watching for certain kinds of drivers. The less witnesses, the better, so they ideally want to find someone who is traveling alone.

A nice car would be preferable, too, the kind of model that people could probably only afford if they had decent jobs and the kind that the owner might insure heavily to compensate for even a single scratch on the beautiful machine. They look at license plates as well, hoping to spot a tourist who would not want to waste time and money to challenge an insurance matter in a faraway state court. After what seems like an hour, they finally settle on a car they can all agree on, a car driven by a man who has no idea he is about to become a victim of a fraud.

Rob's driver follows the man and is eventually able to move in front of the other vehicle. Keeping an eye on the distance between the two cars and adjusting his speed for a preferable amount of impact, Rob's driver slams on the breaks, and Rob holds his breath for a split second to brace himself for the forceful push that occurs when the two cars meet.

Rob's fellow passenger is all set with his fake vomit, ready to moan, groan and rub his stomach at the very second when the innocent driver approaches. Meanwhile, Rob tries to focus on what to say about his back, not wanting to overdo it. (That might call for x-rays and other unbiased medical tests that could expose the fraud.) But Rob wants the

innocent driver to believe he is dealing with enough soreness and pain to warrant a few grimaces and mumbles, especially when turning his neck a certain way.

The innocent driver would normally be cursing at Rob and his friends, but his heart softens as Rob says he feels a little dizzy. Rob and the other members of the ring apologize to the innocent driver all at the same time, competing with one another so much that all he can really make out is something about an animal jumping in front of the car and the word “sorry” again and again.

After swapping driver information, one of the co-conspirators tells the victim they have been on the phone with the police to report the accident. Sometimes when doing these jobs, that is indeed what is happening. But on other occasions, the companion is actually phoning an off-duty police officer who is in on the scheme.

After the accident is squared away, Rob and his gang visit a personal injury attorney who will fight for assorted reimbursements from any applicable insurance companies and who gets all of them an appointment with the same doctor. The doctor’s office is as basic as they come, with no modern equipment in sight or any other visibly sick patients waiting for their own appointments. The doctor’s practice, Rob knows, is only a front for these insurance scams and, come to think of it, so is the body shop that estimated the allegedly major damage on Rob’s already beat-up jalopy.

If those mechanics knew how little they were making from these scams compared to the big cuts that the lawyer and doctor take home each time, they would probably threaten to expose the whole operation. But there is no need to hold a grudge against the doctor. After all, she’s the one who testifies to insurance companies and courts about Rob’s phony back problems, headaches and other nagging soft-tissue ailments that are difficult to disprove. She and the lawyer are the ones with enough power and prestige to get the insurance companies to pay the claims.

The innocent driver will get his car fixed, and he will walk away without a scratch on his body. In this regard, this accident is different from the one in which a scam artist hit and killed a 71-year-old grandmother named Alice Ross and the one in which a driver who was supposed to hit another vehicle accidentally hit a telephone pole and killed 64-year-old Altagracia Arias, who was supposed to witness the staged crash.

Rob might think about these two cases of organized auto insurance fraud gone wrong and feel sad for a moment or two, but this feeling quickly goes away when he is reminded of the insurance checks that will soon be coming his way. From Rob’s point of view, there’s no need to feel guilty, no need to be sad. Nobody died from what took place … not today anyway.

Organized Crime and Real Accidents

Sometimes, an accident is not staged in any way, but doctors, lawyers and their associates work with victims to build a fraudulent case after the fact. Many small, local newspapers summarize accident reports in each issue, and any persistent reporter can usually obtain a copy of a police report or at least get a glance at one for note-taking purposes. For a fee, people called “ringers” or “steerers” might impersonate someone from the press or take advantage of a source at a police station or an insurance company and gather the names of people involved in recent car accidents.

This person might then contact accident victims and, if they have not yet contacted their insurance company, the ringer will suggest they hold off until a particular doctor examines them. If the ringer has reason to believe an insurer already knows about the accident, he or she might tell victims that their insurer insists they see a specific doctor.

At that point, the ringer moves out of the picture, having not committed any claims fraud, and allows the lawyers and doctors to handle the rest of the situation. Maybe these scams work because the doctor and lawyer actually convince the patient that he or she suffers from certain after-effects from the accident. Maybe there are legal, physical or financial threats involved. Or maybe the accident victims recognize an insurance scam when they see one and are perfectly willing to become players in the master plan if doing so might net them a few bucks.

Unorganized Auto Insurance Fraud

As much as this chapter emphasizes organized auto insurance fraud, it is not meant to imply that less organized, less complex auto fraud committed by a single person or a select few no longer deserves any attention. Insurance professionals must still fight against some policyholders who engage in more traditional schemes, such as reporting a car as stolen when the owner can no longer make payments on the vehicle. Insurers who base auto rates on geography, a somewhat unpopular practice among many urban consumers, need to look out for people who use fake addresses to lower their premiums. More recently, according to National Underwriter, the rise in e-commerce has allowed some fraudsters to insure their beat-up old cars online and then claim the car was damaged in an accident.

Some insurers have also been seriously bothered by teenage daredevils with passions for drag racing. In contrast to the classic game of chicken, in which the winner's rewards consist of bragging rights and the continued use of all four limbs, today's victorious street racers often take home a customized part of losers' cars as their trophies. For the hotshot driver who treats each one of his car's bells and whistles as if they were his children, the loss of a race and, therefore, a prized accessory can seem unbearable. In order to compensate for these losses, some racers tell police officers and insurance companies that their vehicles and accessories were stolen, vandalized or damaged in a legitimate accident rather than gambled away or wrecked in a contest.

Red Flags and Auto Insurance Fraud

Of course, if an insurance producer only had to memorize a few red flags in order to put a stop to fraudulent claims, insurance fraud would not be much of an important subject for continuing education. In terms of auto fraud, as well as fraud in connection with other coverage, the developers of this course do not naively believe that the general tips found in this chapter can end fraud. Yet for nearly every section of the industry, there are a handful of common-sense red flags that can at least help professionals minimize such crime.

Before you even begin scrutinizing a particular claim for hints of fraud, you should realize that many successful perpetrators do not just become involved with a single scam. Many of them have committed fraud before.

For this reason, you might find it helpful to view information about a potential fraud as if it were only one piece of a puzzle. Something might appear innocent within the context of a single claim but might not when viewed with the other claims the person has filed. One claim might lead you to investigate another, which might then make you want to review the person's application. Little discrepancies might convince you that digging for more facts to unearth the truth is worth the effort.

To guard against fraud rings, insurance professionals should take note of doctors and lawyers who seem to be involved in an unusually large number of accident cases. Does one doctor typically diagnose patients only with those soft-tissue ailments mentioned earlier, such as back pain and headaches that are difficult to disprove? Do many of the doctor's referrals come to him or her via a lawyer?

Similar advice applies to the people directly involved in auto accidents. Members of a fraud ring often switch roles from one accident to the next. A driver in one crash could be a passenger in another crash. If someone has been listed as a driver or passenger in several accidents, insurance professionals might want to examine the circumstances of each event in order to discover any suspicious similarities. Looking into claims involving people with similar names is also helpful.

Sometimes criminals are easier to spot from the start, and the investigator needs to do less digging to find the truth. Alarm bells should automatically go off when a person claims to have lost control of a car in the rain when there have been no recent reports of rain in the area. Again, odd circumstances do not prove fraud. Maybe it did rain in the driver's neighborhood but not near yours. But such odd circumstances should absolutely force all employees who are working on questionable claims to use their heads and be alert to the possibility of fraud.

Medical Insurance Fraud

The majority of this chapter focuses on insurance fraud committed by policyholders. Agents and brokers who provide health coverage could certainly create a decent-sized list of this kind of activity. That list might include instances of patients abusing prescription drug plans by forging doctors' signatures and placing orders for medicines at multiple pharmacies. Perhaps that list would also include policyholders who mark former spouses on their health plans as dependents.

But according to a study reported by the Journal of the American Society of CLU & ChFC (a financial industries trade publication), health care providers are more likely to commit insurance fraud than patients. On one hand, this makes sense, given the managed care systems in the United States, where many policyholders pay a small fee when visiting a physician and let the provider deal with the necessary claim forms. Because the contact between physician and insurer drastically exceeds the contact between patient and insurer, there is a larger window open for the physician to commit fraud as opposed to the patient. Even if patients receive regular statements from their insurance company about approved benefits and rendered services, they are unlikely to examine their records for billing errors made by a physician unless they have a problem with how much they, themselves, must pay to the provider.

Still, the many documented cases of fraud committed by health care providers may be difficult for insurers to stomach considering the mutually beneficial relationship that

ought to exist between the insurance and medical professions. If people did not put a premium on health care for themselves and their loved ones, consumers would have little reason to buy health insurance, and if insurance companies did not exist, physicians would struggle to secure payment for their services and would almost certainly need to more actively market themselves in order to attract a desired number of patients.

Deep down, health care providers and insurers probably understand that they need each other to survive. However, the relationship between the two professional groups has always been a seemingly begrudging one at best. From some doctors' perspectives, insurance companies have been stubbornly tight with money and intrusive when it comes to treatment issues. Good doctors want to be compensated fairly for their services and wish they had the freedom to serve patients without an insurer telling them a patient does not need a particular medicine or surgical procedure. Meanwhile, a good insurer wants to be certain that physicians are not violating the trust the company has given them by demanding payment for services not rendered.

More so than any other topic discussed in this chapter, medical insurance fraud refuses to allow us to stereotype perpetrators as unethical under all circumstances. Sometimes this kind of fraud seems to operate in a stubborn cycle. In order to provide patients with the best care possible and to ensure that they receive payment for providing this care, physicians might deem it necessary to make an adjustment to a claim. At the same time, insurers realize physicians are distorting claims, thereby cheating the system, and the insurance companies react by getting tougher on health care providers and patients and being even more strict about what their policies will and will not cover.

With each side adjusting to the other's new positions, questions must be addressed by compassionate and fair insurers, as well as compassionate and fair doctors. Professional insurers must ask themselves if they have reached a point where their anti-fraud efforts, which take power away from physicians and reduce the number of affordable treatment options for patients, are actually encouraging health care providers to commit more fraud. Do some insurers enforce such strict rules when managing health care that sometimes the only option for a doctor with a sick patient is to break those rules?

Meanwhile, medical professionals must ask themselves how they can justify fraud for the good of a patient today if their actions will almost certainly force insurance companies to become even more involved in treatment issues tomorrow. They must understand that insurers have justifiable reasons to protect themselves from fraud and that even though there are many good and fair doctors in the system, there are also some bad and selfish practitioners whose frauds have nothing to do with what is best for patients. If insurance companies do not stand up to these unethical doctors by tightening their overall hold on health management, all insureds might suffer the consequences.

Examples of Medical Insurance Fraud

Perhaps the most indefensible forms of medical insurance fraud are those that cheat patients along with insurers. Suppose Mary injures her back and goes to a clinic that she assumes employs specialists who can treat her condition. This is a very busy clinic,

but with one look inside, Mary senses something is different about it. As she observes others and goes through her own appointment, she thinks, “This is the fast-food, assembly-line version of health care.” The employees engage no one in conversation and have an unstated yet still obvious agenda that involves getting patients in and out the door as quickly as possible.

A woman who looks like a nurse runs through some standard procedures, taking Mary’s temperature and checking her weight. Mary tries to go into detail about exactly where and when her back hurts, but the nurse seems focused on something else, looking at the clipboard filled with Mary’s insurance information and not looking up or taking notes. The nurse rushes Mary into a back room filled with bubbling hot tubs like those Mary has seen in spa brochures. She tells Mary to get in, leaves her there for 15 minutes and returns to get her out of the tub and to schedule a follow-up appointment.

Two weeks later, Mary receives a statement from her insurance company regarding her trip to the clinic. She expects trouble, believing there is no way on earth her insurer is going to cover a quarter-hour soak in a whirlpool. But to her surprise, she owes nothing. However, the insurer has paid for some tests Mary does not remember having done and is also paying the clinic a few hundred dollars for some muscle therapy she has never heard of. Mary tosses the statement in a drawer, winces again as she rubs her back and decides to contact a certified medical doctor who might be better equipped to help her manage her pain.

The details in that example were contrived for simplicity and clarity’s sake, but the story’s general outline is based on numerous examples of seedy medical operations that have successfully bilked millions of dollars out of insurance companies by charging them for bogus procedures at phony clinics. As reported by the Wall Street Journal and other news outlets, the state of Florida recognized the serious problems caused by these insurance schemes and took it upon itself to expose the people behind them. Inspectors discovered rudimentary setups, some under the supervision of a licensed physician and others operating thanks to a stolen doctor’s billing number. In many cases, the lax attention these clinics received from regulators, as well as the pressure on insurers to pay claims quickly, allowed crooks to reap large profits. By the time investigators received a tip about a suspicious clinic, there was already a good chance the operation had packed up and reopened elsewhere, and the money for the phony treatments had already been doled out by the insurance companies.

Other medical insurance scams involve purely selfish motives of patients as well as physicians. In a scheme known as “Rent-a-Patient,” doctors appeal to policyholders’ desperation or greed by rewarding them for undergoing pointless medical procedures. A patient might receive the nose job he or she always wanted with the understanding that the surgeon will bill the insurer for necessary surgery as opposed to a cosmetic operation. Sometimes patients are paid in cash for acting as guinea pigs. In an absurd travel promotion, as reported by Knight Ridder Tribune Business News, some 1,800 Utah residents were involved in a scam in which policyholders received an all-expenses-paid trip to California in return for undergoing colonoscopies. Insurers in Utah said total claims from the venture amounted to $27 million.

Detecting Medical Insurance Fraud

Claims departments and investigative teams can sometimes spot medical insurance fraud merely by looking at a situation and applying some common sense to it. One doctor obviously could have benefited from a crash course in mathematics and personal stamina when he claimed to treat 200 patients a day.

To catch potential fraud that is not so obvious, many medical insurance companies have utilized software that scrutinizes doctors' billing practices and alters questionable bills automatically.

Workers Compensation and Disability Insurance Fraud

Workers compensation fraud, which National Underwriter once estimated at costing insurers $5 billion each year, is yet another complex crime that professional insurers ought to examine from various angles.

Stereotypically, this type of fraud brings lazy employees to mind who either stage accidents or fake injuries in order to avoid going to work. But stopping there and only noting that aspect of the issue would be detrimental to the insurance community and unfair to the many hardworking people who deserve financial assistance when their jobs take dangerous turns.

From an insurance perspective, workers compensation fraud is as much an employer problem as it is an employee problem, with many companies actively deceiving insurers to obtain coverage and discouraging injured laborers from claiming the benefits rightfully owed to them.

Before we examine some of the more complex sides of these crimes, let's start comfortably by exploring the stereotypical employee fraud that most people associate with workers compensation and highlight some red flags that might help employers and insurance professionals detect it.

If a workers compensation claim doesn't seem to make sense, it is more than likely that some kind of investigative team will be called in to handle the situation. Sometimes insurance companies employ their own teams, and sometimes employers or insurance companies outsource the work to private investigators.

All witnesses to an accident should be interviewed as soon as possible so that their recollections can either confirm or contradict the injured person's story. If an employer can only provide vague reports of an incident, the investigator's job becomes tougher, and an accusation of fraud could unfortunately boil down to nothing more than one person's word against another's.

An employee's status with a company can hint at the truth surrounding an accident. If an organization has announced layoffs, a person who believes he or she will soon be one of those laid off might panic and turn to workers compensation fraud.

Coworkers are important sources of information in these situations because they might have been the audience for an injured person's thoughts. Or, in a more optimistic outcome, they might be able to assure doubters that the person was a dedicated employee who would probably not engage in serious deceit. Temporary employees and

new hires who make workers compensation claims often arouse some suspicion because their coworkers have not known them long enough to vouch for their character.

Accidents involving no witnesses are obvious causes for concern. This is especially the case when they occur on Monday mornings, since some workers might try to make their employer responsible for injuries they actually suffered on weekends. These employees will seem even less credible if they have reputations around the office as athletes, physical risk-takers or avid outdoorsmen.

Once the worker is out of the office, investigative teams can observe the person from afar. If the employee has a second job, a team might visit the second workplace to see if the injured person shows up for duty. Sometimes teams catch an allegedly disabled person moving heavy furniture, playing an aggressive game of softball or taking part in other strenuous activities that seem to contradict an injury claim.

When these significant discoveries are made, they may lead to a claim being denied, thereby saving the insurer and employer money. In some cases, however, these seemingly defenseless exhibitions of physical strength are not clean-cut examples of people getting caught in a lie. Some injured parties have successfully argued that an investigator merely observed them on one of their better days or did not take note of the many hours they spent recovering from the heavy lifting or the softball game. As weak as those lines of defense may seem, most professional fraud investigators attempt to strengthen their cases against supposed insurance cheaters by documenting an extensive pattern of suspicious activity before challenging a claim.

Red flags also fly when people injure themselves at work despite having a reasonably safe job. Though freak accidents do occur, an employer or an insurer might wonder, for example, why a receptionist or clerical employee has filed for workers compensation benefits twice in the past five years.

In more perilous lines of work, however, fraud detection can seem insurmountably difficult. Consider, if you will, the construction industry. Here is a field packed with physical risks and destined to produce a relatively high amount of legitimate disability claims. Construction workers undoubtedly realize this, and some of the dishonest ones might try to commit fraud.

Like medical insurers, those professionals who offer workers compensation policies to high-risk businesses can sometimes feel ethically torn. They are smart enough to know that some people are engaging in fraud, yet greater scrutiny of claims could inadvertently clog the flow of benefits to deserving recipients and make insurers seem guilty of unethical conduct.

Logic suggests that because people who own construction companies will likely pay a large premium for workers compensation coverage, these employers should be just as serious about fraud prevention as insurers. Undoubtedly, many business owners subscribe to this ethical attitude. But too many others focus on the price of workers compensation coverage and believe that cheating insurers and employees out of money and benefits is the best way to keep premiums down.

Though individual insurers may differ in how they underwrite workers compensation, they generally base their decisions about these policies on the number, salaries and job

duties of the employees who will be covered by a policy. High-risk business owners have been known to misrepresent all of those factors when applying for coverage. Rather than listing their entire workforce on a payroll, a construction company might pay some laborers either partially or entirely under the table. Instead of listing employees properly as roofers, a company might put them in a comparatively safer category, such as general carpentry. These examples nearly mirror a real development, covered by the San Diego Business Journal, in which six construction companies were charged with defrauding several area insurers out of $5.5 million.

Life Insurance Fraud

Life insurance fraud has probably been around as long as insurance itself. History tells us, for example, that two women were hanged in 1884 by authorities in Liverpool, England, for allegedly poisoning men in order to collect beneficiary payments. Yet despite its extensive history, this brand of fraud is still an understandably delicate issue. Imagine your spouse or someone else close to you has just died and someone from an insurance company insinuates that you may be guilty of faking the death or even murdering your loved companion for an insurance check. Most insurers don't want to be seen as heartless and are willing to accept a minimal amount of fraud to avoid this kind of perception from the public.

This type of fraud intrigues us, maybe because many of the related scams seem like storylines from crime novels. Still, these frauds can also make us furious for reasons that have nothing to do with stealing from insurance companies and everything to do with using other people as pawns in selfish games of life and death.

Before discussing specific examples, we will first examine life insurance fraud at its lightest level; light only in the sense that even though money might be stolen from an insurance company, the perpetrator's selfishness does not extend to the physical endangerment of innocent people.

The more intricate life insurance fraud schemes in the United States tend to involve relatively small policies from several companies. Utilizing small policies for these deceptions serves two purposes. First, it allows the criminals to maximize coverage without seeming suspicious to any one insurer. Secondly, because smaller policies are less likely to require physical examinations from policyholders, it gives perpetrators the occasional option of taking out policies on unsuspecting individuals.

Once the policy has been in effect for a reasonable amount of time, the thief tries to secure a falsified death certificate in the insured's name. In one of the more elaborate frauds to attract media attention, this step in the scheme process was completed by a ring-leading funeral director who shared in the insurance payouts. In another case, a woman merely photocopied her deceased first husband's certificate and doctored it so that her living husband was listed.

Arguably the most darkly amusing examples of attempted life insurance fraud are those in which one spouse runs a scam while the other spouse remains completely oblivious to it. The clueless husbands and wives get up every morning, kiss their partners goodbye, go to work and come back home to their companions, all the while not realizing that, at least as far as an insurance company is concerned, they are supposed to be dead. Investigators arriving at homes of alleged widows to discuss beneficiary

issues have been greeted at the door by some understandably confused yet very much alive husbands. One woman, profiled in Forbes magazine, could not understand why her allegedly deceased husband got so upset at her for faking his death without even telling him first.

“He’s such a jerk,” she said in prison. “If it weren’t for him, I wouldn’t be in here.”

Life Insurance Fraud Overseas

People intent on faking someone’s death in order to collect life insurance benefits have had greater success when they have used foreign settings in their stories. A husband might claim, for example, that his wife traveled to Central America and died there.

Cultural and political factors are keys to making these scams work. In some parts of Mexico, for instance, autopsies are not as common as they are in the United States. This would prevent insurers from routinely verifying deaths by matching a body’s fingerprints to those of the policyholder. Deaths are even tougher to prove when they occur in Third World countries where recordkeeping systems are basic at best and, therefore, more easily corruptible. Political strife also hinders fraud prevention, particularly when civil wars claim so many casualties that authorities cannot accurately document all deaths.

Property Insurance Fraud

Property insurance fraud often involves expensive items such as jewelry and paintings. Many companies who insure these items can link fraud cases to the appraisal process. An applicant might purchase a phony gemstone, purposely submit fraudulent valuations to the insurer and buy coverage for thousands of dollars above the item’s actual worth. Eventually, the consumer will call the insurance company and report the stone stolen or severely damaged.

Suppose Jane spots a diamond for sale by a jeweler for $5,000. She pays the price gladly, and why not? The jeweler has appraised the stone at an even $6,500, and Jane figures she can eventually make a nice profit from her purchase. The jeweler gives her receipts and other necessary forms documenting the diamond’s value, and she is able to insure her find for the full $6,500.

Jane has a friend who knows a thing or two about valuable jewelry, and she cannot resist showing her the diamond, expecting her friend to congratulate her for spotting such a fine specimen. But instead of patting her on the back, the friend tells Jane the diamond is worth a couple hundred dollars at most.

For obvious reasons, this news upsets Jane greatly. She becomes instantly mad at the jeweler for conning her and mad at herself for believing a deal that was too good to be true. Jane could sue the jeweler for blatantly lying to her and giving her false documentation of the jewel’s worth, but after thinking it over, she realizes, with all the time and money she would probably spend on a lawyer and a potential court proceeding, she would be lucky if she got half of her money back from the crook. On the other hand, she still has the insurance policy for $6,500. Maybe if she tells a few lies or stages a burglary, she can file a claim and be done with the embarrassing mess.

Even in less extreme situations, buyers and insurers ought to know that some sellers will distort the value of expensive personal property. After all, the seller wants a

customer to believe he or she has gotten a great deal and that the item sold is worth much more to the consumer than what he or she has paid for it. For this reason, even when an applicant appears to be requesting coverage in good faith, it is often wise for an insurance company to obtain an appraisal from an unbiased third party. Along with serving the insurer's best interests, this practice can also help the consumer by either confirming an item's value or alerting the buyer to potential fraud.

Property insurance fraud might also involve arson. Fraud in connection with arson seems to be one of the most difficult insurance crimes to prevent, but industry professionals can still rely on some of the general red flags discussed earlier in this text. Does the applicant seem overwhelmed with debt? Does the applicant appear anxious to buy excessive coverage for a building without considering the cost? Does the applicant have any history of fraud?

Conclusion

As easy as it is to view fraud prevention as something the claims department should handle, the customer probably does not have a trusting relationship with his or her claims adjuster. Nor is the person likely to have a trusting relationship with the top-level insurance executives or trade groups that have traditionally been the ones to make the case for greater fraud awareness. If the industry wants to reach its customers and convince them that insurance fraud is a problem worth tackling, agents and brokers might be its best messengers.

CHAPTER 2: AUTO INSURANCE

At some point, every driver, regardless of skill or fault, will be involved in an auto accident. According to the American Automobile Association, a driver is almost involved in an auto accident every few months and, on average, is actually involved in one every six years. Out of those accidents, according to 2005 figures from the Insurance Research Council, roughly one-quarter of them result in bodily injury for which another driver is liable. The National Highway Safety Council and the Wall Street Journal reported that auto accidents caused more than 2 million injuries and 41,000 deaths in 2007.

Mandatory or not, auto insurance can help people recover financially from accidents. And perhaps just as importantly, it can provide financial assistance to victims who are physically harmed by a driver's mistakes.

Personal Auto Policies

The most common auto insurance policy is the Personal Auto Policy, which was crafted by the Insurance Services Office in the 1970s and has been revised on several occasions. The policy was designed for private passenger vehicles (as opposed to business vehicles) and generally provides four kinds of coverage:

- Liability coverage.
- Medical payments coverage.
- Uninsured motorists coverage.
- Coverage for the policyholder's own car.

Although each auto insurance policy has the potential to be different from all the others, mastering the contents of the Personal Auto Policy will help you answer common questions from motorists and make it easier for you to assess people's insurance needs.

Liability Coverage

When an auto accident occurs, an insurance company or a court will use common legal standards and state laws to determine who was at fault. When drivers are found to be at fault for an accident, damages are meant to be covered by their liability insurance.

Auto liability insurance covers motorists when they cause another person to suffer bodily injury or property damage. The term "bodily injury" can mean any harm to a person's body, including harm that involves an illness or causes death. "Property damage" usually involves harm to a person's vehicle, but it can also mean harm to other property, such as a house, a tree or items stored in a car.

The liability portion of an auto insurance policy does not compensate at-fault drivers for their own losses. Rather, it only provides money to other people who are harmed by a liable person's driving activities. Coverage for an at-fault driver's own losses is provided in other parts of the policy.

The maximum amount of money an insurance company will pay on account of liability is listed on the policy's declarations page. The limit might be listed as a single dollar amount or as three separate dollar amounts. When the limit is listed in three amounts, the policy is considered to have a "split limit."

A policy with a split limit gives the insured different amounts of liability coverage, with each amount depending on the kind of loss and the number of people who experience that loss. The three different kinds of limits are as follows:

- A limit for all bodily injuries sustained by one person.
- A limit for all bodily injuries sustained in a single accident, regardless of the number of people.
- A limit for all property damage that occurs in a single accident, regardless of the number of people.

To demonstrate how split-limit policies work, let's imagine that Joe has auto liability insurance with a $15,000 per-person limit for bodily injury and a $30,000 per-accident limit for bodily injury. Now suppose Joe causes an accident that results in $30,000 of medical expenses for the other driver. Even though Joe's per-accident limit is $30,000, the fact that his per-person limit is $15,000 means his insurance will cover only half of the victim's expenses in this case. The rest will have to be paid out of Joe's own pocket.

Split-limit policies exist because many states do not make drivers purchase equal amounts of bodily injury liability coverage and property damage liability coverage. Therefore, split-limit policies allow drivers to use their cars without having to purchase coverage that isn't legally necessary.

Still, whether it's accomplished through a split-limit policy or not, drivers might be interested in purchasing more liability insurance than is mandated by law. Since medical expenses and awards for pain and suffering can be so unpredictable, consumer

advocates often suggest that driver's purchase liability insurance in an amount equal to the value of their personal assets. Drivers who don't own much but still want to be in a position to fully compensate accident victims will also want to buy extra protection.

Consumers can often opt out of purchasing many major kinds of coverage that are contained in an auto insurance policy, but liability insurance is generally the exception. In most states, people are not allowed to own a vehicle unless they have an acceptable amount of liability protection.

Who's Covered and in Which Cars?

One of the most important things to realize about auto liability insurance is that it doesn't just cover the driver who purchases it. With a few exceptions, the liability protection can apply to accidents caused by the policy's owner or any family members who live with that person. In most auto policies, the term "family member" refers to people who are related to the policy's owner by blood, marriage or adoption. In practice, the term even encompasses unlicensed family members who are too young to drive. People besides family members are covered, too, if they are driving the person's car with permission.

Drivers should also understand that their auto liability insurance extends to cars other than their own. If they borrow a friend's car, their own liability insurance can help pay for damages they cause while driving it. However, coverage beyond their own car generally does not extend to cases in which they are driving a vehicle that is readily available to them on a regular basis, such as a company car.

Liability protection for non-family members (as well as family members who do not live with the policyholder) does not apply if they are driving a vehicle that does not belong to the policyholder. Insurance also rarely offers any help to family members who live with the policyholder but get into accidents in their own cars.

Determining who can be covered under the liability section of an auto insurance policy can be a challenge. Therefore, it may be helpful to go over a few examples. If you have a personal auto policy, here are some hypothetical cases in which your liability insurance is likely to provide at least some financial assistance:

- You hit another vehicle while driving your car.
- Your spouse hits a pedestrian while driving your car.
- Your sister, who lives with you, borrows your car while hers is being repaired and crashes into your neighbor's fence.
- You run over another person's dog while driving a rental car.
- Your friend borrows your car and injures a bicyclist.

On the other hand, here are some examples in which your auto liability insurance probably wouldn't be of much help:

- You injure someone while driving a company car that is frequently available to you.
- Your son, who doesn't live with you, purchases his own car and causes an accident with it.
- A thief steals your car and hits a pedestrian while making his getaway.

- Your roommate rents a car and crashes into your neighbor's tree.

Please note that although auto insurance policies can cover a driver's family members, policyholders may have to inform the insurance company ahead of time about any household family member who will have regular access to their car. Parents, in particular, will want to check in with their auto insurer before giving their children the keys to the family car. At the very least, the policyholder may be required to update the insurer about the number of licensed drivers in a household before the policy is renewed.

Medical Payments Coverage

Medical payments coverage is probably one of the least understood parts of a personal auto insurance policy. In fact, many motorists may not even know they have it.

If you have medical payments coverage, this insurance can be utilized when you, a family member or anyone else who is riding in or driving your car is injured in an accident. Regardless of who is at fault, this coverage is not for the other driver in an accident or for that driver's passengers. Medical payments for the other driver and people riding with that person are meant to be covered by either your liability insurance or the other driver's medical payments coverage.

Medical payments coverage provides a few thousand dollars or more on a per-person, per-accident basis. The money can be used to pay for all reasonable medical or funeral expenses that are related to an auto accident and are incurred within three years of the accident. It does not compensate anyone for pain and suffering.

This traditional form of medical payments coverage usually does not exist in states governed by no-fault insurance laws. Instead, policies in those states are likely to provide "personal injury protection" (PIP). PIP is very similar to medical payments coverage but can usually reimburse people for expenses besides medical ones. With PIP, injured motorists might be covered for non-medical household assistance while recovering from an accident, and they might receive payments for lost wages.

Who's Covered Where?

As is the case with auto liability insurance, eligibility for medical payments coverage under an auto insurance policy will depend on who the injured person is and where the injury occurs.

Coverage is broadest for the policyholder and the family members who live with that person. With a few exceptions, these people can receive medical payments whenever they are hurt by a vehicle. This includes instances in which they are driving a car, riding as a passenger in a car, sitting in a parked car or hit by a car while traveling on foot.

People besides those family members can receive medical payments through the policyholder's insurance policy if they are injured while in that person's vehicle. This includes when they are driving it, riding in it or just sitting in it. They are not covered by the policyholder's insurance while in someone else's car or on foot.

Uninsured Motorists Coverage

Whether we like it or not, there will always be people who believe the law does not apply to them and who will drive without liability insurance. Whereas the rate of

uninsured motorists in Massachusetts is near just 1 percent, more than half of drivers in Detroit are without coverage, according to a 2008 report by the Michigan Chronicle. Nationwide statistics from the Insurance Information Institute show 14 percent of drivers lacked insurance in 2007.

So what can people do if an uninsured driver hits them? They could, of course, sue the person. But that would probably involve finding a lawyer and rearranging their lives around court dates and other hassles. And even if they take legal action, victims might discover that the at-fault driver lacks enough personal assets to pay for damages in the first place.

A portion of an auto policy known as "uninsured motorists coverage" can help in situations like this one. It makes up for the liability coverage the other driver failed to purchase and can compensate victims for bodily injuries, pain, suffering, and (in some cases) property damage. It doesn't let the at-fault driver off the hook, but it gives injured people the money they need with a minimal amount of effort and frees their insurer to take action against the negligent motorist.

Auto insurers provide these benefits if any of the following circumstances arise:

- The policyholder is hit by someone who has no insurance.
- The policyholder is hit by someone who has less insurance than the law requires.
- The policyholder is the victim of a hit-and-run accident.
- The policyholder is hit by someone whose insurer becomes insolvent.

Uninsured motorists coverage is limited to a certain amount per person, per accident. By default, the benefit limit might be equal to the minimum amount of liability coverage that the other driver was required to buy. But drivers often have the option of raising the limit if they're willing to pay more in premiums. Some states require that insurers provide uninsured motorists coverage equal to a victim's own liability coverage.

Overall, the kinds of people and the situations that would be covered under the medical payments portion of an auto policy would also be protected by uninsured motorists coverage. If the policyholder or that person's family members are hurt by an uninsured vehicle while in any car or while on foot, they'll probably receive some insurance money. Non-family members (and family members who don't live with the policyholder) are also eligible for these benefits if they are hit while in the policyholder's car.

Uninsured motorists coverage is mandatory in about half of the country, and most states at least force insurers to offer it. Historically, those mandates have been restricted to bodily injury coverage, but coverage for property damage has become more popular over the last few decades.

Underinsured Motorists Coverage

A somewhat similar policy feature known as "underinsured motorists coverage" can help when an at-fault driver has the required minimum amount of liability coverage but still lacks enough to fully compensate a victim. When this coverage is purchased, the victim may be entitled to the difference between his or her losses and the other driver's liability limit.

For example, let's assume George has $100,000 of underinsured motorists coverage and gets into an accident that costs him $70,000 in medical services. The at-fault driver has complied with the law by purchasing $30,000 of liability insurance for bodily injuries, but this person obviously does not have enough to pay for all of George's medical bills. In this case, the other driver would pay his full $30,000 to George, and George's underinsured motorists coverage would handle the additional $40,000 (the difference between George's loss and the other driver's liability limit).

Although our example might make underinsured motorists coverage seem very simple, some important conditions must be met for the insurance to work. Most significantly, the victim's limit for underinsured motorists coverage usually must be greater than the at-fault driver's liability limit. If the victim has $100,000 in underinsured motorists coverage and the at-fault driver has $100,000 in liability coverage, this part of the victim's policy is likely to be irrelevant. Also, depending on the policy, underinsured motorists coverage might need to be equal to uninsured motorists coverage.

In most states, underinsured motorists coverage must be offered to all policyholders. However, in nearly every part of the country, drivers have the right to reject it. A few states only require that underinsured motorist coverage be included if the policyholder has also purchased a certain amount of uninsured motorist coverage.

Coverage for Your Own Car

In addition to providing important liability protection, auto insurance policies can cover damage to a driver's own car. Like the medical payments coverage mentioned earlier, this insurance can reimburse drivers regardless of who is responsible for an accident. If the policyholder files a property insurance claim for damage to his or her vehicle and the other driver was at fault, the policyholder's insurer can pay the claim and take actions against the other driver to get its money back.

Property insurance for a driver's own car comes in two varieties. "Collision coverage" pays for damage from crashes. "Comprehensive" (or "other-than-collision") coverage protects the policyholder financially from many other perils, including theft and fire.

These two kinds of protection can be purchased individually or together. When both are in effect, a car is generally insured against most risks other than some tire damage, war-related losses, wear and tear and freezing.

Unlike other portions of the typical auto policy, insurance for a driver's car usually calls for a deductible, which must be paid by the policyholder whenever an accident occurs. If multiple cars are involved in the same accident and are covered by the same policy, the deductible only needs to be paid once. If the insurance company takes action against the other driver and wins, the deductible will usually be refunded to the policyholder.

Unlike liability insurance, property insurance on a driver's own car is usually optional. In fact, many of the low auto rates advertised online and on television are quoted under the assumption that the customer will not insure his or her own vehicle against theft or property damage.

Opting against property insurance for their own car does not prevent drivers from collecting from an at-fault driver's policy. However, it does bar them from receiving compensation for property damage if their car is damaged through no fault of another

person. For instance, they would not be covered for repairs if they rear-end another car while following it too closely, and they probably wouldn't be compensated for their losses after skidding into a ditch or hitting a deer.

Collision Coverage

As you can probably tell from its name, "collision coverage" is for damage that is sustained when a car collides with another object. Of course, the most obvious kind of object in this case would be another vehicle, but other kinds of crashes are covered, too. For instance, this insurance is likely to come into play when a driver hits a tree or crashes into a telephone pole.

We tend to think of car crashes in terms of two or more vehicles being in motion at the same time, but collision coverage can still apply while a vehicle is stationary. If someone opens a car door in traffic and has it knocked off by another vehicle, a collision has taken place. The same is true when someone hits a parked car.

Practically the only thing a driver can hit and not have the situation count as a collision is an animal. Collisions with deer and other living things are addressed through comprehensive coverage.

Comprehensive/Other-Than-Collision Coverage

"Comprehensive coverage" (now often referred to as "other-than-collision coverage") tends to be cheaper than collision insurance and protects the driver against more perils. Generally speaking, comprehensive insurance is designed to cover the driver against most major risks other than collisions. Drivers who purchase this insurance are typically insured against the following causes of loss:

- Theft (including property damage caused by thieves).
- Fire.
- Falling objects.
- Missiles.
- Explosions.
- Earthquakes.
- Wind.
- Hail.
- Floods.
- Vandalism or malicious mischief.
- Riots or civil commotions.
- Collisions with animals and birds.
- Broken glass.

Actual Cash Value

If something destroys a car, the owner's insurance company is nearly guaranteed to not cover the cost of a brand-new replacement vehicle. Instead, the car is probably covered up to its "actual cash value."

An item's actual cash value is its replacement cost minus depreciation. Since cars depreciate as soon as they're purchased, a vehicle's actual cash value might be significantly smaller than the owner realizes.

When a car is damaged, the owner's insurance company is expected to pay the cost to repair the vehicle, the cost to replace the vehicle or the vehicle's actual cash value. If these amounts are not equal (and they rarely are), the owner will receive the lowest of the three amounts.

Due to the rapid rate of depreciation, the cost of repairing a vehicle might be higher than the car's actual cash value. When this happens, the car is considered to be a total loss ("totaled") even if it is technically still in drivable condition. Instead of repairing it, the insurer will pay the owner the actual cash value.

Driving Other People's Cars

As you already know, drivers remain insured while driving other people's cars with their permission. If a driver is involved in an accident while operating someone else's vehicle, the owner's insurance will usually pay for damages first. The driver's insurance will pick up whatever losses are above the owner's policy limits.

If drivers are involved in an accident while driving a vehicle that is not theirs but is regularly available to them (such as a company car), their auto insurer will probably not cover the losses. However, they still remain insured while driving a vehicle that is regularly available and owned by a household family member. So if spouses have separate auto insurance policies, they can borrow each other's cars without having to worry about being covered.

Rental Cars

Many travelers are unsure about whether they should purchase insurance from rental car companies. The decision to buy or not to buy the coverage is often made at the last minute, with some people choosing to leave themselves unprotected from major risks and others paying large sums of money for something they don't really need.

Whether coverage is purchased or not, drivers should definitely consider the risks involved with rented vehicles. If someone has an accident with one of its cars, the rental company might be able to hold the person liable for all the damages regardless of who was at fault. Along with having to pay for another person's injuries and damage to any vehicles involved, the renter can even be held accountable for loss-of-use costs if the accident leaves the rental company without enough cars to meet customer demand. (It should be noted, however, that some states have passed laws that limit a person's liability while operating rented vehicles.)

Many of these risks can be managed by purchasing a "collision-damage waiver" (also known as a "loss-damage waiver") from the rental company. But such waivers might not always be helpful. For example, some waivers still leave renters liable for damages if they let a companion take the wheel or drive the rental car through rough road conditions. The waivers are also relatively expensive. If drivers buy all the insurance presented to them by the rental company, they might end up paying more for coverage than for use of the vehicle.

Before purchasing a waiver, drivers might want to see if the risks of renting a car are covered by other insurance. If they have a personal auto policy, they are usually already covered for liability while operating a rental car. Most kinds of damage to the car will be covered, too, if renters have collision coverage and comprehensive coverage for their own vehicles. Bodily injuries that drivers suffer in an accident will fall under their auto policy's medical payments coverage, and homeowners or renters insurance should cover any belongings damaged in the car.

Once drivers know how their own insurer treats rental cars, they can contact their credit card company and inquire about any additional protection. Most card companies provide free insurance for rental cars if the driver's own policy is insufficient. Of course, in order to receive insurance benefits from a particular creditor, the driver must pay for the rental with the appropriate credit card.

Business Vehicles

Personal auto policies are meant to cover people's personal vehicles. Coverage for automobiles that are used in business is either excluded from these policies outright or is only provided on a limited basis.

Admittedly, some circumstances that are indirectly related to business are not excluded under most policies. Driving to and from work is generally not considered a business activity, so a driver remains covered by his or her own policy while performing those tasks. Similarly, it is possible for an employee to remain covered by a personal auto policy while running an errand for an employer in his or her own car.

Still, there are plenty of business-related exclusions that ought to be mentioned here. To manage these risks and avoid confusion, people who use their cars in business may want to purchase a commercial auto policy:

- Vehicles owned by a company or some other business-related entity (other than an automobile from a rental company) are usually not covered by a personal auto policy if they are regularly available to an employee.
- Drivers are not covered while using their personal auto to carry people or things for a fee. (For example, this exclusion has been known to cause problems for drivers who use their personal vehicle to deliver food.)
- A personal auto policy doesn't cover liability while a car is being operated by someone in the course of auto-related business. (For example, a mechanic probably isn't covered while road-testing a vehicle, and a valet might not be covered while parking a car.)

For specifics about business auto coverage, you may want to review the ISO's Business Auto Coverage Form.

Conclusion

Though car owners generally know they must purchase auto insurance, they are probably not aware of all the different ways it can help them manage the risks of the road. By studying and explaining the contents of a typical auto policy, you can get people to think about more than minimum legal requirements. You might even make it

possible for your customers to recover from the inevitable accident with a limited amount of loss and stress.

CHAPTER 3: UNDERSTANDING HEALTH INSURANCE REFORM

For more than 60 years, health care has towered over most other national issues in terms of its importance to voters and its attention from our representatives. Over that time, hardly anyone has argued that increasing access to insurance and reducing the cost of care aren't worthwhile goals. The never-ending debate has centered on how to achieve them.

Divided opinions couldn't stop the establishment of Medicare or the passage of insurance portability legislation like COBRA or HIPAA, but bolder plans for addressing costs and expanding coverage have had a tendency to die swiftly in Congress without becoming law. An exception to the rule, in spite of some ugly policy disagreements, was a package of reforms approved by the Senate, the House of Representatives and the Obama administration in March 2010.

The controversial reforms passed in 2010 were created through two new laws. The massive Patient Protection and Affordable Care Act details most of the alterations to the U.S. health care system. The comparatively brief Health Care and Education Reconciliation Act of 2010 contains many significant amendments to the larger law.

The reforms will be implemented in steps over a 10-year period and are expected to result in insurance for 32 million more people, bringing the rate of insured Americans up to approximately 94 percent. The non-partisan Congressional Budget Office originally estimated that reform (including modifications to the tax code) would cost $938 billion over the next decade and reduce the federal deficit by $124 billion over that period.

The true price tag and effectiveness of reform won't be known for several years, and you won't find any rosy or grim predictions in the rest of this material. While acknowledging that important changes are in store for consumers, employers and insurance companies, we'll keep our focus on the facts of the new laws and try to provide helpful, straightforward answers to the following questions:

- When do insurance companies need to comply with the new laws?
- Will people with pre-existing health problems be able to obtain insurance?
- Can young adults stay on their parents' health plan?
- Is everyone required to purchase insurance?
- Are employers required to insure their workforce?
- What's an "insurance exchange"?
- Do the new laws reduce benefits for people in Medicare?
- How will taxes change to help pay for all this?

Health care's complexity has created opportunities for people to misrepresent the answers to those questions for personal advantage. Just days after the new laws were passed, regulators warned that some salespersons were impersonating federal employees and conning people into buying bogus insurance products.

Though the government will need to clarify many aspects of reform in the years ahead, this guide will provide some basics that might protect you from misinformation. No

matter if you supported reform, opposed it or fell somewhere in between, we'll do our best to prepare you for the insurance-related changes you might see in your business and at home.

Changes for Individuals and Families

As a result of health care reform, many consumers will notice differences in the insurance made available to them. In general, new rules will be implemented to give unhealthy people easier ways of finding and keeping coverage.

In most cases, the rules will apply to health insurance in the individual market and to group plans that are either fully insured (with an employer purchasing coverage from an insurance company) or self-insured (with an employer paying for care out of its own funds). Variations of these rules existed in a few states prior to the new federal mandates, but they rarely impacted both markets and both kinds of group plans. The group market often had to abide by standards that the individual market could ignore, and fully insured plans faced far more state regulation than self-insured plans.

As we go through the reforms for the insurance market, you'll occasionally notice exemptions for "grandfathered plans." These exemptions are for individual and group health plans that already existed on March 23, 2010, and haven't undergone significant changes since then. As a rule of thumb, grandfathered plans might not need to follow the new rules calling for additional benefits. However, they usually need to follow the new rules regarding access to insurance.

In addition to the market reforms, individuals and families will eventually be responsible for maintaining a minimum level of health insurance for themselves or paying a penalty. We'll explain the major reforms and responsibilities in the next several sections, starting with the ones that began in 2010.

Ban on Rescissions

"Rescission" occurs when insurance is cancelled against the policyholder's will and treated as if it never existed. Insurers will sometimes rescind a policy if information on an application turns out to be false or incomplete.

Health insurance is now only rescindable under very limited circumstances. Essentially, an insurance company cannot void someone's coverage unless the person intentionally misrepresented information. No matter how much it conflicts with an insurer's underwriting guidelines, an innocent mistake on an application won't be grounds for rescission. There's no exemption to this provision for grandfathered plans.

Ban on Lifetime and Annual Benefit Caps

Individual and group plans are no longer allowed to impose a lifetime dollar limit on "essential health benefits." These benefits include the following kinds of care:

- Ambulatory services.
- Emergency services.
- Hospitalization services.
- Maternity care.
- Newborn care.
- Mental health care.

- Substance abuse services.
- Prescription drugs.
- Rehabilitation services and devices.
- Preventive care.
- Laboratory services.
- Pediatric services, including oral and vision care.

The ban on lifetime caps is accompanied by a ban on annual caps. Until 2014, plans are prohibited from placing an annual, dollar-based cap on essential health benefits unless the cap is above a preset minimum amount (initially $750,000 per person and rising in subsequent years). In 2014, annual caps on essential health benefits won't be allowed at all.

All grandfathered plans must adhere to the ban on lifetime caps. The ban on annual caps will apply to grandfathered group plans but not grandfathered individual plans. Until 2014, "limited benefit plans" or "mini-med plans," which are designed to cover a narrow range of services in exchange for low premiums, can ask the government for an exemption from the annual-cap requirement.

Preventive Care

One of the main assumptions made by proponents of reform is that health care will become more affordable if medical problems are addressed in their early stages. This line of reasoning is at least partially responsible for new requirements regarding preventive care.

Many vaccines, screenings and other preventive services now must be fully covered by health insurance. Patients can't be forced to pay deductibles, copayments or coinsurance fees for these services unless they receive them from outside their plan's network. (However, if a doctor bills separately for an office visit and for providing preventive care during an office visit, the patient might still need to pay deductibles, copayments or coinsurance fees for the office visit.)

Grandfathered plans don't need to comply with this requirement.

Ban on Pre-Existing Condition Exclusions for Children

Health insurance can be tough to find if you've been treated recently for a medical problem. If you're applying for coverage and were treated for a serious issue within the last few years, a plan in the individual market might refuse to cover you at all. If you've been sick within the past six months and apply for group coverage, the group plan can subject you to a waiting period before paying for any treatment relating to that ailment. For some group members, the waiting period for treatment of pre-existing health problems can last up to 18 months.

People who are 18 or younger can no longer be denied insurance because of a pre-existing health condition. Once they're accepted by a plan, there can't be any waiting period for benefits because of a pre-existing condition.

At the federal level, plans are allowed to limit open enrollment periods for children if those limits apply equally to ALL children. However, if a state has passed laws that require greater access to insurance, those rules must still be obeyed.

Although the requirement to cover children went into effect in 2010, this specific requirement doesn't extend to adults. It also doesn't stop insurers in the individual market from considering a child's health status when setting premiums. (In California, however, enrollment near a child's birthday will prevent the cost from exceeding twice the amount for a healthy child.) Separate requirements related to adults and premiums don't need to be met until 2014. Those requirements will be addressed later in this material.

Like the ban on caps, the requirement to insure children applies to grandfathered group plans but not grandfathered individual plans.

Dependent Coverage for Adult Children

As part of health care reform, adult children have the option of staying on their parents' plan at least until their 26th birthday. Some states had already extended coverage to young adults in their 20s, but the new federal rules offer flexibility in areas besides age. To qualify for inclusion on a parent's plan, adult children don't need to be students, don't need to live with a parent and don't need to be considered a dependent on a parent's tax returns. Children under 26 can even be married without losing their eligibility.

When adult children are accepted into a parent's plan, they must be treated like any other dependent. An insurer can't impose restrictions that only apply to this group of beneficiaries, and the amount charged for covering them can't be higher than for other dependents. For example, if a group plan charges a flat premium for covering an entire family, it can't add another charge specifically for adult children.

In spite of these potentially positive changes for consumers, the new requirement doesn't force a plan to cover adult children if the plan doesn't already accept other children. Nor does it extend insurance to a son or daughter's own children or spouse.

Grandfathered plans need to offer enrollment opportunities to adult children, but grandfathered groups are exempt until 2014 if a child has access to insurance through employment.

Expansion of High-Risk Pools

In 2014, it will be illegal for insurers in the individual market to discriminate against people on the basis of health. Until then, individuals who are too sick to find regular insurance will be able to obtain coverage through a high-risk pool.

The new high-risk pools are open to any citizen or legal immigrant who has a pre-existing condition and has gone without insurance for at least six months. (In most states, a written denial of insurance will serve as proof of a pre-existing condition. A person's medical records might also be used for this purpose.)

The pools aren't allowed to exclude coverage of pre-existing conditions or charge a person more because of poor health. Enrollees have a cap on their annual out-of-pocket expenses (roughly $6,000 to start), and premiums are based on the standard rate for non-group coverage in the area. People might pay more if they're older or smoke.

Federally standardized high-risk pools will be discontinued no later than January 1, 2014. After that, people who obtained insurance from the pools will be able to shop for a

plan in a health insurance exchange. We'll explain how the exchanges are expected to function later in this guide.

Regulation of Health Insurer Spending

Prior to reform, a few states already required that health plans spend a certain percentage of premium dollars on care rather than on administrative expenses. This percentage is known as a plan's "medical loss ratio."

For the year 2011 and beyond, health insurance companies have to report various pieces of data to the government for the purpose of calculating their medical loss ratio. Reporting needs to be done annually for each state where the insurer does business, and separate ratios must be calculated for the individual market, the small-group market and the large-group market. (For the purpose of calculating medical loss ratios, the small-group market is the market for insuring businesses with less than 100 employees. Until 2016, some states may define it as the market for insuring businesses with less than 50 employees.)

The new reforms require different medical loss ratios for different kinds of plans. In the individual and small-group market, insurers are required to spend at least 80 percent of premiums on care-related expenses. For insurers covering larger groups, the requirement is 85 percent. As of this writing, commissions to agents and brokers were not categorized as care-related expenses. (Some insurance lobbyists and members of Congress believe this could result in reduced compensation and have tried to reverse this.)

The Department of Health and Human Services reserves the right to lower the medical loss ratio for the individual market if the market becomes unstable. (HHS has already issued temporary waivers that will delay full enforcement of the requirements in some states.) Meanwhile, states are free to set medical loss ratios above the federal standards.

If an insurer's medical loss ratio dips below federal standards, the company's customers will receive rebates to make up the difference. The way these rebates are distributed is generally left up to the insurance company and may involve cash, checks, or credits. (There are specific disbursal requirements when rebates are only a few dollars and when they are for people who are no longer covered by the insurer.) Data related to a plan year needs to be reported by June 1 of the following year, and rebates are due two months later.

Grandfathered plans need to maintain satisfactory medical loss ratios or give rebates to their customers. However, unlike most of the new insurance reforms, these requirements don't apply to self-insured plans. Smaller insurers, such as those covering fewer than 1,000 people in a state, need to report data to the government but might not need to provide rebates. There also are special rules for plans with annual benefit limits of less than $250,000.

Mandating an "Essential Health Benefits Package"

We've already mentioned "essential health benefits" and how plans are no longer allowed to put lifetime, dollar-based caps on them. Essential health benefits will become an even bigger piece of reform in 2014.

When insurance exchanges open on January 1, 2014, individual and small-group plans will be required to include an "essential health benefits package." The benefits in the package are supposed to be equal to those available through a typical employer-sponsored group plan. The law states that they must include coverage of the following kinds of care:

- Ambulatory services.
- Emergency services.
- Hospitalization services.
- Maternity care.
- Newborn care.
- Mental health care.
- Substance abuse services.
- Prescription drugs.
- Rehabilitation services and devices.
- Preventive care.
- Laboratory services.
- Pediatric services, including oral and vision care.

In 2011, the federal government proposed that the specific covered services in the essential health benefits package reflect those found in a state's chosen "benchmark" plan. Under the proposal, the plan used by a state as a benchmark could be any of the following:

- One of the three largest small group plans in the state.
- One of the three largest state employee plans.
- One of the three largest federal health plan options.
- The largest HMO plan available in the state's commercial market.

As part of the essential health benefits package, plans will need to limit a patient's annual out-of-pocket expenses (not including premiums) for the services listed above and have a minimum "actuarial value." Whereas the out-of-pocket limit reflects the maximum dollar amount an individual will have to pay for covered care in a given year, a plan's actuarial value reflects the percentage of covered care in the essential health benefits package that an insurer ultimately expects to fund for everyone in a health plan.

In a simplified example, let's assume you're involved in an accident and require hospitalization. Your plan has an out-of-pocket limit of $2,500 and an actuarial value of 70 percent. The annual out-of-pocket limit ensures that your deductibles, copayments and coinsurance fees won't end up costing you more than $2,500. Your plan's 70 percent actuarial value, on the other hand, doesn't guarantee that 70 percent of your medical bills will be covered by insurance. It is merely an estimate that is calculated by analyzing the essential health benefits package in its entirety. In reality, some of your bills relating to essential health benefits might be covered beyond 70 percent, while others might be covered at a lesser amount. The percentage you ultimately need to pay will depend on the specific kinds of care you receive.

The maximum out-of-pocket limit might inflate by the time this requirement goes into effect in 2014, but, for the sake of a ballpark figure, it would be approximately $6,000 for

individuals and $11,000 for families in 2010 dollars. The minimum actuarial value of an essential health benefits package will be 60 percent.

In an attempt to make the insurance marketplace easier to navigate in 2014, plans will be categorized by their actuarial value. Those with the bare-minimum value of 60 percent will be known as “bronze” plans. Plans with an actuarial value of at least 90 percent will be known as “platinum” plans. “Silver” and “gold” plans, with respective actuarial values of 70 percent and 80 percent, will also be available.

Some shoppers in the individual market will have the option of purchasing a high-deductible plan that has essential health benefits but puts few limits on cost-sharing. This “catastrophic” plan will only be sold to people under 30 and people who aren’t required to maintain a minimum amount of coverage. It won’t be available through an employer or an insurance exchange.

The new rules about providing the essential health benefits package won’t apply to grandfathered plans or self-insured plans.

Ban on Pre-Existing Condition Exclusions for Adults

On September 23, 2010, it became illegal for some health plans to deny coverage to children because of a pre-existing condition. In 2014, the ban will expand to protect adults, too.

Like the ban for children, the ban for adults will apply to grandfathered group plans but not grandfathered individual plans.

Restrictions on Premium Rates

If you have a pre-existing condition and shop for a plan in 2014, you’ll discover that reform’s anti-discrimination provisions don’t just pertain to access to insurance. They relate to pricing as well.

When they’re forced to eliminate exclusions for pre-existing conditions, insurers in the individual and small-group markets will also be prohibited from charging people more because of personal health. Gender-based pricing will be illegal in these markets, too. In fact, when two people (or two small groups) purchase exactly the same kind of health insurance, only the following factors will be used to charge them different rates:

- Age (with the cost for one age group equaling no more than three times the cost for another age group).
- Tobacco use (with the cost for smokers equaling no more than 1.5 times the cost for nonsmokers).
- Geographic rating area (as determined by each state).
- Whether the insurance is for an individual or a family.

In essence, the rating reforms mean people in the individual market will be charged as if they were part of a large group. Although the cumulative health status of their geographic rating area will impact the cost of insurance, their own health status won’t have much of an effect on what they pay.

People in the small-group market are already part of a pool for the purpose of pricing, but the new rules will make the size of that pool much bigger. For better or worse, the

risk of insuring unhealthy people will be spread out and shared among a broader population.

Probably because they already cover big pools of people, large group plans won't be affected directly by these requirements in 2014. However, if a state ever decides to let a large-group insurer join a health insurance exchange, all insurers in the large-group market will need to follow the new rating rules.

The rules about rating don't seem to apply to grandfathered plans, but the federal government might arrive at a different legal interpretation between now and 2014.

Limits on Waiting Periods

As a way of keeping costs down, a group plan sometimes forces new enrollees to wait a certain amount of time before they can actually use their health insurance. Starting in 2014, groups won't be allowed to make new members wait longer than 90 days after enrolling. Grandfathered plans aren't exempt. (Group HMO plans will continue to be limited to a 60-day period for newly eligible enrollees and a 90-day period for late enrollees.)

Clarification Regarding Grandfathered Plans

In all the preceding sections about insurance reform, we've mentioned how the new rules impact grandfathered plans. Once again, grandfathered plans are health plans that were already in existence on March 23, 2010, when reform became law. However, it's possible for a plan to lose its grandfathered status. Plans that lose their grandfathered status will need to follow the same rules as new plans.

In interim final rules published in June 2010, the federal government said a grandfathered plan can lose its grandfathered status if it unreasonably reduces benefits or increases cost-sharing for group members. Specifically, the rules say a plan's grandfathered status will be revoked if any of the following occur:

- Benefits change so that necessary treatment for a particular medical problem is no longer covered.
- Coinsurance fees increase. (These fees are expressed as the percentage of a medical bill that a patient must pay.)
- Compared to amounts in place prior to reform, copayments increase by more than 1.) the rate of medical inflation, as calculated by law, plus 15 percent OR 2.) $5 adjusted for inflation, whichever amount is greater. (Copayments are the flat dollar amounts a patient must pay for care. Unlike coinsurance fees, they aren't expressed as a percentage.)
- Compared to amounts that were in place prior to reform, deductibles increase by more than the rate of medical inflation, as calculated by law, plus 15 percent.
- Compared to amounts in place prior to reform, the employer's percentage-based share of premiums drops by more than 5 percent.
- The plan reduces an annual cap on benefits.
- The plan introduces an annual cap on benefits that doesn't replace a lifetime cap.
- An annual cap on benefits replaces a lifetime cap, and the annual cap is lower than the old lifetime cap.

- An employer forces employees to switch to a less beneficial plan just so it won't have to offer a non-grandfathered plan.
- An employer merges one plan with another plan just so it won't have to offer a non-grandfathered plan.

Despite those limits, a plan that existed on March 23, 2010, can do any of the following without losing its grandfathered status:

- Add benefits.
- Raise premiums (as long as the employer's share doesn't drop by more than 5 percent).
- Make changes to comply with state or federal laws.
- Continue to enroll people, regardless of when they become eligible to join.
- Raise deductibles and copayments to keep pace with inflation.
- Be replaced by a similar plan from a different insurance company.
- Switch to a different third-party administrator (if the plan is self-insured).
- Make changes in accordance with collective bargaining agreements that were reached prior to March 23, 2010.

Plans that think they're grandfathered need to say so in their written materials. They also need to maintain records showing what they were like on March 23, 2010.

Individual Mandate

The new rules allowing consumers to purchase insurance regardless of their health status are made possible by what's known as the "individual mandate." In 2014, most citizens and legal residents in the United States will need to be covered by insurance or pay a penalty. Theoretically at least, the mandate will push healthy, previously uninsured people into the insurance market. Then, the low health risks associated with those new customers will cancel out some of the high risks associated with unhealthy customers. Since the pool of insured people will be so large, people's individual medical histories will become a less important part of the underwriting process.

In general, citizens and legal residents will be compliant with the individual mandate if they (and their dependents) are insured through any of the following entities in 2014:

- An employer-sponsored group plan.
- A plan in the individual market.
- A grandfathered plan.
- Medicare.
- Medicaid.
- TRICARE for Life (for military families).
- A U.S. health system for veterans.
- The Children's Health Insurance Program (CHIP).
- The Peace Corps.
- A high-risk pool.
- Other entities, as determined by the Department of Health and Human Services.

People with low or moderate incomes (up to 400 percent above the poverty line) might qualify for government subsidies if they can't obtain insurance through an employer. The law also waives the individual mandate for the following groups:

- Members of certain religious organizations.
- Members of an American Indian Tribe.
- Illegal immigrants.
- People who go without insurance for no more than three months in a calendar year.
- People in prison.
- People who are offered insurance through an employer but would have to spend more than 8 percent of their household income on self-only coverage. (In general, "household income" is your modified adjusted gross income plus the modified adjusted gross income of everyone who got you a personal exemption on your tax returns AND is required to file a tax return.)
- People who aren't offered insurance through an employer and would have to spend more than 8 percent of their household income on the cheapest "bronze" plan in their local insurance exchange.
- People who aren't required to file federal income taxes. (Note, however, that you'll have to find insurance for these people if you claim them as dependents for tax purposes.)
- Individuals experiencing financial hardship, as determined by the Department of Health and Human Services.

If you go without insurance and aren't exempt from the individual mandate, you'll be fined by the Internal Revenue Service. Experts say the government might be able to enforce the fine by withholding tax refunds, but violators won't lose other kinds of property or face jail time.

The fine for not having insurance will change with time. For tax year 2014, the annual fine will be $95 per person (with a family cap of $285) or 1 percent of household income, whichever is greater. For tax year 2015, it will rise to $325 per person (with a family cap of $975) or 2 percent of income. In 2016 and beyond (with adjustments for inflation), the penalty will be $695 per person (with a family cap of $2,085) or 2.5 percent of household income, whichever is greater. The percentage-based penalties won't include the portion of household income below the IRS's cash-filing threshold. In other words, it won't include the portion of income that people are allowed to earn without having to file income-tax returns.

The annual fines will be adjusted for adults who lack insurance for less than a year. For example, someone who goes without coverage for six months will only be fined half of the annual amount. The monthly fine for not covering a child will equal half of the fine for an adult.

As we already mentioned, you won't be fined if you're uninsured for three months or less in a calendar year. But if you remain uninsured for a longer period, you'll be fined for the entire period, including the first three months.

Medicaid Expansion

Many citizens and legal immigrants will be able to comply with the individual mandate by enrolling in an expanded version of Medicaid. In 2014, this health insurance program for the poor will be available to just about anyone whose income puts them within 133 percent of the poverty line, depending on the state where they live. This expansion will include childless single people under 65, most of whom aren't currently eligible for enrollment.

Medicaid's bills are paid jointly by states and the federal government, with each party contributing roughly half. But specifically for the people who are allowed to enroll because of reform, the states will be allowed to pay a smaller portion of expenses. From 2014 through 2016, the entire cost of covering the new people will be funded entirely by the federal government. The federal contributions will decrease gradually in subsequent years until 2020, when they will be set permanently at 90 percent.

People who satisfy Medicaid's new income requirement won't have to meet an asset-related requirement if they aren't eligible for other insurance. In other words, Medicaid eligibility will depend on a person's income, not on what the person owns. This new rule regarding assets and eligibility generally won't apply to other people on Medicaid. Seniors on Medicare (as well as anyone else who qualifies for other insurance) might still be forced to spend down most of their savings before joining the needs-based program.

When the two health care reform laws were passed, the expansion of Medicaid to people living within 133 percent of poverty was viewed essentially as a new requirement. Although a state had the right under the new laws to not expand Medicaid to those low-income individuals, a state that exercised this right could have lost all of its federal funding for the entire Medicaid program. In June 2012, the U.S. Supreme Court ruled that penalizing the states in this fashion would have been unconstitutional. As a result, governors in some states (including Texas, Louisiana and others) have already indicated that they won't expand Medicaid to include any new groups of people. Time will tell whether a particular state's stance on Medicaid expansion will be permanent.

Government Subsidies

Citizens and legal residents who have to comply with the individual mandate but have low or moderate incomes might qualify for financial assistance from the federal government. People with household incomes up to 400 percent of the poverty line will receive subsidies that will effectively put a limit on premiums. (In 2010, 400 percent of the poverty line was approximately $43,000 for one person and $88,000 for a family of four.) Married couples who want the subsidies will have to file their taxes jointly.

Subsidies can only be applied to a plan bought by an individual in a health insurance exchange. Therefore, most people who are eligible to join an employer-sponsored group plan won't receive them. Taxpayers who are offered insurance through an employer will only receive subsidies if they don't enroll in the employer's plan AND either of the following statements is true:

- The plan's actuarial value is less than 60 percent.

- The premiums for self-only coverage would exceed 9.5 percent of household income. (It's widely assumed that this requirement will be revised to mean 9.5 percent of an employee's W2-stated income.)

Individuals who shop for insurance in a health insurance exchange will be told they might qualify for premium tax credits. These credits can be given out before taxes are filed, so people receiving them won't have to pay for everything out-of-pocket and wait several months for reimbursement.

The premium tax credits will be calculated to ensure that shoppers will only have to use a certain percentage of their income for the second-cheapest "silver" plan in a health insurance exchange. (Remember, a "silver" plan is one with an actuarial value of 70 percent.) Recipients of the credits will be allowed to apply them toward a more expensive plan, but they'll have to pay for the difference out of their own pocket.

Credits will be calculated on a sliding scale, so people making less money will receive larger amounts. The biggest credits will cap premiums at 2 percent of income and will go to households earning up to 133 percent of the poverty line. (These largest credits will be given mainly to legal immigrants who haven't been in the country long enough to qualify for Medicaid.) The smallest credits will go to households with incomes ranging from 300 percent to 400 percent of the poverty line. They'll limit premiums to 9.5 percent of income.

Many people who qualify for premium credits will also be eligible for reduced cost-sharing. Via two layers of assistance, the government will pay insurance companies to limit deductibles, copayments and coinsurance fees for essential health benefits in "silver" plans.

In the first layer, federal payments will raise a silver plan's actuarial value for people who earn up to 250 percent of the poverty line. Like the premium credits, these cost-sharing adjustments will be higher for lower-paid people. Those earning up to 150 percent of the poverty line will have their plan's actuarial value for essential health benefits boosted to 94 percent. Those earning between 200 percent and 250 percent of the poverty line will qualify for an actuarial value of 73 percent. (For a review of actuarial values and how they fit into a "silver" plan, refer back to the section "Mandating an 'Essential Health Benefits Package.'")

In the second layer of cost-sharing subsidies, households with low or moderate incomes will have lower out-of-pocket limits than everyone else. Households earning between 100 percent and 200 percent of the poverty line will have their annual out-of-pocket limit reduced by two-thirds. Those earning up to 250 percent of the poverty will have the limit cut in half.

Health Insurance Exchanges

We've mentioned health insurance exchanges several times in this text. So what, exactly, are they?

You can think of an insurance exchange as a centralized marketplace for individuals and small businesses. Private insurers that want to sell through an exchange will all be held to the same rules (including the many consumer protections mentioned in the first several pages of this material), and shoppers will be able to compare plans side-by-

side. People who favor the creation of exchanges generally believe a centralized, government-monitored marketplace will improve transparency and encourage insurers to compete on the basis of price.

In proposed rules published in July 2011, the federal government said an exchange's website will need to provide the following pieces of information (among other things) for all participating plans:

- Premium and cost-sharing information.
- Summary of benefits.
- Level of coverage (bronze plan, gold plan, silver plan, catastrophic plan, etc.).
- Insurer's medical loss ratio.
- Results of surveys designed to measure customer satisfaction.

Contrary to what was discussed in the months leading up to reform, the exchanges won't offer a "public option" or government-run health plan. All plans will be from private companies.

Insurers won't be forced to join an exchange, but most are likely to do so. Since premium tax credits and cost-sharing subsidies can only be applied to plans purchased through an exchange, that's where most new customers in 2014 are likely to shop. Between now and then, states will be monitoring premium increases. If an insurer raises rates to an unjustifiable degree, it might lose the chance to join an exchange.

By January 1, 2014, each state will have an exchange for individuals and small businesses. There can be separate exchanges for those two groups, as well as multiple exchanges serving one of the two groups. No matter the number, each exchange will be for consumers within a specified geographic area.

Exchanges for individuals will be used by citizens and legal residents who don't have health insurance through their employer and don't qualify for Medicaid. Prisoners and illegal immigrants won't be able to purchase insurance through an exchange even if they intend to pay for it entirely with their own money.

Exchanges for individuals (but not small businesses) are expected to have an initial open enrollment period when they become operational and an annual open enrollment period in subsequent years. As is the case regarding the group health plans of today, individuals will also be allowed to enroll at other times if an enrollee experiences certain qualifying events (such as marriage, the birth or adoption of a child or the loss of other health insurance). In proposed rules published in July 2011, the government suggested that the initial enrollment period last from October 1, 2013, through February 28, 2014. In those same rules, an annual enrollment period was proposed that would last from October 15 through December 7 of each year. Applicants who apply for insurance through an exchange during an annual enrollment period would have their insurance start on January 1. According to the proposed rules, someone who is allowed to switch plans outside of the initial or annual enrollment period because of special circumstances will not be allowed to enroll in a plan at a different level. (In other words, an applicant would generally not be allowed to switch from a "bronze" plan to a "silver" plan.)

The exchanges will be maintained by the states, who can establish a government agency to run them or contract with a non-profit organization. If a state doesn't want to run an exchange, the federal government will do it.

Federal funding will be provided to set up exchanges, but each exchange must be self-sustaining by 2015. An exchange can charge participating insurers a fee to cover its expenses.

States also have the option of excluding individuals with incomes up to 200 percent of poverty from the exchanges and creating a single plan for them. In this case, the plan would contain the same consumer protections as other plans in the exchange. But instead of giving subsidies to enrollees, the federal government would give money to the states.

Changes for Employers

Despite the creation of insurance exchanges, satisfying the individual mandate will probably be simplest for people who already have access to insurance in the workplace. With this in mind, health care reform includes some incentives for businesses to offer a group plan today and will penalize larger employers who go without one in 2014. We'll address reform's impact on employers in the next few pages.

Tax Credits for Small Businesses

Beginning in 2010, some small businesses with a health plan became eligible for a new tax credit. For a business to qualify, all of the following must be true:

- The business pays for at least half of the plan's premiums.
- The business has fewer than 25 full-time employees. (Owners and their family members are usually excluded from this number. Part-time employees will have their annual regular hours added together and divided by 2,080.)
- The business pays its employees an average of less than $50,000 per year.

Contrary to what the law actually says, the Internal Revenue Service has clarified that businesses with exactly 50 employees or that pay an average of exactly $50,000 won't receive the credit.

The size of the credit will depend on the exact number of employees and the exact average salary. From now through tax year 2013, the credit will max out at 35 percent of the employer's premium contributions. If the employer is a non-profit organization, the maximum credit will be 25 percent. For both kinds of businesses, the largest credits will go to businesses that pay less than $25,000 per year and have 10 or few workers.

Starting in tax year 2014, the maximum credit will rise to 50 percent among for-profit entities and 35 percent for non-profits. At that point, it will only be available to small businesses buying a plan through an insurance exchange. Businesses will be able to receive the newer version of the credit for the first two years that they buy through the exchange.

Please note that this explanation of the tax credits is just a summary. For more detailed information about these credits (or the aforementioned subsidies for individuals), you should speak to a tax professional.

Exchanges for Small Businesses

Like consumers in the individual market, small businesses will be able to shop for insurance through a health insurance exchange in 2014. A basic summary of how exchanges are expected to function can be found in the section "Health Insurance Exchanges."

In 2014 and 2015, states can limit exchanges for small businesses to entities with 50 or fewer employees. In 2016, all states must let businesses with up to 100 employees access the exchanges. In 2017, exchanges will be allowed to offer plans to bigger businesses.

Employer Mandate

The individual mandate to purchase insurance will be coupled with an employer mandate to offer insurance to employees. In general, an employer with the equivalent of 50 or more full-time employees must have a health plan by 2014.

The employer mandate won't apply to businesses with fewer than 50 employees. Businesses are also allowed to ignore it if none of their employees purchases their own insurance and qualifies for a government subsidy. In other words, if a business pays all its employees enough so that their household income is above 400 percent of the poverty line, the business won't need a health plan. However, if even one employee receives a subsidy, the business will have to make insurance available to all employees or pay a penalty.

In terms of the employer mandate, the number of full-time employees at a business will be based on the average number of people working 30 hours per week. (Note that this is a different number than the one related to tax credits for small businesses.) For new businesses that didn't exist throughout the previous calendar year, the number of full-time workers will be a projected estimate for the current year. For all other businesses, it will be an average from the previous calendar year.

Businesses that are required to offer insurance and don't do it will be fined. The annual penalty will be $2,000 per employee but will include an exemption for the first 30 workers. (So, for an employer with exactly 50 full-time employees, the penalty would be $40,000.) Like the fine for individuals, the annual fine for employers will be adjusted if noncompliance lasts less than a year.

A business with 50 or more workers can also be fined if its plan requires excessive premium contributions from employees or has an unacceptably low actuarial value. A penalty will be imposed if, in spite of having access to the employer's plan, an employee receives a government subsidy. As was mentioned earlier in this material, employees will qualify for subsidies if they don't enroll in their employer's plan AND either of the following is true:

- The employer's plan has an actuarial value below 60 percent.
- The employer's plan would require an employee contribution beyond 9.5 percent of household income for self-only coverage. (It is widely assumed that the maximum employee contribution will eventually be changed to 9.5 percent of the employee's W-2 stated income.)

If a business with 50 or more workers has a health plan but has employees who receive government subsidies, the fine will be the lesser of the following amounts:

- $3,000 per employee who receives a subsidy.
- $2,000 per employee, including those who don't receive a subsidy (but excluding the first 30 workers).

Businesses with fewer than 50 employees won't be fined if premiums are too high or actuarial values are too low.

Changes in Medicare and Medicaid

Much of the focus of the new reforms has been on insurance bought in the private market. Yet there are millions of Americans outside of that market who have their care covered by Medicare. With so many people enrolled in this plan for seniors and the disabled, it's only natural to wonder how reform will affect it.

The new laws don't eliminate benefits that are already guaranteed by the federal government. In fact, they add a few. But some changes will be made to the way Medicare is funded. Let's briefly mention what's ahead for the program.

Ending the Doughnut Hole

When Congress created prescription-drug coverage for seniors under Medicare Part D, it left enrollees with an insurance gap. When Part D patients' drug expenses reach a certain amount, their prescription coverage is temporarily suspended until they pay several thousand dollars out of their own pockets. This gap is known as the "doughnut hole."

Health care reform will gradually reduce the doughnut hole and eliminate it entirely by 2020. To start, seniors who fell into the doughnut hole in 2010 received a one-time $250 check from the government.

In place of checks, seniors in the doughnut hole in 2011 received a 50 percent discount on name-brand prescription drugs. At the same time, the cost of generic drugs in the gap started decreasing.

Medicare Checkups and Preventive Care

In addition to having a deductible, seniors in Medicare pay a coinsurance fee for doctor visits. As of 2011, most kinds of preventive care are now covered with no deductibles, copayments or coinsurance fees.

Medicare recipients are also newly eligible for a free physical examination each year. Prior to reform, patients were only entitled to one free exam near the time when they entered the program.

Funding for Medicare Advantage

When you become eligible for Medicare, you have two ways of getting your benefits. You can enroll in the traditional version of Medicare, which is administered by the federal government, or you can enroll in a Medicare Advantage plan, which is administered by a private insurance company. Medicare Advantage plans are funded, in large part, by the government and are required to cover at least the same services as traditional Medicare (although sometimes with different copayments and other forms of

cost-sharing than the regular program). They often feature added benefits, too, such as vision care and lower out-of-pocket expenses. In exchange for the added benefits, Medicare Advantage patients tend to have a more limited listed of doctors to choose from and might need pre-approval for certain services. According to the Henry J. Kaiser Family Foundation, approximately 24 percent of Medicare beneficiaries were enrolled in a Medicare Advantage plan in 2010.

Many pundits have claimed or implied that health care reform reduces benefits in Medicare and eliminates Medicare Advantage plans. In reality, benefits under traditional Medicare remain intact and so does the market for Medicare Advantage plans. Medicare Advantage plans will still be required to cover at least the same things as traditional Medicare.

What's true, however, is that the amount paid by the government to most Medicare Advantage will decrease until a new funding formula is set permanently in 2015. When commentators mention health care reform and reduced Medicare benefits, they're basically assuming that the reduction in federal subsidies will cause Medicare Advantage plans to either eliminate their extra benefits (those unavailable to people in traditional Medicare) or leave the market. Someone who loses a Medicare Advantage plan would ultimately be able to receive Medicare benefits from a different source, but only time will tell how the change in funding will play out for most seniors.

Though funding will drop overall for Medicare Advantage plans, some plans will receive more money based on quality. The government has established a quality-rating system for insurers participating in Medicare Advantage. A plan earning at least a four-star rating will receive more federal dollars.

The Independent Payment Advisory Board

When Medicare costs rise, politicians typically have a hard time agreeing on how to solve the problem. In 2015, some of the decisions on how to save money can be made by a newly created "Independent Payment Advisory Board."

When Medicare spending increases beyond a rate set by law, the board will come up with ways to bring spending down. Congress will be required to implement the board's suggestions or find alternative solutions. The board won't be allowed to suggest changes that would raise premiums, increase taxes, reduce benefits or limit eligibility, but it may make suggestions that would impact medical providers and how care is coordinated.

Paying for Reform

It's only natural to wonder how the Congressional Budget Office can claim that health reform will cost $938 billion over 10 years and cut the federal deficit at the same time. For deficit reduction to be possible, the government will have to find new ways to save money or create revenue.

Some of the projected savings can't be supported dollar for dollar by looking exclusively at the new laws. For example, while many supporters of reform believe insuring people will be more cost-effective than making them go to emergency rooms, that's an expectation, not a guarantee.

We won't bother with predictions about what will save money and what won't. But that doesn't mean we have to ignore the concrete ways in which reform will change the tax code and cut certain types of funding. The kinds of revenue creation that are clearly backed up by the law will be summarized in the next several sections.

Payroll Taxes

Under current law, employers are required to withhold 1.45 percent of their employees' income in order to fund Medicare. Employers contribute an additional 1.45 percent on their employees' behalves. Self-employed people are responsible for paying the entire 2.9 percent tax.

Beginning in tax year 2013, higher-income people will pay 0.9 percent more in Medicare taxes on a portion of their income. The increase will be applied to amounts in excess of $250,000 for married couples ($125,000 if they file separately) and $200,000 for single taxpayers. The amount employers need to contribute won't change.

At the same time, taxpayers at that income level will pay a 3.8 percent tax on investment income, including dividends, capital gains and rents. These kinds of income are currently exempt from payroll taxes.

The 3.8 percent tax will be applied to the lesser of the following amounts:

- The person's net investment income.
- The person's modified gross income in excess of $250,000 (if married filing jointly), $125,000 (if married and filing separately) or $200,000 (for single taxpayers).

The 3.8 percent tax won't apply to investment income from retirement accounts or to people with lower incomes. For more specifics, speak to a tax professional.

Medicare Advantage Subsidies

As was mentioned earlier, federal payments to Medicare Advantage plans will start to decrease in 2012. Some plans will receive more money if they receive high marks for quality service. Payments in 2011 will remain at 2010 levels.

Excise Tax on "Cadillac" Plans

Beginning in 2018, health plans will incur a tax penalty if their premiums exceed $10,200 annually for an individual or $27,500 for a family. Because they often cover a wide range of care with little or no cost-sharing from the patient, these plans are known as "Cadillac plans."

Medical Tax Deductions

Under current law, people who itemize their income-tax deductions are allowed to deduct non-reimbursed medical expenses that exceed 7.5 percent of their income. Starting in tax year 2013, that number will rise to 10 percent for most filers. It will remain at 7.5 percent for people 65 and older until 2017.

In 2013, employers will face new limits on what they can deduct when they cover a retiree's drug benefits. Employers who receive federal subsidies for providing drug coverage to retirees won't be allowed to deduct the amount of those subsidies.

Changes to Health Savings Accounts and Flexible Spending Accounts

For tax purposes and other reasons, an increasing number of Americans have health savings accounts (HSAs) or flexible spending accounts (FSAs). In 2011, account holders will start to notice changes that impact how much they can put into these accounts and what those accounts can be used for. For specifics, contact a tax professional.

Contributions From Health Insurers

From 2014 to 2016, the government will operate a reinsurance program to help insurers cope with the cost of covering high-risk customers. Insurers in the individual and group markets will contribute a total of $25 billion to fund the program.

In 2014 and beyond, the health insurance industry will collectively pay billions of dollars in fees to fund reform. The fees, which start at $8 billion and rise over time, won't be imposed on self-insured employers.

Conclusion

Many details of health care reform can seem like a confusing jumble no matter how long you study them. We hope this guide has cleared up some questions and concerns without adding too many new ones.

Keep in mind that many specifics won't be known until the federal government issues regulations explaining how these reforms will be implemented. Regulations for the most immediate reforms either had just been published when this material was being written or were very close to coming out. Guidance related to later portions of reform are more likely to be released sometime around 2014.

Some Congressional opponents of reform have publicly stated their intent to repeal the new laws. Constitutional rules make it very unlikely that a full repeal will happen (the Supreme Court upheld the constitutionality of the individual mandate in 2012), but it's possible that smaller pieces of reform will change between now and their effective dates.

For the most recent news about health care reform, you can contact the Department of Health and Human Services or visit the department online. Updates on tax issues will be provided by the Department of the Treasury.

CHAPTER 4: DISABILITY INSURANCE

Disability insurance replaces a portion of people's income when they are too sick or too hurt to do their job. It isn't exactly health insurance, yet it can ensure that there is enough money for life's essentials during a health crisis. It isn't exactly life insurance, yet it can serve a similar purpose by providing financial assistance to dependents when the head of a household becomes incapable of paying bills.

Injury or Illness

For insurance purposes, having a disability usually means a person is suffering from an accidental injury or illness. The injury or illness can involve many sorts of circumstances and does not need to have occurred in conjunction with performing one's job duties. The injury must have occurred during the policy period, and an illness must have started during that same period.

If symptoms of an illness were noticed prior to the policy period and were strong enough to cause a reasonable person to seek medical attention, the illness will be viewed as a pre-existing condition. Disabilities linked to pre-existing conditions might not be covered at all or might only be covered after a long waiting period.

A few disability products are accident-only policies and do not cover losses brought on by sickness. This coverage is often impractical because the majority of disability claims are linked to cancer and other diseases. Like life insurance policies that only cover people who die of a specific illness or from a specific kind of accident, an accident-only policy is probably only suitable for workers who cannot qualify for or afford other coverage.

Loss of Ability

To trigger disability insurance benefits, an injury or illness must be severe enough to have had a negative impact on the insured's professional life. More specifically, a policy will probably state that the injury or illness must be preventing the person from performing essential job duties. Depending on the insurance contract, the worker might need to be unable to perform one essential task, all essential tasks or a certain portion of tasks, such as 20 percent.

These requirements can be modified to emphasize a time element rather than a task element. As an example, consider someone who can still perform all individual job duties but must work fewer hours because of pain or fatigue. In this case, the worker might be eligible for benefits if lost time is equal to a certain percentage of a regular workweek. Like a situation involving someone who can perform some duties but not others, this is an example of a partial or "residual" disability. More information about partial and residual disabilities (which are not covered under some disability insurance contracts) appears elsewhere in this course material.

When coverage is contingent on the inability to perform job-related tasks, those tasks are usually related, for a limited time, to a person's specific occupation. Suppose Jim, a writer, and Jane, a mover, are both injured to the extent that they are unable to engage in heavy lifting. Since heavy lifting is not considered a normal aspect of a writer's job, Jim will probably not qualify for disability benefits. Jane, on the other hand, has a job that requires heavy lifting. Therefore, she might receive some insurance payments.

Coverage based on the person's own job duties is known as "own-occupation" coverage and is usually only available for a few months or a few years. Eventually, a person might only be eligible for continued benefits if the individual is incapable of having any job that is in line with his or her education level and experience. You'll read more about own-occupation insurance shortly.

Loss of Income

Some disability policies base coverage strictly on a person's inability to perform tasks, but many contracts in today's market also require a loss of income at some point. A number of insurers will not provide money to a person with a partial disability unless an injury or illness has reduced the insured's income by at least 20 percent.

Own Occupation vs. Any Occupation

The best (and often most expensive) kinds of disability insurance base their definition of "disability" on the insured's own occupation. People with own-occupation coverage will receive compensation when they cannot perform their basic job duties. Their ability to do a different job is irrelevant.

To demonstrate the positives of own-occupation coverage, let's use the classic example of a disabled doctor. Suppose a hand injury prevents the doctor from treating patients. If the doctor lacks own-occupation coverage, the insurer might deny his claim and argue that he could earn a living as a lecturer at a medical school. But if he has own-occupation coverage, the insurer cannot make that case, and the doctor might be eligible for full disability benefits until he can practice medicine again.

In the past, high-income professionals could even receive own-occupation coverage that catered to their exact specialty. If a heart surgeon could no longer perform heart surgery but remained capable of working as another kind of physician, she would still receive full benefits. Today, this form of insurance is either unavailable or only offered at a very high price.

Other varieties of own-occupation insurance that have been available over the years are explained below:

- If people are unable to perform the duties of their own occupation, they can get a job in another field and still receive their full benefits.
- If people are unable to perform the duties of their own occupation, they can receive their full benefits until they choose to do some other kind of work. After that, their benefits will end.
- If people are unable to perform the duties of their own occupation, they can receive their full benefits until they choose to do some other kind of work. After that, they will receive a portion of the difference between their pre-disability income and their new income.
- If people are unable to perform the duties of their own occupation, they can receive their full benefits until they choose to do some other kind of work. After that, they will receive limited payments until their new income equals a particular portion of their pre-disability income.
- If people are unable to perform the duties of their own occupation, they can receive full disability benefits for a limited period of time, such as two years or five years. After that, they can only continue to receive benefits if they meet stricter requirements. (This is the most common kind of own-occupation coverage.)

If a policy does not include own-occupation coverage (or if own-occupation coverage has expired while the person is still disabled), the insured probably has what can be called "any-occupation" coverage. In general, this kind of disability insurance pays full benefits when people cannot perform the duties required by their own occupation and also cannot handle any job that would be suitable for them, based on their education, experience and training. An injured doctor, for example, would not receive disability payments if he was still capable of working at a medical school.

Long-Term Disability vs. Short-Term Disability

A working person can be covered by "short-term disability insurance" or by "long-term disability insurance." Short-term policies allow disabled people to collect benefits for a brief period of time, usually no longer than six months in most parts of the country. Long-term policies let people receive money for a few years, until they retire or, in rarer cases, until they die.

Workers in a few states are entitled to a portion of their regular income when they suffer a short-term, non-occupational disability. Benefit periods range from six months in some areas to one year in states such as California. Sources of funding differ too, with some states (including California) requiring employee contributions from workers, and others mandating self-insurance by employers.

Most people who work (but not necessarily reside) in the following states or territories are covered for short-term disabilities by law:

- California.
- New York.
- New Jersey.
- Rhode Island.
- Hawaii.
- Puerto Rico.

Someone with a short-term disability policy will probably receive benefits sooner than someone with a long-term policy. Short-term disability benefits from private companies usually go into effect immediately after an injury and no more than a week after the beginning of an illness. (The current waiting period under California's state plan is seven days for all disabilities.)

Long-term disability insurance often provides no benefits to the insured unless an injury or illness has lasted for several months. This waiting period is known as the policy's "elimination period" and will be explained in greater detail in the next section.

In most states, short-term disability insurance is purchased by employers as part of a group plan and is rarely marketed to individuals. Long-term disability insurance can be either provided through an employer-sponsored group plan or purchased outside of the workplace by one person. Though some businesses have established "integrated disability plans" that feature both kinds of coverage, many insurers only sell one or the other.

Please note that this course material will not focus specifically on California's short-term disability insurance plan (SDI). Requirements and other assorted details about the plan can be obtained from the state's Employment Development Department.

Elimination Periods

The benefits made possible by disability insurance are usually not approved immediately after an injury or illness. Most likely, the insured will receive no financial assistance from the insurer until after the passage of a time-based deductible known as

the “elimination period.” Any losses that occur during this period are not the insurer’s responsibility.

The elimination period begins on the first day the insured is unable to work. It can last anywhere from a few days to a few years. Short-term policies in many states often have no elimination period for injuries and a week-long elimination period for illnesses. Long-term policies tend to have 30-day, 60-day or 90-day elimination periods and do not have separate waiting periods for injuries and illnesses.

Recurrent Disabilities and Exceptions to the Elimination Period

Most policies have a “recurrent disability clause,” which explains how the elimination period is applied when disabilities go away for a while and then reoccur.

Suppose, for example, that someone with a 90-day elimination period was disabled for a year, came back to work for a week and has realized that more recovery time is needed. Does the person have to wait another 90 days before benefits can begin again?

The insured is usually not subjected to a new elimination period if the same disability reoccurs within six months of the person’s initial recovery. Some policies in some states extend this timeframe to a full year if the person is covered for a disability for life or through age 65.

Benefit Periods

When a disability insurance policy’s elimination period ends, the policy’s “benefit period” begins. The benefit period is the maximum amount of time the insurer will pay benefits to the policyholder for a disability. The insured will receive payments from the insurer until he or she is no longer disabled or until the end of the benefit period, whichever comes first.

Like the elimination period, the benefit period can have a major impact on a policy’s price and its availability. Usually, the longer the benefit period, the higher the premiums will be. Unhealthy individuals who would otherwise not qualify for disability insurance might be able to purchase a policy with a short benefit period.

Not surprisingly, there are different benefit periods for short-term and long-term disability insurance. Short-term policies typically have benefit periods no longer than three or six months. A benefit period for long-term disability insurance might last two years, five years, until normal retirement age or until death.

Benefit Amounts

Since disability insurance is meant to replace income, it should not be at all surprising to learn that the benefit amount will be based on a worker’s salary or wages. The income used to calculate the benefit amount will be the insured’s taxable income during the 12 months prior to the disability, or perhaps the average income earned over the previous few years.

Like workers compensation, disability insurance will not replace the insured’s entire paycheck. For most people, the benefit amount will be 60 to 70 percent of their pre-disability income. Insurers and state regulators enforce this percentage-based limit in

order to encourage people to return to work and discourage them from committing fraud.

High-income workers might receive benefits below 60 to 70 percent of their pre-disability income. This is possible because the benefit period often has a dollar limit in addition to a percentage limit. For example, an insurer might agree to pay 60 percent of a person's salary but cap monthly benefits at $5,000 per month. Based on those figures, workers making $50,000 would have 60 percent of their income replaced by insurance, but workers making $150,000 would have their monthly benefits capped at $5,000 and would therefore receive only 40 percent of their regular income. Dollar limits are especially common in group disability plans, which might explain why many doctors, lawyers and business executives prefer individual coverage.

How to Find Disability Insurance

People interested in obtaining disability insurance can start their search in one of two ways: They can inquire about coverage that might be available at their workplace or through a trade association. Or they can contact an insurer independently and look into buying an individual policy.

Each of these options has positives and negatives pertaining to affordability, availability and more. As we go over them here, try to think about the kinds of people who might be best suited for each kind of coverage.

Group Disability Plans

Other than in states with a government-run program, most workers who have disability insurance obtained it through an employer's group plan. Businesses start group plans because they help attract qualified job applicants and because they can solve the ethical and financial issue of whether to keep paying a valued employee while the person can't work. Employees like them because they are often open to anyone regardless of health status and usually cost less than individual insurance.

Funding for group disability plans can be structured in many ways. Premiums might be paid entirely by the employer, entirely by the employee or split between the two. Plans that shift the cost of coverage to the worker are becoming more common, but participation in them must be voluntary. An employer cannot force an employee to contribute to a group plan in order to keep the plan's premiums down or to keep the group's insurance from being cancelled.

Strong participation is vital to group plans because it diversifies the group's risk and makes it possible for coverage to be available to members who have a higher chance of disability. To avoid situations in which only the disability-prone members of a group opt for insurance, a carrier might only approve guaranteed-issue coverage when both of the following conditions are met:

- The group plan will cover at least 10 to 15 participants.
- A significant portion of eligible participants join the plan.

Businesses that do not satisfy those requirements may still be eligible for insurance at a group rate. However, each prospective member of the group might have to be medically underwritten on an individual basis.

The usual absence of major medical underwriting in group disability plans does not mean every group will be eligible for decent and affordable insurance. Underwriters in the disability market are likely to evaluate a group by looking at the following factors:

- The group's size.
- The group's median income.
- The group's average or median age.
- The percentage of men and women in the group.

Many group plans are configured so that the employer pays for a very basic policy and the employee has the option of purchasing additional coverage at a group rate. Exercising that option might require some medical underwriting, but it can help the person get around some of the problems associated with traditional group plans.

Negative aspects of some group disability plans are as follows:

- Group policies usually provide no more than two years of own-occupation coverage.
- Group coverage is often not portable when a person changes jobs.
- Benefit amounts for group plans are often capped at a lower amount than individual policies.
- Benefits from employer-funded group plans are taxed as income to the employee.
- Group coverage can be cancelled by the insurer or the employer without the employee's permission.
- When the insurer denies a group member's claim, federal law makes it difficult for group participants to sue for pain and suffering, exemplary damages or reimbursement of legal fees.

No matter its positives and negatives, group disability insurance remains a non-issue for millions of employees in most parts of the country. Many smaller businesses don't offer it at all, and companies that do are not always required to make it available to their entire staff.

Individual Disability Policies

If group disability insurance is unavailable or insufficient, a worker can apply for an individual disability policy. Individual policies, which cover one person, are only purchased by a very small portion of the population, but they are popular among high-income professionals. These policies are superior to group coverage in the following ways:

- Individual policies can pay a disabled person a larger portion of income.
- Individual policies are more likely to compensate a disabled person for the loss of bonuses and other kinds of performance-based income.
- Individual policies are portable when the insured changes jobs.
- Benefits from individual policies are usually tax-free.

- Federal law does not prevent the insured from suing the insurer and collecting more than the dollar amount of a disputed claim.
- Individual policies are owned by the worker and cannot be cancelled by anyone else other than the insurance company.

Potential drawbacks to individual coverage include less availability and higher premiums. Lower costs and reduced medical underwriting might be possible if the individual policy is bought from the same insurer that handles the person's employer-sponsored group coverage.

Conclusion

Disability policies aren't always easy to understand, but gaining an understanding of them and passing this knowledge along to the public can be worth the effort. People who are unaware of disability insurance might end up relying on workers compensation or Social Security and discover all too late that those sources of protection are sometimes unavailable or inadequate.

Of course, no insurance can prevent all bad things from happening. But comprehensive disability insurance can allow people to focus on recovering from physical problems without having to worry too much about financial ones.

CHAPTER 5: HOMEOWNERS INSURANCE

With so much wealth and warm feelings invested into every inch of a dwelling, it's no wonder nearly every homeowner in the United States has insured his or her property against several common perils. Even after their mortgage loans have been paid off in full and the choice between being covered or uninsured is left up entirely to them, these people rarely tempt fate by cancelling their policies altogether. Their gut and experience tell them that anything from a fire to a burst pipe can take away some of that dwelling-related pride at any moment, and they have no intention of paying entirely out of pocket in order to get it all back.

It Begins With a Mortgage …

Even if a prospective homeowner remains unsold on the benefits of having insurance, the person's mortgage lender will require coverage. If the person refuses to abide by the lender's terms, the loan will be cancelled, and the potential real estate transaction will be quashed.

By requiring insurance, the lender is not just looking out for the borrower's best interests. Rather, it is doing what it can to protect its own financial stake in the property. Should a fire ever reduce a home to nothing but ash, the mortgage company or bank wants to be certain it will still be able to recover the loan balance.

Traditionally, lenders have forced borrowers to purchase insurance that is equal in value to their mortgage loan. This amount is often relatively close to the home's replacement value at the time of purchase, but it may be higher or lower than that. When the level of insurance mandated by the lender is not equal to the home's replacement value, the owner is in the undesirable position of being either underinsured or over-insured.

The risk of underinsurance rises with each passing year of home ownership. This is because increases in construction costs often outpace any inflation guards that may or

may not have been incorporated into the insurance contract. The jump in prices for materials and labor isn't bad news for the lender, whose investment will be protected regardless of what builders charge. But for the homeowner, it can be a major problem that inhibits the rebuilding process.

Who Is the Insured?

In addition to listing other important details, the declarations page of a homeowners insurance policy will contain the name of the "insured." In most cases, the insured is the policyholder who is responsible for paying premiums to the insurance company and is eligible for compensation after an insured loss. Though the typical insured is both the owner and occupant of the entire dwelling, an insured can also be someone who owns or occupies just a portion of a dwelling or who owns a building under construction. Even a tenant can be an insured if he or she takes some initiative and purchases the appropriate policy.

Coverage of liability and personal property is often broad enough to apply to individuals other than the named insured. Such protection extends to any relatives who live with the insured, as well as to a non-relative who is under 21, lives at the insured premises and is being cared for by the insured or the insured's family. This means everyone from the insured's spouse to the insured's foster child or parent can be covered by homeowners insurance, assuming they all reside with the named insured.

Under limited circumstances, the liability section of a homeowners insurance policy may extend to non-relatives and third parties who live in their own homes. For example, if an insured leaves his dog with a friend while he is on vacation, the friend will be covered by the dog owner's policy for liability if the dog bites the friend's mail carrier.

It would be unwise, however, to assume that homeowners insurance is a big tent that covers everyone who is remotely affiliated with the named insured. Contrary to popular belief, tenants who are not related to the insured are not protected by their landlord's policy. Even an insured's relatives might lack coverage if they are merely guests in the insured's home instead of permanent residents.

Six Policies for the Price of One

Several decades ago, property owners insured their homes through a "dwelling policy." This kind of insurance only addressed the most basic of perils, including fire, and did not contain personal liability protection. In order to cover themselves comprehensively, families had to purchase separate polices or add riders to their dwelling contracts. (Dwelling policies are still used today as a way of covering rental properties that are not owner-occupied.)

Since purchasing separate policies took up too much time and cost too much money, many carriers left dwelling forms behind in the 1950s and encouraged homeowners to buy a multi-part product that had been designed specifically for their insurance needs. That product, known as "homeowners insurance," built upon the basic dwelling policy and features six important kinds of coverage all rolled into one.

Each of the six kinds of coverage has its own letter. "Coverage A" covers a person's dwelling, while "Coverage B" takes care of detached structures, such as garages and sheds. "Coverage C" reimburses people for the loss of their personal property, and

"Coverage D" gives them money when their dwelling is uninhabitable. Since coverages A through D all relate, in some way, to the insured's property, they are mentioned one after another in Section I of most policy forms.

Personal liability is covered under Coverage E, and Coverage F pays for other people's medical costs after an accident regardless of who is at fault. Since coverages E and F both relate to damage to third parties or their property, they follow each other in Section II of most policy forms.

Each kind of coverage has its own dollar limit, but these limits are generally dependent upon one another. An insurer's limit of liability for Coverage B, for instance, is often equal to 10 percent of its limit for Coverage A. Although each insurer may require its customers to purchase a minimum amount of coverage, people are allowed to increase any of the six limits of liability by paying more in premiums.

To better understand the strengths and weaknesses of the standard homeowners insurance policy, let's go through these six kinds of coverage one at a time.

Coverage A

As mentioned previously, Coverage A insures a person's dwelling. In simplest terms, the "dwelling" is the structure a person lives in. Most often, the dwelling is a one-family building used by the insured and the insured's relatives. However, a multi-unit building might be considered a covered dwelling if it is designed for two, three or even four families and is occupied in part by the policyholder. (Companies using older coverage forms might still limit the number of units to two.) In most homeowners policies, the dwelling and all the land and other structures surrounding it are collectively known as the "residence premises."

In addition to covering the dwelling, Coverage A is used to insure other structures that are both on the residence premises and attached to the home. An attached garage would be insured through Coverage A, as might a deck. Garages and other structures not attached to the dwelling are covered by another part of the policy.

The Confines of Coverage A

Coverage A is probably the most important and most commonly utilized component of a homeowners insurance policy, but it has some limitations. The coverage generally applies to a single residence premises and not to any other residential or rental properties the person owns. It might not insure a vacation home, for example, unless the address of the vacation home is specifically added to the policy and listed on the declarations page. Coverage A also excludes losses related strictly to land, including the land beneath and around a dwelling. This exclusion applies to physical damage as well as to any decrease in the land's value.

Coverage B

Coverage B is property insurance for a homeowner's detached structures. A "detached structure" may be defined as a structure that is separate from a dwelling but still situated on the residence premises. According to policy language adopted by the Insurance Services Office (ISO), the detached structure may be separated from the dwelling by way of open space, a fence or a utility line. Common examples of these structures are listed below:

- Detached garages.
- Barns.
- Sheds.
- Pools.
- Mailboxes.
- Driveways.
- Sidewalks.
- Satellite dishes.

A little bit of Coverage B is included in most homeowners insurance policies, even in cases where the insured doesn't have any detached structures at the property. By default, this insurance is usually equal in value to 10 percent of the homeowner's dwelling coverage. So if a dwelling is insured for $100,000 through Coverage A, detached structures on the same residence premises will be insured for $10,000. These structures can be covered for as much as their replacement cost if the insured pays the appropriate premium.

Coverage C

Coverage C is more commonly referred to as "contents coverage." In general, contents coverage is for all the belongings the insured owns or uses. Although the insurance for these items is part of a homeowners policy, the insured's contents remain covered outside the home, too. In fact, Coverage C is meant to insure people's personal property all over the world.

Like the dollar limit for Coverage B, the dollar limit for Coverage C is expressed as a percentage of Coverage A. Most policies provide the insured with contents coverage equal to at least 50 percent of the person's dwelling coverage. So if a dwelling is insured for $100,000, the insured will be entitled to no more than $50,000 to repair or replace all damaged or stolen items.

Since tenants and condo owners receive minimal benefits under Coverage A, these individuals are allowed to insure their belongings for a dollar amount of their own choosing. Special polices for these kinds of consumers are mentioned in greater detail elsewhere in this chapter.

Fair Warnings About Contents Coverage

There are a few negative aspects of Coverage C that the consumer should know about. First and foremost, the insured needs to understand that the standard homeowners form will only reimburse people for their personal property's "actual cash value." An item's actual cash value is its replacement cost minus depreciation.

As an example, suppose someone purchases a new television set for $800, uses it for five years and loses it in a fire when its estimated value has dropped to $300. In this case, the insurance company would only need to reimburse the person for a $300 loss. It would not necessarily need to pay for a new TV.

Insurance that does not take depreciation into account is known as "replacement cost coverage" and can be purchased at an additional price.

An insured should consider upgrading or downgrading his or her contents coverage as living situations at the residence premises evolve. If a spouse or an elderly parent moves in with the insured, additional coverage may be necessary in order to fully cover everyone's belongings. If an adult child or a former spouse has moved out of the dwelling, it may be possible to get by with less insurance.

Of course, the amount of appropriate coverage will depend on the kinds of valuables a person possesses. Families with nothing more than basic belongings (such as clothes, furniture and the most common types of appliances) are likely to need less contents coverage than a family known for having all the latest gadgets.

Limits on Location

Coverage C insures the policyholder's personal property on a worldwide basis. But in spite of this flexibility, the standard policy allows the insurer to limit coverage depending on where the lost or damaged property was normally stored. If an item was normally kept at a residence premises that is occupied by the insured but not listed on the policy's declarations page, reimbursement will amount to no more than 10 percent of the person's Coverage C limit or $1,000, whichever amount is greater.

As an example, pretend a homeowner has insured the contents of a country house for $50,000. Let's further suppose the homeowner also keeps an apartment in the city and does not have a renters policy for it. If a fire were to break out in the apartment and destroy $50,000 worth of contents, the homeowner would still be able to make a claim on his policy. But he would be reimbursed for no more than $5,000.

Limits on Special Items

Insurance companies generally have no problem covering basic belongings that are common to the average household. But in an effort to mitigate risk and keep premiums down, they set coverage limits on some highly valued items. These limits are enforced on a per-claim basis and are sometimes known as "special limits of liability." In most policies, these limits apply to the following kinds of personal property:

- **Jewelry**: Though not defined in most policies, "jewelry" can mean any item that adorns a person's body for a decorative purpose, including all kinds of rings, necklaces, earrings or watches. Homeowners insurance will provide no more than $1,500 to replace these items when they are stolen. While there is no special limit of liability when a jewelry claim involves a covered peril besides theft, the insured should keep in mind that most policies only cover personal property against perils that are named specifically in the insurance contract. Mysterious losses—including those that occur when a stone comes off its setting or when a ring falls down a drain—are typically not covered by homeowners insurance.
- **Furs**: If a fur is stolen, the insured will receive no more than $1,500 as compensation for the loss. If an insured files claims for stolen jewelry and furs at the same time, the insurer will pay up to $1,500 combined for both kinds of items. It will not apply $1,500 toward the jewelry and another $1,500 toward the furs.

- **Silverware and similar items**: Coverage of silverware, gold-ware, platinum-ware and pewter-ware is limited to $2,500 in the event of theft. There is no specific limit when these items are affected by other covered perils.
- **Money**: Coverage of lost or damaged cash, bank notes, bullion, debit cards and some metals is limited to $200.
- **Valuable documents**: Insurers put a $1,500 limit on manuscripts, passports, stamps, tickets, letters of credit, deeds, securities and other important kinds of documentation. It makes no difference whether these documents are printed on paper or stored electronically.
- **Guns**: Firearms and ammunition are only covered for up to $2,500. This limit applies only to instances of theft.
- **Boats**: All watercrafts and all their related parts and accessories are covered for up to $1,500.
- **Trailers**: Trailers and semi-trailers are insured for up to $1,500.
- **Electronic items and accessories**: Some electronic devices receive limited coverage when they are kept on or inside a motor vehicle. For a $1,500 coverage limit to apply, a device must be versatile enough to be used with and without the help of the vehicle's electrical system. Presumably, a cell phone or a portable music player would fall under this category. According to the ISO, accessories impacted by the $1,500 limit include audio tapes, CDs, wires and antennas.
- **Tombstones**: Believe it or not, homeowners insurance makes special mention of grave markers and mausoleums. These items are covered for up to $5,000 per occurrence.

Coverage D

Having insurance to help replace or repair a dwelling or personal property can be a blessing. But what are homeowners and their families supposed to do between the time a loss occurs and the time they are allowed to move back into a permanent residence? How are they supposed to handle all the expenses that arise from being displaced?

Those questions are answered by Coverage D, which is commonly known as "loss of use coverage." Loss of use coverage is exactly what it sounds like. It pays money to the insured when the residence premises is made uninhabitable by a covered peril.

When thinking of examples in which loss of use coverage would come into play, it's easy to envision a disaster that causes a total loss. However, loss of use coverage might also be utilized in cases in which only a portion of a dwelling has been severely damaged. For example, if a tornado makes the only bathroom in a dwelling unusable, the insured might be able to receive some benefits through Coverage D.

Depending on their situation, homeowners are entitled to one of two kinds of benefits while their residence premises is effectively out of service. The most common kind comes in the form of "ALE benefits," which pay for "additional living expenses." Additional living expenses are those expenses the homeowner encounters as a direct result of not being able to use his or her home. Among other possibilities, these expenses may include the cost of meals and temporary lodging.

A lesser-known benefit is available to landlords when a rented portion of the residence premises becomes unusable. This benefit reimburses the insured for the fair rental value of a dwelling until necessary repairs are completed.

Some insurers limit benefits under Coverage D to a set percentage of Coverage A. When a dollar limit is used, it is often equal to 20 percent of the dwelling's insured value. So if a house is insured for $100,000, the owner will have $20,000 of coverage for loss of use. Renters and condo owners are typically entitled to loss of use coverage that is equal to 20 or 40 percent of their contents coverage.

Before moving on to other portions of the standard policy, let's examine ALE benefits in greater detail.

Additional Living Expenses

Barring other specific limits, additional living expenses will be covered for the reasonable amount of time it would take to either repair the damaged dwelling or move permanently to a new one. During this time, homeowners are reimbursed only for the difference between their pre-loss and post-loss expenses. So if a family spent $400 each month on food prior to losing their home and has spent $600 each month since then, the carrier will reimburse the family for the extra $200. The other $400 will not be considered an additional living expense.

ALE benefits may also be reduced by the amount of expenses that are eliminated by a loss of use. If an insured is spending an extra $800 dollars on temporary housing but is no longer spending $100 on utilities, the carrier might knock the reimbursable portion of the housing costs down to $700.

ALE benefits are designed to help homeowners and their families maintain their standard of living. This is a particularly important point when a displaced individual is looking for a temporary place to live. A family of four, for example, will not be forced by the carrier to move from a two-bedroom house into a studio apartment. Likewise, the carrier will probably not cover the cost of moving from a three-room unit to a multi-story house.

Beyond housing, ALE benefits can help pay for food, utilities and storage costs. They might even reimburse people for transportation expenses if they need to travel farther than usual to get to work. But even though the ALE section of most policies does not contain any specific exclusions, that hardly means all goods and services will be covered. In a 2005 look at crime risks, for example, the trade publication Best's Review examined ALE benefits and said an insured would probably not have coverage for emotional counseling or temporary housing after a burglary.

Coverage E

Coverage E is an important yet often overlooked component of a homeowners insurance policy. It provides personal liability insurance to the homeowner and other insureds in the amount of $100,000 or more.

This insurance applies when a third party accuses the insured of being negligent and causing accidental harm to the person or the person's property. As simple as that may sound, properly understanding the applicability of Coverage E requires us to address several factors.

The first factor we need to cover is "negligence." In general, a person who acts negligently does not take reasonable steps to ensure the safety of other people or their property. Depending on the circumstances, a homeowner might be considered negligent if he or she allows ice to form on the residence premises and a visitor slips on it. Similarly, the insured might be termed negligent if the insured's dog is allowed to roam free and attacks a stranger.

The insured's alleged negligence needs to have resulted in loss or damage to property or in bodily injury to the third party. In the case of property damage, the third party's property needs to have been broken, devalued or made unusable in some way. According to policy language used by the ISO, bodily injury must involve "bodily harm, sickness or disease, including required care, loss of services and death."

The personal liability insurance made possible through Coverage E can pertain to an insured's alleged negligence anywhere in the world, with a few exceptions. The worldwide reach of the coverage seems to be applicable when the alleged damage is tied to the insured's actions. So if an insured accidentally breaks someone's nose by hitting the person with an errant baseball, he or she should be covered for the damages no matter if the incident occurs in the insured's backyard or at a park across the country.

Geography does matter when damages aren't caused directly by the insured but are related to conditions at a particular location. Suppose a person owns a house and a condo and has only insured the house. If the person throws a party at the condo and a guest has a serious fall there and sues, the owner might not be covered by homeowners insurance. In this situation, coverage might only be possible if insurance for the house was purchased before the owner bought the condo.

Benefits remain available to an insured when the damage arises out of a location that the insured is renting temporarily for non-business purposes. Under the right conditions, for example, the policy could be used to cover injuries in an insured's hotel room or at a banquet hall that the insured has rented.

Damage to Other People's Property

Major claims for benefits under Coverage E often involve cases in which bodily harm has been done to another person. However, a homeowner can also file claims under Coverage E when he or she has damaged another person's property.

The standard homeowners insurance policy provides up to $1,000 (sometimes $500) to cover the replacement cost of another person's damaged property even if there hasn't been any negligence. This provision allows benefits to be paid to the owner of the damaged property regardless of whether the insured is technically at fault. The insurance can even be used to pay damages caused by the intentional acts of an insured who is younger than 13. So if a homeowner's young son intentionally hurls a ball at a neighbor's garage or window and damages the neighbor's property, the parent's insurance company will pay to repair the damage.

Beyond those $1,000 or so, damage caused by an insured to another person's property might not be covered unless the insured has been negligent.

Personal Liability Exclusions

The Coverage E portion of a homeowners insurance policy contains several significant exclusions. To prevent conflicts at claim time, insurance producers might want to discuss these exclusions with buyers before a policy is ever issued.

Homeowners should remember that Coverage E only gives them personal liability insurance. It does not help them manage professional liability risks or business liability risks. If homeowners injure another person or damage another person's property during the course of conducting business or rendering professional services, they are unlikely to be protected by their homeowners insurance in any way. In order to address those kinds of risks, they will need to purchase other insurance products.

Coverage E also does not help the insured deal with liability claims not related to bodily injury or property damage. Therefore, if a person is fearful of being sued for libel, slander or invasion of privacy, homeowners insurance is not the solution to the problem.

In some cases, the personal liability insurance will be worthless, depending on how the insured caused bodily injury or property damage. A homeowner is not insured for personal liability when the injury or damage is linked to sexual, physical or mental abuse of another person. Also, as a result of AIDS-related lawsuits in the 1980s and '90s, homeowners insurance no longer pays claims for bodily harm when an insured is liable for the spread of a communicable disease. Claims related to the use, creation, possession, delivery or sale of controlled substances will also be denied, including those linked to marijuana, cocaine and LSD.

Defense Costs

With the price of defending oneself in court so high these days, it is important for an insured to know that defense costs are included in nearly all homeowners insurance policies. The insurer has a duty to defend the inured in court, no matter if the suit against the person is legitimate or frivolous. The money to pay for this defense comes out of the insurance company's pocket and generally will not run out until the insurer has paid settlement costs or damages in an amount equal to Coverage E's limit of liability.

The insurer's obligation to pay defense costs is usually greater than its obligation to pay damages or settlement costs. To demonstrate this point, let's imagine a situation in which a homeowner has been sued because of someone else's death. If a court were to rule that the death resulted from the homeowner's intentional acts, the insurance company would probably be within its rights to deny any claims for damages or settlement costs. However, until it is clear that the homeowner's acts were indeed intentional, the carrier would likely be responsible for handling defense costs.

Some courts have allowed insurers to deny coverage of defense costs in situations like the one mentioned above, but many of those rulings have been reversed on appeal. At the very least, insurance professionals should realize that denying defense coverage to homeowners is not an easy thing to do.

Coverage F

The sixth major type of coverage found in homeowners insurance policies is "Coverage F." Coverage F provides up to $1,000 for medical expenses when a third party is injured

by the insured or on the insured's property. It covers these expenses regardless of whether the insured is at fault.

The $1,000 of coverage made available through Coverage F can be applied to medical expenses that an injured third party incurs within three years after an accident. The $1,000 can be used to pay for any of the following:

- Private nursing.
- Hospitalization.
- Ambulance services.
- X-rays.
- Dental work.
- Physician services.
- Surgery.
- Prosthetic devices.
- Funeral expenses.

Coverage F is only intended to pay for expenses that are indisputably medical in nature. It is not designed to reimburse an injured third party for non-medical losses, such as any loss of income while a victim recovers from an injury.

In order for an insurer to authorize benefits under Coverage F, at least one of the following circumstances must apply:

- The person was injured while on the insured's property and was not guilty of trespassing.
- The person was injured directly by the insured or the insured's activities.
- The person was injured by the insured's household employee while the employee was fulfilling his or her job duties.
- The person was injured by an insured's pet.
- The person was injured near the insured's property because of the condition of the insured's property. (In this case, think of a tree with hazardous branches that extend into a neighbor's yard.)

Coverage F cannot be used as medical insurance for anyone who is considered an insured by the insurance company. So if a husband is mopping his kitchen floor and his wife slips and injures herself, the wife's medical expenses will not be covered by homeowners insurance. Injuries sustained by an insured's domestic employees might represent exceptions to this exclusion, but the insurer will still refuse to pay any expenses when an alternative form of reimbursement is available through disability laws or workers compensation laws.

Common Coverage Forms

Up until now, we have studied homeowners insurance policies and their corresponding terms and conditions in a very general sense. However, consumers need to realize there are several distinct variations on the typical homeowners insurance policy.

Most property insurance companies in the United States use homeowners insurance policies with language written by the Insurance Services Offices (ISO). The ISO's standard policies have names that feature the letters "HO" followed by a number. In theory, a person could purchase an HO-1, HO-2, HO-3, HO-4, HO-5, HO-6, HO-7 or HO-8 policy.

Some property insurance companies do not base their policies on ISO language. Alternatively, they might use terms and conditions authored by the American Association of Insurance Services (AAIS). In Texas, the names of homeowners insurance policies contain the letters "HO" followed by another letter of the alphabet.

Because the ISO's policy forms are much more common than AAIS forms, the information in this course was derived from common interpretations of ISO language. Before heading deeper into specific contractual language, let's summarize the most commonly recognized homeowners forms from the ISO.

HO-1

The HO-1 policy form is sometimes referred to as the "basic form." Rarely sold these days, it insures the homeowner's property against fewer perils than the typical homeowners policy, and it contains very broad exclusions by comparison.

An insurance policy modeled after the ISO's HO-1 form insures the homeowner against property losses caused by the following perils:

- Fire.
- Lightning.
- Wind.
- Hail.
- Explosion.
- Riot and civil commotion.
- Aircraft.
- Vehicles.
- Smoke.
- Vandalism and malicious mischief.
- Theft.
- Volcanic eruptions.

As mentioned earlier, the dwelling's insured value represents the dollar limit for Coverage A, and many of the policy's other dollar limits are based on this number. With an HO-1 policy in force, detached structures are covered for 10 percent of Coverage A. Coverage of contents is equal to 50 percent of Coverage A. Loss of use coverage is equal to 10 percent of Coverage A.

HO-2

The HO-2 policy form is sometimes referred to as the "broad form." This policy is fairly popular and insures the homeowner against property losses caused by many common

perils. In addition to covering losses brought on by all the perils mentioned in the HO-1 form, the HO-2 form reimburses the insured for losses related to the following:

- Falling objects.
- Weight of ice, snow or sleet.
- Accidental discharge of water or steam.
- Accidental overflow of water or steam.
- Freezing.
- Sudden and accidental tearing, cracking, burning or bulging of heating, air conditioning, water or steam systems.
- Sudden and accidental discharge from artificially generated electrical current.

With an HO-2 policy in force, detached structures are covered for 10 percent of Coverage A. Coverage of contents is equal to 50 percent of Coverage A. Loss of use coverage is equal to 20 percent of Coverage A.

HO-3

The HO-3 policy form is sometimes referred to as the "special form." It is generally considered the standard version of modern homeowners insurance. When phrases such as "the typical policy" and "the standard policy" are used in this chapter, the reader should infer that we are talking about the HO-3 policy form.

Unlike previously mentioned homeowners forms, the HO-3 form covers the insured dwelling and detached structures on an "all-risk" basis. This means a loss will be covered by the policy unless the insurance contract specifically excludes it. Simply put, an all-risk policy is as comprehensive as insurance tends to get.

When explaining the positive features within HO-3 policies, insurance producers sometimes forget to mention that the all-risk coverage applies only to the dwelling and detached structures. By default, HO-3 policies cover personal property on a "named-peril" basis just like HO-1 policies and HO-2 policies. This means a loss pertaining to personal property will only be covered if it has been caused by a peril specifically mentioned as a covered peril in the insurance contract. With respect to personal property, the covered perils in an HO-3 policy are basically the same as those in an HO-2 policy.

With an HO-3 policy in force, detached structures are covered for 10 percent of Coverage A. Coverage of contents is equal to 50 percent of Coverage A. Loss of use coverage is equal to 20 percent of Coverage A.

HO-4

The majority of residential tenants do not have renters insurance. However, this insurance can be an important element of proper risk management for millions of consumers.

Contrary to popular belief, a renter's personal property is generally not covered by the landlord's insurance policy. This is true no matter if damage to the property is caused by the property's owner or by another tenant in the same building.

From a liability standpoint, tenants without renters insurance might have to pay out of pocket for legal services and court-awarded damages if they are ever sued by a third party. While a landlord might still be held liable for slip-and-fall injuries on the property's steps, adjoining sidewalks or common areas, a renter can be held liable for similar injuries suffered inside his or her portion of the residence premises. The renter might also be liable for hazards—such as a fire—that start in his or her portion of the premises and spread far enough to damage another tenant's property.

All these potential problems may be managed through the HO-4 policy form, which is used to insure renters and their belongings. The HO-4 policy form insures personal property against the same perils named in the HO-2 form. But the typical renters insurance policy is different from other homeowners policies in several respects.

The most significant difference between HO-4 policies and the other forms we've previously discussed is that the HO-4 policy's emphasis is on contents coverage rather than on dwelling coverage. This makes sense because the responsibility of maintaining the building and fixing structural problems usually belongs to the landlord. Instead of expressing the dollar limit for contents coverage as a percentage of Coverage A, a renters policy is meant to provide as much contents coverage as the tenant wants. It also often provides personal liability protection.

Despite its emphasis on contents coverage, a renters policy may contain a very limited amount of dwelling insurance. This coverage can be used to reimburse tenants when they have made improvements or additions to their rented dwelling and suffer damage to those improvements or additions. This insurance can only be utilized if the tenant paid for the improvements or additions and has not been reimbursed by the landlord.

If a person shares a rented dwelling with a roommate who is a non-relative, his or her renters policy probably does not cover the roommate's belongings or the roommate's liability. Policies that jointly cover non-related residents of the same dwelling can be obtained from some insurance companies upon request.

The HO-4 policy form is for renters and not for landlords. But that doesn't mean landlords will receive no insurance benefits when a loss occurs entirely within the privately rented portion of their building. Many homeowners insurance policies cover a landlord's furnishings in rented rooms, rented homes or rented apartments for up to $2,500. Covered furnishings may include appliances and carpeting. This insurance does not apply when a landlord's furnishings have been stolen.

With an HO-4 policy in force, the tenant's improvements or additions to the rented portion of the dwelling are covered for 10 percent of Coverage C. Loss of use coverage is equal to 20 percent of Coverage C.

HO-5

The HO-5 policy form gives the insured all-risk coverage for both the dwelling and personal property. As good as that may sound, HO-5 policies can be very expensive.

If a person prefers all-risk coverage for both the dwelling and its contents, the insurer will probably not even bother selling the person an HO-5 policy. Instead, the all-risk coverage for personal property will simply be added onto an HO-3 policy for an additional cost.

HO-6

Condominiums and townhouses are covered by a "master policy," which is purchased by an elected association on behalf of all residents at the complex. The master policy will cover damages to a building's exterior, as well as common areas such as basements and hallways. The extent to which the master policy insures each individual unit is left up to the association.

The portions of each unit that are not insured by the master policy will be disclosed in the association's bylaws or in similar documents. At the very least, the policy ought to cover the unit's walls, ceiling and floors.

Those parts of the unit that aren't covered by the master policy are the individual owner's responsibility. Of course, each individual owner is also responsible for obtaining his or her own insurance for personal property and personal liability.

To address the concerns of condo dwellers and townhouse owners, insurance companies sell policies based on the HO-6 form, also known as the "unit-owners" form. The unit-owners form features named-peril coverage for the insured's personal property and a little bit of named-peril coverage for the unit itself. The named perils in an HO-6 policy are the same as those in an HO-2 policy.

With an HO-6 policy in force, the unit and detached structures are often covered by default for $1,000. Loss of use coverage is equal to 40 percent of Coverage C.

HO-7

HO-7 policies are meant to insure mobile homes, which can also be covered by adding endorsements to other homeowners forms. Because HO-7 policies are rarely mentioned in the same breath as other homeowners forms, they will not be addressed at any other point in this chapter.

HO-8

The HO-8 policy form is sometimes known as the "modified" form. It is not used in all states and is typically used to cover older homes in urban areas when the dwelling's market value is considerably lower than its replacement cost.

In many ways, the coverage available through an HO-8 policy is identical to the coverage in an HO-1 policy. However, in a very important difference, HO-8 policies cover the dwelling only up to its actual cash value. Unlike the HO-2, HO-3 and HO-5 forms, they do not insure the dwelling up to its replacement cost.

In general, actual cash value is the property's replacement cost minus depreciation. A few states have multiple definitions of "actual cash value" with regard to dwellings. In California, for example, actual cash value generally means replacement cost minus depreciation. But if a dwelling in that state is covered for actual cash value and is completely destroyed, the owner might receive the dwelling's fair market value or the policy's dollar limit, whichever is less.

Unlike all other common kinds of homeowners policy forms, the HO-8 form limits coverage of theft to $1,000 per occurrence, and it generally does not cover instances of theft in a place other than the residence premises.

With an HO-8 policy in force, detached structures are covered for 10 percent of Coverage A. Coverage of contents is equal to 50 percent of Coverage A. Loss of use coverage is equal to 10 percent of Coverage A.

Coinsurance Clauses

When consumers decide how much replacement cost coverage to purchase for their dwelling, they need to think about more than just the possibility of a total loss. Smaller losses will not be covered in full if the amount of replacement cost insurance is less than the amount listed in the policy's "coinsurance clause." In order to differentiate it from the slightly different coinsurance requirements in commercial policies, a coinsurance clause in a homeowners insurance policy is often called an "insurance to value provision."

The coinsurance clause in a homeowners policy gives people an extra incentive to adequately insure their dwellings. The clause is basically the insurance industry's way of acknowledging that small claims are more common than large claims and that people should buy more insurance in order to make small claims less burdensome for everyone.

The typical homeowners insurance policy has a coinsurance clause that requires the insured to cover a dwelling for at least 80 percent of its replacement cost. In this context, the replacement cost would be the cost of rebuilding a similar structure on the same spot at the time of the claim. This is an important point because a person who insures a home at only 80 percent of its replacement cost at the time of purchase will not satisfy the policy's coinsurance requirement if construction costs increase over time. If the person were to suffer a loss, he or she would probably be looking at some steep out-of-pocket expenses.

If a homeowner does not insure the dwelling for at least 80 percent of its replacement cost and suffers a partial loss, the insurer will not reimburse the insured for the entire loss. Instead, the insured will be entitled to the actual cash value of the damaged portion of the property or an amount that is prorated based on how close the person is to meeting the coinsurance requirement. The larger of these two figures will be paid by the insurance company. The rest of the loss will not be covered.

Some Coinsurance Examples

Even for insurance veterans, coinsurance clauses can be confusing. Let's look at a few examples of how this kind of clause might affect a homeowner.

Sally purchased replacement cost coverage for her home in the amount of $80,000. After a fire, it was determined that the cost to replace the home would have been $100,000. Since Sally's amount of replacement cost coverage ($80,000) was equal to 80 percent of the home's replacement cost ($100,000 × 80% = $80,000), she met her coinsurance requirement and had her claim paid in full, up to her Coverage A limit.

Jim purchased replacement cost coverage for his home in the amount of $175,000. After a windstorm damaged the dwelling's roof, it was determined that the cost to replace the home would have been $200,000. Since Jim's amount of replacement cost coverage ($175,000) was greater than 80 percent of the home's replacement cost ($200,000 × 80% = $160,000), he met his coinsurance requirement and had his claim paid in full, up to his Coverage A limit.

Mark purchased replacement cost coverage for his home in the amount of $300,000. After a major hailstorm, it was determined that the cost to replace the home would have been $500,000. Since Mark's amount of replacement cost coverage ($300,000) was less than 80 percent of the home's replacement cost ($500,000 × 80% = $400,000), he did not meet his coinsurance requirement and was only covered for a portion of his losses.

Pro-Rated Settlements

When a settlement is pro-rated because of a failure to satisfy coinsurance requirements, an insurance professional can look at the coinsurance clause, plug in the appropriate numbers and determine the amount, in dollars, the insurance company will pay to the policyholder.

To determine the covered portion of a loss, we must first determine the size, in dollars, of the coinsurance requirement. This is accomplished by multiplying the 80 percent coinsurance requirement by the home's replacement cost at claim time. So, for our friend Mark, we would multiply 80 percent by $500,000 and get a result of $400,000.

In the next step, we need to divide the amount of purchased replacement cost coverage by the size of the coinsurance requirement in dollars. For Mark, we would divide $300,000 by $400,000 and get a result of 0.75. This means Mark would be covered for no more than 75 percent of any losses to the dwelling except after a total loss.

Now all we have to do is multiply our answer from the previous step by the actual loss. Suppose the hailstorm caused $40,000 of damage to Mark's building. His insurance company would multiply $40,000 by 75 percent and get a result of $30,000.

Unless the actual cash value of the damaged portion of the property is greater than $30,000, this is the amount Mark will receive from his insurance company. The remaining $10,000 would be considered an uninsured loss.

The preceding steps can be summarized in the form of the following equation:

- Pro-rated settlement = [Coverage A limit ÷ (80 percent × replacement cost at claim time)] × actual loss

As important as the coinsurance clause sometimes is, it is often only a factor when there is partial damage to a building. It is often not applicable when a building is completely destroyed, and it does not impact coverage of contents, additional living expenses or personal liability claims. The clause does not exist in H0-4, HO-6 or HO-8 policy forms.

Conclusion

As the reader can see, homeowners insurance does much more than protect people's homes. Its unique offerings of dwelling coverage, contents coverage, liability coverage and other benefits make it more than just one of the most important kinds of insurance. It is also an indisputably versatile product that addresses many common risks. Its broad appeal can help a knowledgeable insurance producer become a great success.

CHAPTER 6: LIFE INSURANCE

Historically, people have bought life insurance in order to ensure that a dependent or other loved one will not suffer financial hardship after a death. Sometimes, the death

benefit—the amount paid to a beneficiary—is helpful because it allows an otherwise independent person (such as a working spouse) to adapt to life without a shared income. More importantly, life insurance can create adequate income for those dependents who either need even longer periods to adjust to a devastating financial reality or might never be able to adapt to such a major change.

Examples of possibly needy beneficiaries might include a stay-at-home spouse who would suddenly need to find a job with competitive pay in order to make ends meet, a child who would need such essentials as food, clothing and a decent education, an elderly parent who would need to hire someone to help with various household tasks or any loved one with special needs.

Life insurance can also help beneficiaries pay specific expenses in either a short-term or long-term capacity. A policy boasting significant benefits could help satisfy a mortgage loan on a family home or free a spouse from other debt obligations. A small policy might be enough to ensure that a low-income family will not need to lose thousands of hard-earned dollars in order to cover the cost of a respectable funeral.

No matter if their child is a few days old or has already spent years in the school system, middle-class parents might want to eventually borrow money from a life insurance policy and create a substantial college fund for a son or daughter, thereby making the policy not just a risk management tool but also a source of investment gains.

That last example can help us bridge the gap between traditional views on life insurance, which center on death benefits, and current views on the policies, which treat life insurance as yet another wise addition to a diversified financial plan. Following the annuity's lead, some life insurance policies have been marketed as smart investments for eventual retirement. Customers have been told about the various tax incentives that some life policies might provide. Even businesses have noted the financial flexibility of the product by taking out policies on valued employees and using life insurance as a prominent feature in buyout agreements.

Needs Analysis

Insurance producers can help reduce the millions of underinsured and over-insured people in this country by performing a "needs analysis." A needs analysis tries to determine how much insurance a person ought to possess. This analysis should be influenced by each individual applicant's concerns and risk potential.

A proper needs analysis analyzes a customer's death-related risks and insurance objectives. When calculating a dollar amount for a proper death benefit, the producer and the applicant might find it helpful to ask and answer the following questions:

- How much money will dependents need in order to maintain their current standard of living and keep up with inflation?
- How much money will dependent children need for school tuition and basic necessities?
- How long is a person likely to remain a dependent and rely on income from a policy?

- How much money should beneficiaries receive—regardless of need—as a gift from the deceased?
- If the insured is in training for a potentially lucrative career, how much money should dependents receive in order to offset the loss of expected high earnings?
- How much money should beneficiaries receive in order to offset debts (such as a mortgage loan) that the insured person would normally pay for?
- How much should beneficiaries receive in order to pay estate taxes?
- How much money should beneficiaries receive in order to pay funeral costs, burial costs and other expenses related to the insured person's death?
- How much money should be reserved for a favorite charity or some other non-traditional beneficiary?

A needs analysis can lead buyers and sellers to the best kind of life insurance policy for a given situation. For instance, a high-income applicant might prefer a policy that could maximize the amount of death benefits without causing major estate tax problems. Middle and low-income applicants, on the other hand, are less likely to need this same kind of policy because their estates do not commonly face significantly negative tax consequences upon death. Instead, their financial situations might call for a traditional policy that guarantees necessary death benefits to children, spouses and other dependents in as simple a manner as possible.

Life Insurance and Taxes

As long as a policyholder does not borrow money from or cancel a policy, life insurance proceeds are generally exempt from income taxes. This tax break serves beneficiaries well, but the policy might still be taxable as part of the deceased person's estate. The value of life insurance might be taxed against the deceased's estate if the deceased owned the policy within three years of death or if the estate is the beneficiary.

The federal estate tax (generally due within nine months of a death) can drastically reduce compensation for legal heirs. To combat this situation, many financial advisers champion the use of insurance trust funds. An insurance trust puts the policy irrevocably under the control of an executor. This person acts on the deceased's behalf by giving policy proceeds to beneficiaries at designated times and in designated amounts.

On occasion, policyholders look to avoid estate taxes by transferring policy ownership to heirs. In order for the proceeds to receive an exemption from estate taxes, such transfers must occur at least three years before the original policyholder's death.

Transferring ownership of a life insurance policy can still require the original policyholder to pay gift taxes. In general, a person can pass along assets worth up to roughly $10,000 to non-spouses, without fair compensation, and avoid gift taxes.

Kinds of Life Insurance

Before we begin to investigate the purpose and intention of various life insurance provisions, terms and conditions, we will first review the most common kinds of life insurance policies.

Term Life Insurance

Term life insurance is sometimes called “pure insurance” because, unlike other policies, it lacks investment options and has no cash value. Instead, term life customers pay premiums only so that beneficiaries can potentially receive the policy’s “face value.”

The face value is clear to the insurer and the policyholder when the policy is issued, and it generally does not change as long as premiums are paid. The face value is generally not dependent on the economy or the performance of investments. If a person who is insured through a $100,000 term life policy dies, the insurance company pays $100,000 to beneficiaries, barring any unusual circumstances.

As their name suggests, term life policies remain in effect for a contractually agreed-upon time and then expire. People who opt for a term life policy instead of a permanent life policy tend to have short-term needs and view beneficiaries’ welfare as their top life insurance concern. A father, for example, might purchase a term life policy in order to ensure that his young children will have some financial support if he were to die before they reach adulthood.

When a policy’s term concludes, the insured individual often can reapply for another term insurance policy. However, premiums for the new term policy are likely to be higher than premiums under the old policy. This is because the person’s susceptibility to mortality risks will have increased with age.

If policyholders have no interest in renewing a term life policy they can sometimes exchange it for one of the several permanent life policies we will discuss later.

Permanent Life Insurance

Permanent life insurance is very different from term life insurance. Whereas term life insurance is either renewed frequently or allowed to expire after a specified number of years, permanent life insurance should cover the insured individual no matter how long a person lives. Also, whereas the cost of some term life policies can increase dramatically as the insured person ages, many permanent life policies feature locked-in premiums that remain the same for several years.

Cash Value

In addition to paying premiums for possible death benefits, people who purchase permanent life insurance are engaging in a financial investment. Permanent coverage allows buyers to turn the money they spend on their policy into accessible cash that will hopefully increase in value over time. Part of the premiums paid to the insurer is set aside and allowed to grow in tax-deferred accounts until the policyholder decides to use the money. The sum of paid premiums and accumulated interest is known as the policy’s “cash value.”

Cash value makes permanent life insurance a very versatile asset. In many cases, it can be utilized to keep premiums at a level amount even as the insured person grows older. It also allows policyholders to either obtain a low-interest loan from their insurer or use their policy as collateral for a loan from another lender. It also gives people who no longer want their policies the chance to recover a portion of the money that was spent on the insurance. This amount of money is known as the “cash surrender value.” The

cash surrender value is equal to the policy's cash value minus any unpaid policy loans and unpaid premiums.

Permanent life insurance ideally benefits the person buying coverage as well as the company selling it. The buyer not only remains covered as long as premiums are paid. He or she also has a financial incentive to maintain the coverage for various investment purposes. At the same time, the insurer benefits from offering this incentive because customers who maintain their coverage give the company a steady supply of capital to invest.

Despite this give and take, some critics say cash-value accumulation takes too long to materialize. This waiting period for growth exists, in part, because much of the premiums paid during the early years of coverage go toward sales commissions and administrative fees rather than toward the policy's cash value.

Whole Life Insurance

Unlike the different kinds of term life insurance, the various types of permanent life insurance policies differ significantly in ways beyond their premiums. The three main varieties of permanent coverage are whole life insurance, universal life insurance and variable life insurance.

Whole life contracts can usually remain in force at least until the insured person reaches age 100, and premiums for these policies usually stay the same as long as the policyholder pays them on time. The price for whole life insurance pays for more guarantees than a person will find in a typical universal life or variable life policy, and the product remains popular among people who want permanent coverage but remain fearful of possible economic downturns.

Universal Life Insurance

"Universal life insurance" tends to get tagged with the adjective "flexible" quite often. This product attracts people because it allows them to make changes to their insurance in a far simpler manner than under a whole life agreement.

Rather than needing to pay an agreed-upon premium for permanent coverage, a universal policyholder has some control over the size and even the frequency of premiums. A person looking to grow a universal policy's cash value can increase premiums when interest rates are high and decrease premiums when those interest rates drop. Of course, the policyholder might also have personal reasons for raising or decreasing premiums at any given time.

Universal premiums are often disclosed in a divided manner, showing how much of each payment ultimately goes toward the death benefit and how much goes toward the policy's cash-value component. The portion of premiums that goes toward the death benefit is known as the "mortality cost." In order for the policy's death benefit to remain fully guaranteed, premiums paid by the policyholder must be at least as much as the mortality cost.

Due to its flexibility and its emphasis on mortality cost, universal life insurance policies are less likely than whole life policies to fully guarantee large death benefits. Some insurers have offered policy riders that can fatten the guaranteed payouts, but these riders can make a universal contract cost just as much as (or even more than) a whole

life policy. Fully guaranteed death benefits from a universal life policy tend to only apply when the policyholder has paid at least a specified minimum amount of premiums to the insurance company. The amount of premiums paid to the insurer must have been enough to fully offset the policy's mortality cost.

Variable Life Insurance

Perhaps no life insurance product demands as much caution and expert consultation as "variable life insurance." Like universal life insurance, variable life insurance features a death benefit, allows customers to see where the money from their premiums is going and allows for greater personal control than whole life insurance.

The major difference between universal and variable life insurance is that a variable life policy transfers significant investment responsibilities from the insurer to the policy's owner. Unlike whole or universal life contracts, variable policies lack minimum investment guarantees. A variable policy's cash value might experience major increases over time or major losses, and it is the policyholder—not the insurer—who absorbs market risks.

When a customer pays a premium for variable life insurance, any investment portions of the premium go into a separate account with the policyholder at the controls. The customer must then decide how to invest his or her money.

Each insurer will feature its own assortment of investment options that work somewhat like mutual funds. Investment dollars are pooled together from all policyholders with similar investment preferences, and the pool's designated manager works to maximize growth. Investment options might include domestic or foreign stock funds, bond funds, money market funds and more.

Policyholders can diversify their investments by allocating different dollar amounts to different funds. They are usually neither taxed by the government nor charged fees by the insurer for moving their money around within the insurer's assorted investment vehicles.

Beneficiary Designations

Correctly designating a beneficiary on a life insurance policy might seem like a simple act. But because an invalid or incorrect beneficiary designation could defeat the purpose of buying the insurance in the first place, buyers and carriers must have a mutual understanding of how a policy bestows death benefits upon selected individuals. When a person's life insurance policy does not clearly list a valid, identifiable beneficiary, death benefits will become part of the deceased's estate. Contrary to popular belief, a dead person's last will and testament will often not suffice when survivors try to overrule designations made on insurance beneficiary forms.

There are two general ways in which beneficiaries can be categorized. The first way categorizes beneficiaries by their permanence. Some beneficiaries are "irrevocable beneficiaries." No matter the policyholder's changing wishes and no matter any assignment of ownership, these beneficiaries will remain listed on the policy unless the policyholder cancels the coverage. Other beneficiaries are "revocable beneficiaries." No matter their own desires, these individuals can be removed from a policy at the owner's command.

Beneficiaries are further categorized as either “primary beneficiaries” or “contingent beneficiaries.” Primary beneficiaries are first in line to receive any death benefits. If a policy lists more than one primary beneficiary, the listed individuals will share death benefits based on the percentage that the owner has designated for each party. Multiple contingent beneficiaries may also share benefits, but they can only receive compensation if no primary beneficiaries are alive at claim time.

Settlement Options

The manner in which a beneficiary receives policy benefits is called a “settlement option.” Many companies have a default way of paying benefits, but this does not mean beneficiaries must always accept the insurer’s preferred method.

Historically, most life insurance beneficiaries have received their money in a lump sum. This settlement option is perhaps the least complex one and can be attractive to beneficiaries who have a pressing need for money. It also tends to suit people whose shares of death benefits are relatively small.

People who receive large death benefits might opt to have their money rationed and given out periodically so that they can count on a steady income that continues for several years. This option basically transforms the life insurance policy into an annuity.

Several insurance companies allow beneficiaries to invest death benefits in money market accounts. This option gives people more time to consider what they should do with large sums of money and gives the death benefit a chance to grow in an interest-bearing environment. When a beneficiary decides that the death benefit can be put to good use, he or she can withdraw some or all of the invested funds via check-writing privileges. Be aware, however, that interest earned by the beneficiary on death benefits might be taxed as income.

Conclusion

By now, you should be able to comprehend the versatility of life insurance products. From term life all the way to the latest hybrid contracts with variable life features, the insurance industry has done its best to develop fresh provisions that cater to a broad base of consumers. But a wide variety of products and consumer options might do little to promote lasting business relationships between insurers and the public if insurance workers forget to explain some of the complexities of these products. When consumers establish a relationship with an astute and informed insurance representative, they end up with risk management assistance that can be worth far more than the size of any premium.

CHAPTER 7: ANNUITIES

An annuity is a long-term contractual arrangement in which an investor gives money to an insurance company and is expected to get it back in either a lump sum or a series of regularly scheduled payments. In most cases, the purpose of an annuity is to provide the investor with a permanent stream of income that cannot be outlived. The income stream might be needed immediately if personal savings and Social Security checks don’t adequately cover a retired individual’s expenses. Alternatively, it might be a deferred tool that can help working people develop a retirement strategy far in advance.

Although annuities don't remove all the uncertainty and personal responsibility from retirement planning, they can ensure that seniors receive at least some dependable income in addition to Social Security benefits. This may explain why many people consider an annuity to be the reverse of a life insurance policy. Whereas life insurance financially supports beneficiaries if someone dies too soon to support their family, an annuity can financially support someone if he or she lives too long and runs out of savings.

There are annuities to attract conservative investors and annuities for people who are willing to take more risks. Products called "fixed annuities" guarantee a return of the money investors put into them and will often promise higher interest rates than certificates of deposit (CDs). Products called "variable annuities" are less likely to guarantee a full return of a person's initial investment, but they have the power to produce higher returns.

Long-term investors and long-term savers are also sometimes won over by the annuity's tax features. Most annuities go through an "accumulation period." Throughout the accumulation period, interest earned on an annuity grows on a tax-deferred basis, and the interest may be compounded. So, in simplistic terms, no one pays taxes on the money until it comes out of the account, and interest can be credited to *both* the amount invested (known as the "principal") and any previously earned interest. Consumers receive these positive benefits in exchange for less liquidity than they might find in CDs or mutual funds.

Fixed and Variable Annuities

People who care more about saving money than engaging in high-risk, high-return ventures tend to prefer fixed annuities over variable annuities because fixed annuities are required to contain guarantees. The traditional fixed annuity guarantees a return of all money given to the insurance company plus a guaranteed amount of interest.

The risk to the fixed annuity purchaser is minimal because the insurance company invests the person's premiums in conservative bonds and government securities. The consumer is responsible for picking the right contract and insurer, while the insurer is responsible for investing the principal in a manner that will satisfy the contract's guarantees. However, purchasers of fixed annuities need to be aware that the guarantees provided by the insurer might not keep up with inflation.

Variable annuities appeal to investors who are willing to put some of their principal at risk in exchange for potentially higher returns. The owner typically shoulders the responsibility of investing his or her money in one or several mutual funds, and the annuity's account balance will go up or down depending on how those funds perform. In addition to absorbing market risks, owners of variable annuities will usually be charged account management fees on an annual basis.

Deferred and Immediate Annuities

Fixed and variable annuities can be either immediate or deferred. The annuity shopper's choice between an immediate annuity and a deferred annuity will depend on when the person wants to start receiving payments from the insurance company. Let's go over the options.

Deferred Annuities

A “deferred annuity” is often favored by individuals who don’t need consistent, additional income at the time of purchase but envision needing it in the future. When people buy a deferred annuity, their goal is to watch their principal expand for several years. Presumably at a much later date, they’ll cash in their deferred annuity for a lump-sum payout or for divided payouts that will be disbursed throughout their remaining lifetime.

Between the time it’s purchased and the time payments begin, a deferred annuity goes through an accumulation period. During the accumulation period, the owner’s account is expected to grow without negatively affecting the person’s tax situation.

Immediate Annuities

An “immediate annuity” creates an income stream for the owner soon after the sale date. In general, the owner starts receiving payouts within one year of entering into the contract.

People who buy immediate annuities might care less about growing their principal and more about maintaining their current income level for as long as possible. An immediate annuity can help them achieve their goals by giving them payouts on a monthly, annual or other set schedule rather than in a lump sum.

Immediate annuities don’t go through a traditional accumulation period because money is being taken out of them at the same time that the account would otherwise be growing in value. Also, opportunities for tax deferral with an immediate annuity are relatively minimal because taxation on an annuity begins when money is taken out of the owner’s account.

The amount of money someone receives regularly from an immediate annuity will be determined by the principal, the person’s life expectancy and the fixed or variable status of the annuity. With all other factors being equal, a larger principal will translate to bigger immediate payouts because the insurance company will have more money to give out in the first place. But because annuities are designed as supplementary sources of income that last a lifetime, immediate payouts offered to a younger person can be lower than those offered to an older person. This can be true even if the younger individual invests more principal.

Most immediate annuities are fixed and give budget-conscious owners the security of knowing that their scheduled payouts will not dip below a guaranteed minimum dollar amount. However, because the ceiling on interest rates is only so high, some people worry that these products will not keep up with inflation. In efforts to confront that concern, insurance companies have designed some riders (add-on features in insurance contracts) that can either automatically increase annuity payouts every year or at least ensure that payouts will temporarily keep pace with consumer price indexes.

A minority of annuity owners choose to receive variable immediate payouts, which can combat inflation without the help of a rider. Variable immediate annuities will not help someone craft a budget because, without riders, they offer no minimum guarantees. The insurance company calculates an initial payout for a variable immediate annuity, based on life expectancy and economic conditions, but subsequent payouts can rise or fall with the financial markets.

Parties in an Annuity Contract

No matter who sells the product or how the seller has organized it, an annuity is a legal agreement that bestows rewards and responsibilities upon multiple parties. These parties include the insurance company, the annuity owner, the annuitant and the beneficiary.

The Insurance Company

The insurance company behind the annuity has a contractual obligation to eventually pay money to a person or other entity. In return, the insurer collects fees from investors or is allowed to invest owners' money and keep a portion of any positive yields.

The Annuity Owner

The "annuity owner" is the person who puts money into the annuity. He or she chooses how much to invest and, in the case of variable annuities, how the invested amount should be allocated among various funds. The owner is usually (but not always) the party who will be held responsible for paying taxes on the annuity.

The annuity owner has many of the same rights as the owner of a life insurance policy. The owner can surrender the contract, choose a beneficiary and, in some cases, borrow money from the annuity's cash value. The owner hangs onto these rights until the contract expires or is terminated. An annuity may be owned by one person, several people, a trust or a corporation.

The Annuitant

An annuity owner also gets to designate an "annuitant." The annuitant is the person whose life expectancy influences the size of payouts from the insurance company. In most (but not all) cases, the annuitant is also the person who receives the income created through the annuity. Because annuity payouts are determined, in part, by life expectancy, an annuitant must be an actual person, rather than a trust or corporation.

In most cases, the annuity owner and the annuitant will be the same person. In other words, people will invest their own money with a goal of creating an income stream for themselves. But it's also possible to have one person as the owner and another person as the annuitant. For example, one spouse might own an annuity that pays income to the other spouse, or a company might own an annuity that pays income to a former employee. However, designating different people as the owner and annuitant can create unexpected tax problems and may even cause death benefits to go to beneficiaries at an inappropriate time. (Beneficiary and tax issues will be explained in more detail later in this chapter.)

Unless he or she is also the owner, the annuitant lacks the right to borrow money from the annuity, alter investments within the annuity, or partake in any of the previously mentioned privileges that are granted to the annuity owner. In fact, some contracts let the owner eliminate an annuitant from the original contract and choose a new one.

The Beneficiary

The "beneficiary" is a person, corporation or trust that receives death benefits if someone passes away before income payouts have begun. Depending on the annuity,

a beneficiary might also be entitled to benefits even if the insurance company has already started making payments from the owner's account.

The annuity owner chooses the beneficiary and can alter that choice after the annuity has been issued. As is the case with a life insurance policy, owners can designate multiple beneficiaries, divide death benefits equally or unequally among those multiple beneficiaries, list contingent beneficiaries or pick themselves as beneficiaries. If the owner and the beneficiary are different people, the beneficiary cannot borrow from the annuity, alter investments within the annuity, or partake in any of the other previously mentioned privileges that are granted to the annuity owner.

The role of the beneficiary may seem simple, but it can be complicated if the annuitant and the owner aren't the same person. Some annuities require that any applicable death benefits be paid to beneficiaries when the annuitant dies. Others will only pay death benefits when the owner dies. Annuities that will pay death benefits only when the owner dies are considered "owner-driven." Annuities that will pay any applicable death benefits if the annuitant dies before the owner are considered "annuitant-driven." (For tax reasons, an annuitant-driven annuity might also need to provide death benefits to a beneficiary if the owner dies before the annuitant.)

Because of the different rules for owner-driven and annuitant-driven contracts, the owner's choice of a beneficiary should be made with great care. Imagine, for example, a husband and wife who are involved in an annuity transaction. The couple's intention is for the surviving spouse to eventually be able to benefit from the annuity and for their children to receive death benefits when both spouses die.

Now assume the couple decided to purchase an annuitant-driven annuity with the husband as the owner, the wife as the annuitant and their children as beneficiaries. If the wife dies before the husband, the money from the annuity might flow immediately to the children rather than to the husband. To avoid this problem, the husband could have listed himself as the main beneficiary and listed his children as contingent beneficiaries.

Now imagine the same couple is involved but that the husband dies first. Again, any death benefits from the annuity might go to the children as beneficiaries instead of to the surviving spouse. If the husband had intended for his wife to benefit from the annuity after his death, he could have listed her as the main beneficiary and listed his children as contingent beneficiaries.

There are even scenarios in which a co-owner automatically forfeits a financial interest in an annuity upon the other owner's death. To ensure that the intended beneficiaries only receive death benefits at the intended time, annuity contracts should be examined thoroughly by all parties and drafted with care.

Annuitization

If an annuity owner is ready for the insurance company to start paying an income stream, the "annuitization" process will begin. During traditional annuitization, the insurance company usually pays out the same amount in installments on a set schedule to an annuitant.

An assortment of newer annuity contracts allows the owner to opt for payouts that are scheduled to go up or down after a certain date. This option can be helpful if the owner

foresees a significant change in the annuitant's need for income. For example, the scheduled conclusion of a mortgage agreement might be reason enough for the owner to want payouts that start large but get smaller after a certain date. Some variable annuities allow the owner to choose between receiving level payouts upon annuitization or payouts that will go up or down depending on market performance.

In most annuitization situations, payouts are fixed at an equal amount and are scheduled to continue throughout the annuitant's lifetime. When the owner chooses this option, the amount of each individual payout owed to the annuitant will depend on the account balance and a figure called the "benefit rate." The benefit rate is the dollar amount the insurer will pay in each installment (usually on a monthly basis) for every $1,000 in the owner's account.

The benefit rates offered by different insurance companies will vary, but all benefit rates will be based, to a large extent, on the annuitant's life expectancy. Payouts from most immediate annuities will reflect the benefit rate that was offered by the insurer when the annuity contract was signed. Payouts for most deferred annuities will be based on either the benefit rate offered by the insurer at the time of annuitization or the guaranteed minimum benefit rate that was offered by the insurer when the contract was signed.

With life expectancy serving as such an important factor in the calculation of benefit rates, it ought to come as no surprise to the reader that older people receive higher benefit rates than younger people and that men receive higher benefit rates than women of the same age. Some insurers will also increase their benefit rates for annuitants with serious health problems.

Once annuitization has begun, the insurer generally may not reduce the benefit rate or the size of the scheduled payments. Suppose, for example, that someone bought an annuity and annuitized the account for life when it was worth $100,000 at a benefit rate of $10 per thousand. The person would then be entitled to $1,000 each month for life. This would be the case even if the annuitant ends up living longer than the insurance company originally expected. In this regard, the risk to companies selling annuities differs from the risk to companies that only sell life insurance. For the life insurer, the risk is that the person will die too soon to make the company profitable. For the annuity issuer, the risk is that a person will die too late.

Very often, people use the term "annuitization" as if it were synonymous solely with lifetime, monthly income. In fact, modern annuitization involves several other options for the owner. Instead of occurring monthly, lifetime payouts can go to the annuitant every year, every season, twice each year or on a different schedule.

In rarer cases, the payout schedule might not be linked to the annuitant's lifetime at all. For example, payouts might be set to continue regularly until the insurer has given a specific, cumulative dollar amount to the annuitant. A "period certain annuity" (which should not be confused with a "life with period certain annuity") pays money to the annuitant only until a predetermined date, even if the person is still alive after that date.

The choice of when and how to annuitize one's money rests with the annuity owner. The owner can annuitize before leaving the workforce, upon reaching retirement age or much later in life. Unlike money in an IRA or employer-sponsored 401(k) plan, money

from an annuity generally does not need to be withdrawn at all when the owner turns 70 ½. (There are exceptions for annuities purchased within 401(k) plans and IRAs.)

Income Tax Concerns

Tax breaks represent one of the most significant reasons why annuity sales have been so fruitful over the past few decades. At this point, we will look at the relationship between the federal tax code and annuities and cover some of the tax consequences that prospective buyers should know about.

The material presented here is intended only to *summarize* an annuity's potential tax features. Specific questions about how the Internal Revenue Service might interpret an individual's tax situation should always be referred to a professional with substantial knowledge of tax law.

Tax Deferral

Like an IRA, an annuity is one of the few financial options available today that allows investors to accumulate money and temporarily avoid paying taxes on investment gains. This opportunity for tax deferral doesn't make an annuity tax-free or tax-deductible. The owner merely has the choice to wait awhile before paying certain taxes to the government.

On a federal level, an annuity generates no tax bills until the owner or the annuitant receives a payout from the insurer. If a deferred annuity goes untouched, the owner will encounter no tax penalties during the accumulation period. If the owner makes a partial withdrawal from a deferred annuity but doesn't annuitize the funds, he or she will only pay taxes on the withdrawal, and the money left over will continue to grow on a tax-deferred basis. Fixed immediate annuities are poor vehicles for tax deferral because payouts begin right away and some of that money is automatically treated as taxable income.

Qualified vs. Non-Qualified Annuities

The federal tax treatment of an annuity payout will depend on how the owner paid for the contract. "Qualified annuities" are paid for with pre-tax dollars, which means the principal in these accounts was not previously counted as part of the owner's taxable income. Since the principal was never taxed, taxes must be paid on the entirety of any money received from the insurance company.

Qualified annuities are often purchased within employer-sponsored 401(k) plans and IRAs. Like those common retirement vehicles, qualified annuity contracts limit the initial amount of money investors can contribute to their accounts. They also require that payouts begin by a specific date, usually by the time the accountholder is 70 ½.

"Non-qualified annuities" are funded with after-tax dollars, which means the principal was already counted in one form or another as part of the owner's taxable income. Since the principal was already taxed, only a portion of a person's annuity income will be taxable.

Unlike qualified annuities and many kinds of employer-sponsored retirement plans, non-qualified annuity contracts usually do not limit the amount of money investors may put into their accounts, and they don't need to be annuitized by the time the accountholder

reaches age 70 ½. The tax-related information in this course (unless stated otherwise) applies solely to non-qualified annuities.

Taxation of Annuity Death Benefits

When beneficiaries receive money from the insurance company, they will usually need to pay taxes on the difference between the account's value and the owner's principal investment. Although death benefits from a deferred annuity will generally need to be paid out when the owner dies, the annuity can continue to grow on a tax-deferred basis if the beneficiary is the owner's spouse.

Depending on the annuity, money left in a deceased owner's account may be subject to estate taxes. In general, the entire value of the annuity can be considered part of the owner's estate for tax purposes if the person's death occurs before annuitization. If death occurs after annuitization, the value of payments that will continue after the person's death can be considered part of the estate. If no one will receive payments or death benefits after the owner's death, the annuity will have no remaining value and won't be part of the estate. Most estates, though, are exempt from federal estate taxes. In 2012, only estates valued at more than $5 million after a person's death were taxed.

Surrender Charges

"Surrender charges" are often the biggest drawback to annuities and help show why the products do not suit every consumer's financial situation. These charges result in a percentage-based deduction from the owner's account if the owner withdraws money or opts out of the contract before a specific date.

The owner's inability to access money from an annuity can create problems big and small. A relatively small problem concerns the interest rates applied to fixed annuities. Imagine, for example, that a person buys a fixed deferred annuity that will credit 5 percent interest to the person's account annually for seven years and also features a surrender charge that will remain in force for seven years. Three years pass, and an improved economy creates a financial climate in which many insurers now offer fixed deferred annuities with short-term interest guarantees of 7 percent. The person in our example knows about these better deals but would not be able to get out of the existing contract for another four years without having to pay a significant surrender charge.

Now, suppose the circumstances are more serious and that the owner needs money to handle a financial emergency. Even in these urgent cases, the account balance could still suffer a big blow thanks to surrender charges

Federal Surrender Charges

IRS-mandated surrender charges suggest that the federal government approves of annuities when they are used for retirement purposes but frowns upon them when they are bought and sold with other motives in mind. Owners who make early withdrawals will need to pay regular income taxes on the money they receive and will also surrender an additional 10 percent to taxes if a withdrawal occurs before they turn 59 ½. The regular income taxes and the additional 10 percent penalty will be applied to any portion of a withdrawal that is not considered a return of the owner's principal. (Regardless of the principal amount, a portion of practically any withdrawal or payout will be treated as taxable income.)

There are some exceptions that can nullify the 10 percent tax penalty (but not the requirement to pay regular income taxes). The 10 percent penalty generally does not apply if any of the following statements are true:

- The owner is at least 59 ½.
- The owner is disabled.
- The owner has died, and payments are going to a beneficiary.
- The annuity involved is immediate, and payouts are being received on a regular basis in substantially equal amounts.
- The owner has decided to annuitize and will be receiving substantially equal payments based on his or her life expectancy for at least five years or at least until the owner turns 59 ½ (whichever is scheduled to happen later).

Even if an owner is willing to accept the 10 percent penalty, an early withdrawal can create a bigger tax bill than expected. Under a concept known as "last in, first out," an early withdrawal will first be treated as a gain and then as a partial return of principal. In other words, if an owner purchases an annuity for $10,000 and makes a $5,000 withdrawal after the account has grown to $15,000, the entire withdrawal will be fully taxable. Similarly, if the owner were to make a $6,000 early withdrawal from that account, $5,000 of it would be fully taxable, and only the remaining $1,000 (the amount in excess of the account's gains) would be treated as a non-taxable return of principal.

There may be additional exceptions (or exceptions to the exceptions) that can impact taxpayers. In addition, like issues related to beneficiaries, the rules regarding early withdrawals and taxation can be very complicated if the annuitant and the owner are not the same person. For more specifics regarding federal withdrawal penalties, contact the IRS or speak to a tax professional.

Company-Mandated Surrender Charges

Even if an owner has passed age 59 ½ and can avoid federal surrender charges, the owner might still need to pay a company-mandated surrender charge when money comes out of an annuity prematurely. Insurance companies tend to lose money on an annuity during its early years. Surrender charges help make up for losses if the owner cancels the contract before the issuing company can make a profit on it.

Surrender charges can differ greatly depending on the type of annuity and market conditions. In some cases, the surrender charge will come out of the annuity's total cash value. At other times, an insurer might only take surrender fees out of the principal and leave accumulated interest alone. On occasion, principal will remain intact, and the insurer will deduct the interest earned over a set period of time from the owner's account.

If consumers research annuities via the mainstream media, they will probably come to the conclusion that there is a standard surrender charge for annuities that starts at 7 percent or so and lasts roughly seven years, with each passing year resulting in a 1 percent reduction in the fee. In reality, the size and duration of a surrender charge can be better or worse. In terms of length, research conducted during the development of

this course uncovered annuities with surrender fees that were as brief as three months and as long as the annuitant's lifetime. In terms of size, one annuity came with a surrender charge that began at a rate of 25 percent. Another product combined long duration with large size by reportedly featuring a surrender charge that started at nearly 18 percent and lasted 17 years. (Be aware that many states have rules regarding the duration and/or size of surrender charges. Some of the mentioned examples from this paragraph came to our attention because they resulted in disciplinary action.)

Free Withdrawals

Insurers soften their sometimes rough surrender penalties by usually giving owners a chance to withdraw small amounts of money from their annuities without losing any additional principal or interest. Most contracts allow annual withdrawals that may not exceed 10 percent of principal at one time

Before they prepare to withdraw from an annuity, owners should understand there might be a waiting period (perhaps one year) before the penalty-free withdrawals can begin. Owners should also know that these withdrawals might not be permitted forever. The insurer can limit withdrawals by disallowing them after a pre-determined number of years or by putting an end to them once cumulative withdrawals reach a set percentage of the principal.

The free 10 percent withdrawals keep surrender charges at bay for people who need a little extra cash now and then. They do not, however, exempt the owner from tax laws. People must still pay income taxes on these partial withdrawals, and the government can still knock payouts down by 10 percent if they occur before the owner turns 59 ½.

Death Benefits

The typical annuity offers a death benefit equal to at least the principal investment, minus any withdrawals of principal that were made by the owner. If an annuity experiences positive investment gains and is worth more than the principal sum when someone dies, beneficiaries can collect this larger amount instead and will be required to pay income taxes on the extra money.

At first, this might sound fair or even favorable to beneficiaries, but there's a big catch. The standard death benefit sometimes only applies if someone dies while the annuity is in the accumulation period. If an owner has an immediate annuity or has annuitized a deferred annuity, the insurer might pocket the remaining balance in the account and use the money to make payouts to its other customers.

An annuity that only pays a death benefit if the annuitant dies during the accumulation period is sometimes called a "straight life annuity" or a "single life annuity" because the money given to the insurance company is meant to last for the rest of one person's life and is not invested with dependants in mind. The insurance company bases the size of payouts from this kind of annuity on the annuitant's remaining life expectancy at annuitization and is not contractually obligated to pay out any money after the annuitant dies, unless annuitization never began. Because straight life annuities provide money to an annuitant or a beneficiary but not to both parties, the insurance company can afford to give straight life annuitants its highest benefit rates.

People who want to be a little less risky and allow for some death benefits after annuitization can opt for a single life annuity with "period certain." When the period certain option is added to a single life annuity, the annuitant still receives lifelong payouts from the insurance company, but the period certain helps guard against the annuitant dying suddenly after annuitization and leaving nothing for heirs.

The period certain option guarantees that payouts will at least continue for a contractually mandated time period, usually in the neighborhood of 10 to 20 years. If, for example, the annuitant starts receiving payouts from a single life annuity with a period certain provision of 10 years and dies after five years, a beneficiary could then step into the annuitant's place and receive payouts for the remaining five years of the contract. If that same annuitant bought that same contract and received payouts for at least 10 years, the insurance company would not need to pay any money to a beneficiary upon the annuitant's death. When the period certain ends, so does the beneficiary's right to any death benefit.

Because life with period certain annuities involve limited guarantees to more than one person after annuitization, the individual payouts will be slightly smaller than those available through straight life contracts. The degree to which benefit rates are reduced will depend on the length of the period certain. A short period might not affect payouts or rates much at all, while a long period could translate to a substantial financial sacrifice for the annuitant during his or her lifetime.

A third settlement option can give beneficiaries a death benefit no matter when someone passes away. In this setup, beneficiaries receive a refund of any principal that remains in a deceased person's account. Beneficiaries receive none of the interest that might have accumulated in the account, and they get nothing if the person lived long enough to receive a full return of principal. The refund of principal can go to beneficiaries in one of two ways. In a "cash refund" annuity, the beneficiary receives the death benefit in a lump sum. An "installment refund" breaks up the death benefit and awards money to the beneficiary periodically until all the principal has been paid back.

Keep in mind that some annuities will only pay death benefits when the owner dies and some will pay if the annuitant dies first. In most cases, the distinction will be a non-issue because the owner and the annuitant will be the same person. However, in cases where the owner and annuitant are different people, death benefits may be provided in ways and amounts that are different from what we have described. If the annuitant and owner aren't the same person, the contract's death benefit provisions must be examined with extra care.

Conclusion

Each annuity has the potential to intimidate or confuse everyone from the inexperienced investor to the veteran bank or insurance customer. Even people with a background in insurance or finance might wonder what a certain annuity contract provision really means.

It is important that you not only explain annuities well but also listen carefully to people's concerns and goals. By taking both of those responsibilities seriously, you give yourself a good chance of being a professional success and a leader in your field.

CHAPTER 8: LONG TERM CARE INSURANCE

Contrary to popular belief, many kinds of private and public health insurance plans (including Medicare) will refuse to pay for care in a nursing home unless certain conditions have been met. Similarly regular kinds of health insurance rarely help patients pay for "custodial care." Custodial care is care that does not need to be performed or supervised by a skilled medical professional. It includes help with such basic activities as bathing, eating or getting dressed.

Though mainly thought of as a senior citizen's product, long-term care (LTC) insurance can help consumers fill holes in health coverage at any age. In general, LTC policies absorb the costs of skilled, intermediate and custodial care that a chronically ill or recovering patient requires beyond 90 days. Since debuting in the 1970s, LTC policies have evolved from pure "nursing home insurance" into flexible risk management tools that allow policyholders to receive health services in other settings, including in assisted-living facilities, continuing-care communities and private homes.

This chapter will briefly touch on the basic components of LTC policies. Before going any further, we will first review the kinds of situations in which coverage will not apply.

Standard Exclusions

LTC insurance producers must know what kinds of care insurance companies may exclude from policies, and they must communicate these uncovered risks to potential clients. Federal and state governments generally do not require insurers to cover LTC when it is associated with the following circumstances:

- **Pre-existing conditions**: Though applicants are unlikely to obtain any long-term care insurance when they have pre-existing cases of AIDS, multiple sclerosis, muscular dystrophy, cirrhosis or Parkinson's disease, many insurers will grant coverage to applicants with other pre-existing conditions—such as diabetes or a heart problem—as long as the policyholder agrees to pay out of pocket for all treatment related to the condition within a specified time frame. For example, a policyholder might need to pay for the first six months of diabetic care before the policy applies benefits to those services.
- **Mental illnesses or nervous disorders**: This exclusion typically does not apply to Alzheimer's disease. However, an applicant who already has Alzheimer's disease still risks being denied insurance.
- **Drug addiction**: This exclusion applies to alcoholism, as well as to dependence on illegal substances.
- **Acts of war**: Treatment for injuries sustained in an incident that is deemed an "act of war" by insurers and the federal government might not be covered, even if the injured person is a civilian.
- **Self-inflicted injuries**: This exclusion applies to suicide attempts, as well as to serious yet non-life-threatening incidents.
- **Military injuries**: The Department of Veterans' Affairs is usually responsible for giving cash grants to military personnel who are injured during active duty.
- **Aviation injuries**: This exclusion applies when the insured was not a paying passenger in an aircraft.

- **Care covered by other insurance**: This exclusion applies to treatment that would otherwise be covered by either private or public insurance plans, including Medicare and workers compensation.

Benefit Triggers

Assuming care is not specifically excluded by an LTC policy, buyers and sellers need to understand what must occur for insurance coverage to begin. Back in the days when LTC insurance was synonymous with nursing home insurance, some policyholders received no benefits unless the cause of their health problems resulted in a three-day hospital stay. Limiting coverage in that way is now illegal throughout much of the United States.

More commonly, policy benefits will go into effect when the insured can no longer perform specific "activities of daily living" (ADLs). Most LTC policies have ADL-related triggers that are contingent on the insured's inability to perform at least two of six standard activities. The six standard ADLs are as follows:

- **Bathing**: Including the ability to move in and out of a shower or tub, clean oneself and dry oneself.
- **Dressing**: Including the ability to put on clothing and any medical accessories, such as leg braces.
- **Eating**: Including the ability to chew and swallow food and use utensils.
- **Transferring**: Including the ability to move in and out of beds, cars and chairs.
- **Toileting:** Including the ability to get to a restroom and perform related personal hygiene.
- **Continence:** Including the ability to control the bladder and bowel muscles and perform related personal hygiene.

The ADL concept is not a terribly difficult one for buyers to grasp, but they and their trusted advisers sometimes forget to view ADLs from both a physical and mental perspective. Suppose, for example, that a woman in the 1980s insisted on an LTC policy that did not exclude care for Alzheimer's patients. Nothing in her chosen policy specifically mentioned the disease, but the policy's ADLs were limited to the standard physical tasks mentioned above. Years later, the woman was diagnosed with the disease and needed to be looked after. But because the ailment did not prevent her from independently performing various physical tasks, the LTC policy gave her and her family no financial relief.

Maybe her insurance agent knew all along about the deficiencies in the policy and was more concerned about a commission than about customer satisfaction. Or maybe, like the woman, the agent simply did not have a thorough-enough understanding of the policy to form a clear picture of the uninsured risk. Either way, the woman made a very costly error.

Insurers and state governments have tried to rectify these kinds of situations by including multiple benefit triggers within LTC policies. Though not required to do so by law, some carriers include triggers that are based on a person's inability to perform

specified “instrumental activities of daily living” (IADLs), which might involve mental capabilities as well as physical ones. Common IADLs are as follows:

- Taking medication at prescribed times.
- Cooking.
- Performing housework.
- Driving.
- Paying bills.
- Balancing check books.
- Shopping.
- Using a telephone.

In order to more firmly ensure coverage for physically healthy but mentally inhibited policyholders, many states require LTC policies to feature “cognitive impairment” as a benefit trigger. This term could make coverage mandatory when insured people patients lose their memory, misjudge place and time, or struggle to reason.

Benefit Periods and Elimination Periods

When consumers are receptive to the idea of purchasing LTC insurance, they are likely to ask themselves, “How much coverage should I buy?” The amount of purchased coverage will be represented in direct and indirect ways by the policy’s “benefit period” and “elimination period.”

The benefit period addresses how long coverage will last. This figure is often discussed in terms of time, with most benefit periods lasting a few years.

Elimination periods are essentially deductibles that are expressed chronologically rather than as concrete dollar amounts. They spell out how long an insured person must pay for LTC services before a policy’s benefits will begin. Some LTC policies have no elimination period and allow the insured to receive benefits immediately after being deemed an LTC patient. Most policies, though, feature an elimination period ranging from one month to six months.

Conclusion

Insurance producers who embrace service to those who might need long-term care are likely to have plenty of opportunities for successful sales. These opportunities may seem more prevalent in the coming years because of the looming retirement of the Baby Boomers.

Of course, the chances for knowledgeable professionals to prosper are likely to continue long after the Baby Boomers have gone. The tools, technology and products associated with insurance are bound to change, but the concerns of society’s aging population are likely to remain the same from one era to the next.

No generation wants to experience physical deterioration or disease, and no generation wants to have those problems made worse by financial struggles in old age. There will always be risks in the world; potential dangers that thoughtful adults will inevitably need

to confront and manage. With a knowledgeable insurance professional at their side, consumers can tackle those great challenges with a reasonable degree of confidence.

CHAPTER 9: MEDICARE AND MEDIGAP INSURANCE

It's not difficult to understand why senior citizens get a little nervous when the government proposes changes to Medicare. The federal program covers millions of elderly or disabled people who would probably struggle to obtain comprehensive health insurance from any other source. Using figures from the government's Administration on Aging, the Center for Medicare Advocacy says approximately 95 percent of Americans age 65 or older are covered through Medicare. Before the program went into effect, half of the country's seniors weren't insured at all.

Lawmakers created Medicare in 1965 through Title XVIII of the Social Security Act. The program is managed by the Centers for Medicare & Medicaid Services (CMS) and has four parts:

- **Part A** provides hospital insurance.
- **Part B** provides "supplementary medical insurance" (including coverage of office visits and outpatient care).
- **Part C** provides basically the same benefits as parts A and B but is administered by private insurance companies rather than the federal government.
- **Part D** provides prescription drug benefits.

Since nearly every worker is paying taxes to fund it, Medicare is everybody's business. If you're involved in helping older people make wise insurance decisions, you should know what Medicare pays for and what it doesn't. Even if your career has nothing to do with health insurance, you might want to learn about the program so you can assist older relatives or plan for your own retirement.

While the basics of Medicare rarely change, specifics can differ from year to year. Deductibles and required copayments tend to rise with medical inflation, and covered services are occasionally added or eliminated. The material you are about to read is based on information from 2012 and includes explanations of health care reforms that were passed in 2010. For the most up-to-date details related to Medicare, you should contact CMS.

Eligibility

Unlike other federally funded insurance programs, Medicare eligibility is generally not based on need. It's available to the rich and the poor, and once you reach a certain age, you can enroll regardless of your health status. Some of the more complex eligibility rules will be explained at later points in this course. For now, let's go over the basic requirements and learn how most people start receiving Medicare.

65 and Over

Nearly every citizen or permanent resident of the United States is eligible for Medicare upon turning 65. Though the retirement age for full Social Security benefits has risen to 67 for many Americans, age requirements for Medicare have not changed. You can enroll in Medicare and continue to work full time, and you can receive Medicare benefits without also receiving Social Security benefits.

What people pay for Medicare at 65 will depend somewhat on their work history. If you or your spouse has paid Medicare taxes for at least 10 years of your lifetime, a significant portion of Medicare will be free to you. If you or a spouse hasn't paid taxes for that long, you might be charged a monthly fee for hospital insurance. Non-citizens who are 65 or older but haven't paid enough Medicare taxes will also need to have been permanent residents in this country for the past five years.

If you're planning on enrolling in Medicare on the basis of your age, you'll have your first chance to do it during a seven-month period near your sixty-fifth birthday. The period starts three months prior to the month you turn 65 and ends three months after the month of that birthday. So if you were born on June 15, your first enrollment opportunity would last from March through September.

Disabled

Though originally intended just as a health plan for seniors, Medicare started covering disabled people of any age in 1972. To be eligible, you generally need to have received disability payments from Social Security for 24 months. Since there's a five-month waiting period for receiving Social Security's disability benefits, people effectively need to have been disabled for a total of 29 months before they can join Medicare.

There are a few exceptions to the rules regarding waiting periods and disabilities. For example, individuals with Lou Gehrig's disease are eligible for Medicare immediately upon being eligible for Social Security. They don't need to go through a 24-month waiting period.

Like Medicare eligibility, eligibility for Social Security benefits depends on your work history and the number of years you've paid into the system. The exact requirements differ from age to age. If you can't qualify for Social Security on your own, you can receive benefits based on your spouse's work history or (if you're a dependent child) your parents' work history.

Some workers pay Medicare taxes but don't pay into Social Security. In these relatively rare cases, a person would still be eligible for Medicare after being disabled for 29 months. Receiving Social Security wouldn't be a prerequisite for being on Medicare.

People's Medicare eligibility can end if they stop receiving disability benefits from Social Security, but it depends on the circumstances. If your disability checks stop because you aren't disabled from a purely medical standpoint anymore, your Medicare eligibility will stop on the first day of the month after the month you're notified about your checks being terminated. If you're still disabled but your Social Security benefits are reduced or terminated because you returned to work and have earnings that are beyond the allowable threshold, you can remain on Medicare as long as you're still disabled from a medical point of view. After being on Medicare for eight and a half years without receiving any more disability checks, you'll have to pay more to stay in the program.

End-Stage Renal Disease

Patients with end-stage renal disease (kidney disease) can join Medicare even if they haven't turned 65. They or their spouse (or a parent if they're considered dependent children) needs to have paid into the Social Security system for a particular number of years, but they don't need to wait 24 or 29 months like people with other disabilities.

Medicare Part A (Hospital Insurance)

As was mentioned in our introduction, Medicare has four parts. Each part has its own set of rules and covers its own variety of treatments and services. Everyone who is eligible for Medicare can choose to be covered through Part A.

Part A is sometimes known as “hospital insurance” because it covers inpatient services but not office visits. Patients are insured through Part A when they’re admitted to a hospital or nursing home. This portion of Medicare also pays for hospice care (in just about any environment) and can even pay for care in a private residence under limited circumstances.

Part A usually requires patients to satisfy a deductible and make copayments for covered services, but most people don’t pay any premiums for it. As long as you or your spouse has paid Medicare taxes for at least 10 years during your lifetime, you won’t need to pay a premium for Part A after turning 65. Minus the deductibles and copayments, Part A is also free for people with end-stage renal disease or another disability.

If you enroll in Part A at age 65 and need to pay a premium for it, the cost will depend on how long you or your spouse has paid Medicare taxes. In 2012, the monthly Part A premium was $248 for people who had paid Medicare taxes for at least seven and a half years. For people who had paid taxes for a shorter amount of time, it was $451.

Seniors who are enrolled in Part A and need to pay a premium will typically have it deducted from their Social Security checks. If you’re required to pay for Part A and don’t comply, your insurance will be discontinued after your third month of nonpayment.

Anyone who pays a premium for Part A also needs to enroll in another portion of Medicare called “Part B.” If you get Part A for free, enrolling in Part B is optional. You’ll learn about Part B, which covers medical office visits and outpatient services, later in this chapter.

Benefit Periods, Deductibles and Copayments

Whether they pay a premium for Part A or not, patients receiving hospital care are responsible for certain deductibles and copayments. The amounts owed by Medicare recipients depend on where a person is in regard to his or her “benefit period.”

A benefit period begins when a patient starts receiving care under Part A at a hospital or nursing home, and it typically stops when the person hasn’t been hospitalized or in a nursing home for 60 consecutive days. (If you’re in a nursing home but aren’t receiving care that can only be provided by a medical professional, your benefit period would’ve ended when you stopped receiving that special level of care.) There is no limit to the number of benefit periods you can have in your lifetime.

Each new benefit period resets the Part A deductible and copayment requirements. In 2012, patients were responsible for a $1,156 deductible during each benefit period. After beneficiaries satisfied the deductible, Medicare paid for 100 percent of hospital care for the first 60 days of each benefit period. Following those first 60 days, patients made a $289 per-day copayment for days 61 through 90.

If a benefit period lasts beyond 90 days, hospitalization will continue to be covered by Part A if the person has any remaining "lifetime reserve days." Everyone in Part A starts with 60 lifetime reserve days. As their name suggests, these days will need to last a lifetime and cannot be regained. Once a person's lifetime reserve days have been used up, Medicare stops paying for hospitalization until the start of a new benefit period. In 2012, patients paid a $578 per-day copayment for hospitalization during each lifetime reserve day.

Since most people are accustomed to deductibles and copayments that are reset on an annual basis, benefit periods in Part A can be difficult to understand. Let's try to clear up some of the confusion with the help of a few examples.

Example 1: In 2012, Mrs. Smith got into a car accident and spent 80 days in the hospital. She paid $1,156 toward her deductible and nothing for the first 60 days of her stay. For the last 20 days of hospitalization, Medicare charged her a total of $5,780. ($289×20 = $5,780)

Example 2: In 2012, Mr. Jones fell down some stairs and broke his leg. He stayed in the hospital for five days and was sent home. After three days on his own, he lost his balance, re-aggravated his injury and went back into the hospital for another five days. Since he spent less than 60 days out of the hospital between his two stays, his benefit period was never reset, and he was only required to pay the $1,156 deductible.

Example 3: In 2012, Ms. Williams had a massive stoke and ended up in the hospital for 110 days. Due to some serious health problems in her past, she had already used up 50 of her lifetime reserve days and only had 10 left. When she finally got out of the hospital, she was held responsible for the following amounts:

- Her $1,156 deductible.
- A total of $0 for days one through 60.
- A total of $8,670 for days 61 through 90 ($289×30 = $8,670).
- A total of $5,780 for days 91 through 100 ($578×10 = $5,780).
- All hospitalization costs for days 101 through 110.

Example 4: In 2012, Mr. Johnson developed an infection in his kidneys and was admitted to the hospital for four days. Seventy-five days after being sent home, the infection came back and caused him to be readmitted for another two days. Even though he ended up in the hospital for the same problem, Mr. Johnson was required to pay the $1,156 deductible twice because his 75-day stay at home was long enough to start a new benefit period.

Example 5: In 2012, Mrs. Thompson spent 10 days in the hospital after undergoing back surgery. Thirty days after being discharged, she returned to the hospital for five days due to a bout with pneumonia. Since she was out of the hospital for less than 60 days between her two stays, she only needed to pay the $1,156 deductible once, and her benefit period was never reset. The fact that one hospital stay wasn't related to the other didn't make a difference.

Care at Skilled Nursing Facilities

In addition to paying for hospitalization, Part A will pay for a specific portion of a patient's stay in a nursing home. In Medicare terminology, nursing homes are known as "skilled nursing facilities."

Part A's nursing home coverage isn't as long-lasting as its hospitalization coverage. As a result, many insurance advisers believe people who are close to enrolling in Medicare should also consider purchasing long-term care insurance.

For your stay at a nursing home to be covered by Medicare, a doctor must authorize that you need "skilled care." Skilled care is treatment that can only be provided or supervised by a specially qualified nurse or therapist. It can include tasks like changing bandages, inserting feeding tubes or providing physical therapy. It doesn't include custodial tasks like bathing, dressing or normal feeding, but custodial care might be covered if a patient also needs skilled care.

Since nursing homes can be expensive, Medicare will only pay for one when providing skilled care in another setting is impractical. The care also needs to be necessary on an everyday basis, although care that's needed five times a week can suffice if it involves physical, occupational or speech therapy.

Nursing home care won't be covered by Medicare unless the patient has satisfied a few requirements related to hospitalization. First, the person needs to have been hospitalized for at least three days. Time spent as an outpatient under observation generally doesn't count toward this requirement. The day the person is discharged from the hospital doesn't count either.

Next, the reason for needing nursing home care usually needs to be related to the patient's hospitalization. For example, if someone spends three days in a hospital because of a heart attack, those three days normally can't be used to get the person nursing home care on account of a broken leg. The three-day hospitalization requirement can be satisfied when any of the following statements are true:

- The reason for entering the nursing home is the same as the reason for entering the hospital.
- The reason for entering the nursing home isn't the same as the reason for entering the hospital, but the medical condition requiring skilled care was still treated during the three days of hospitalization.
- The reason for entering the nursing home was originally the same as the reason for entering the hospital, but the patient needs additional skilled care because of another condition that started at the nursing home.

Finally, the minimum three days of hospitalization need to have occurred within 30 days prior to the person's entry into the nursing home. For the purpose of an example, let's imagine you were hospitalized for a stroke for five days. You then qualified for care at a skilled nursing facility and stayed in one for two weeks. Now, after returning home for 45 days, you and your family determine that you really should be back in a nursing home. But because you've been back home for more than 30 days, your return to the facility won't be covered by Medicare unless you go back into the hospital for another three days.

What complicates matters even further is that people receiving care at skilled nursing facilities still need to be aware of how benefit periods can impact their costs. Despite the lack of a deductible for nursing home care, benefit periods will still play a role in determining a patient's copayments. In 2012, Part A paid for 100 percent of care at a skilled nursing facility during the first 20 days of a patient's stay during each benefit period. The patient was responsible for a $144.50 per-day copayment for days 21 through 100 and all costs after that.

Let's modify some of our earlier examples to see how costs can add up for Medicare patients in skilled nursing facilities.

Example 1: In 2012, Mrs. Smith got into a car accident and spent 30 days in the hospital and 30 days in a nursing home. She paid $1,156 toward her Part A deductible and no copayments for her month in the hospital. She also paid nothing for her first 20 days at the nursing home but was billed a total of $1,445 for days 21 through 30. ($144.50×10 = $1,445)

Example 2: In 2012, Mr. Jones fell down some stairs and broke both his legs. He stayed in the hospital for five days and was sent to a nursing home for a week. After three days on his own, he lost his balance, re-aggravated his injuries and went back into the nursing home for another five days. Since there wasn't a 30-day gap between his hospitalization and his second admittance to the nursing home, his second stay at the home was covered by Medicare. The fact that he didn't go in for another three-day hospital stay didn't make a difference. For all his troubles during this 13-day stretch, he was only responsible for the $1,156 Part A deductible.

Example 3: In 2012, Ms. Williams had a major stoke and ended up in the hospital for 80 days and in a nursing home for 40 days. Then, after living with her family for three months, she fell and broke her arm and needed three days in the hospital followed by five days in a nursing home. She ultimately had to pay the following costs:

- $1,156 toward her Part A deductible for her stroke-related hospitalization.
- A $0 copayment for days one through 60 for her stroke-related hospitalization.
- A $5,780 total copayment for days 61 through 80 of her stroke-related hospitalization ($289×20 = $5,780).
- A $0 copayment for days one through 20 of her stroke-related stay at the nursing home.
- A $2,890 total copayment for days 21 through 40 of her stroke-related stay at the nursing home ($144.50×20 = $2,890).
- $1,156 toward her Part A deductible for her arm-related hospitalization.
- A $0 copayment for her arm-related hospitalization.
- A $0 copayment for her arm-related stay at the nursing home.

You probably noticed that Ms. Williams was required to pay two deductibles and that her copayments were reset after she broke her arm. Those amounts were reset because the three-month period she spent at home was long enough to end one benefit period and start a new one. Remember, a benefit period stops when a patient goes more than 60 days without being hospitalized or in a skilled nursing facility.

Example 4: In 2012, Mr. Johnson developed an infection in his kidneys and was admitted to the hospital for four days. Three weeks after being sent home, he was diagnosed with a rapid case of Alzheimer's disease, and his children decided to put him in a nursing home due to that diagnosis. But because the disease didn't require three days of hospitalization and didn't start when Mr. Johnson was in the nursing home for his infection, Medicare didn't pay for his second stay in the skilled nursing facility.

As you can see, having hospital insurance through Part A doesn't completely eliminate a patient's out-of-pocket medical costs. Some of the deductibles and copayments mentioned in these examples might be covered by a supplemental insurance product known as a "Medigap" policy. You'll read about what's available in the Medigap market later in this chapter.

Medicare Part B (Supplementary Medical Insurance)

When people become eligible for Part A, they also become eligible for Part B. Whereas Part A pays mainly for inpatient medical care, Part B is meant to pay for outpatient treatments and visits to doctors' offices.

Although they usually can opt out of Part B, most Medicare beneficiaries choose to take it. If you decline it the first time around, you may be penalized if you need it later. If you want Part A and need to pay a premium for it, you're required to enroll in Part B, too.

One reason why people might decline Part B is that it isn't free. Unlike Part A, which has no premiums if you've paid enough taxes, Part B requires a monthly premium from all enrollees. A new premium is announced every fall. The same premium applies regardless of how many years a person has paid Medicare taxes. It is usually deducted directly from people's Social Security payments.

The 2012 Part B monthly premium for most Medicare recipients was $99.90. High-income beneficiaries pay more than other Medicare recipients. Additional charges are applied on a sliding scale and impact taxpayers who make more than $85,000 when filing as individuals or $170,000 when filing taxes jointly with a spouse. Health care reforms from 2010 will freeze the affected income levels until at least 2020.

Once treatment has been received under Part B, patients are responsible for paying a deductible and coinsurance fees. The deductible ($140 in 2012) is applied annually, meaning that the complex "benefit period" formulas from Part A aren't used in Part B. No matter how long a patient goes between doctor visits, there's only one deductible to pay during each calendar year.

Coinsurance fees are equal to 20 percent of the reasonable charge for a given treatment or medical procedure. They might not equal 20 percent of what a physician actually bills. (We'll clarify this point in the section "Charges and Assignment.")

Since Part B requires beneficiaries to pay monthly premiums, some people choose to go without it. Anyone who is considering not enrolling in Part B should keep in mind that that they may face some financial penalties at a later date. The penalties are designed to encourage people to enroll in Part B as soon as possible instead of waiting until they're sick.

If someone declines Part B and later decides to enroll, the person will often be forced to pay a higher monthly premium. A 10 percent penalty will be added for every 12-month period that the eligible person went without Part B. For seniors who decline Part B and enroll later in life, the penalty lasts as long as they're in Medicare. For people under 65, it lasts until their 65th birthday. The penalty is waived in situations where a person went without coverage for less than a full 12-month period.

As an example, let's take someone who went two full years without Part B before enrolling in 2011. Since the 2011 base monthly premium for most people that year was $115.40, Medicare would've billed the person an extra 20 percent for a monthly total of $134.48. (The total premium would be slightly higher for someone making more than $85,000 a year.)

People who decide against retiring at age 65 are probably glad there's a big exception regarding Part B penalties: The 10 percent penalty will be waived for people who decline Part B if they're already covered by group health insurance through current employment. This waiver also applies to people under 65 with disabilities, but not to people with end-stage renal disease.

People who decline Part B because they already have group coverage through their employer or a family member's employer can change their mind and enroll in Part B at any time while they're still covered by the group plan. In these cases, coverage will begin on the first day of the month of enrollment.

When their group coverage or the employment related to the group coverage ends, people will have a limited amount of time to enroll in Part B without facing the 10 percent penalty. The period to enroll in Part B without paying higher premiums lasts eight months and begins on the day when group coverage ended or when the employment related to the group coverage ended, whichever is earlier.

Office Visits

Part B will pay 80 percent of Medicare-approved charges for doctor visits. The patient or other insurance will need to pay the remaining 20 percent, as well as the annual deductible.

Charges and Assignment

Health care providers who treat Part B enrollees need to follow certain rules. The exact rules to follow will depend on whether a provider is a "participating provider," a "non-participating provider" or an "opt-out provider." These terms tend to confuse people. So if you're in a position to help a senior with insurance questions, you will want to read the rest of this section very carefully.

Participating providers in Medicare agree to accept "assignment" whenever they provide services under Part B. Assignment refers to the amount of money that Medicare believes should be charged for a particular service and how a Medicare claim is made. When doctors accept assignment, Medicare directly pays them 80 percent of the government's assigned charge and makes the patient responsible for the remaining 20 percent. Participating providers cannot charge Medicare patients more than the government's assigned charge. However, they are still allowed to set their own fees for services that aren't covered by the program.

Non-participating providers can choose whether to accept assignment on a case-by-case basis. When they accept assignment, Medicare directly pays for 80 percent of the assigned charge, and the patient pays the remaining 20 percent. The assigned charge for a non-participating provider will be slightly smaller than for a participating provider. When they accept assignment, non-participating providers are not allowed to charge more than the assigned amount.

When non-participating providers decide not to accept assignment, they can charge more for services than Medicare's assigned amount. The patient will need to pay the difference between the provider's actual charge and Medicare's assigned charge, but the actual charge can be no more than 115 percent of the assigned charge. In addition to paying the difference between the provider's actual charge and Medicare's assigned charge, patients will also be responsible for 20 percent of Medicare's assigned charge.

Regardless of how much they actually owe, patients who see non-participating doctors who don't accept assignment might have to pay providers personally for their care and then file a claim afterwards with Medicare for reimbursement. In other words, Medicare might not pay the provider directly.

Since the rules regarding non-participating providers can be confusing, let's consider an example. Imagine that Medicare has assigned a $100 charge for a medical procedure from a non-participating provider and that the provider has refused to accept assignment. The provider would be allowed to charge up to $115 for the procedure, and the expenses would be handled as follows:

- $80 would be paid by Medicare, since Medicare pays 80 percent of the assigned charge. (The patient might need to pay this amount directly to the provider first and then seek reimbursement from Medicare.)
- $20 would be paid by the patient as coinsurance, since Part B enrollees are responsible for 20 percent of assigned charges.
- $15 would be paid by the patient as an additional out-of-pocket expense because the non-participating provider declined assignment.

It's very important not to confuse non-participating providers with opt-out providers. Opt-out providers have signed an agreement stating they will not accept Medicare as payment for services. If a Medicare beneficiary is treated by an opt-out provider, Medicare will usually not pay for any of the treatment. In general, opt-out providers will only be compensated by Medicare if they treat someone in an emergency situation. All other charges from an opt-out provider will need to be paid by the patient or by other insurance.

A provider has one chance each year to enroll as a participating provider or a non-participating provider. Opt-out providers need to wait at least two years before re-enrolling as participating providers or non-participating providers. Some types of medical professionals are required to be participating providers. Others are allowed to be non-participating providers but are not allowed to be opt-out providers.

Most physicians are either participating providers or non-participating providers and, therefore, accept payments from Medicare. But simply asking a doctor if he or she "accepts" Medicare won't guarantee that the patient will have the lowest-possible out-of-

pocket expenses. The more specific question to ask is, “Do you accept assignment?” Medicare’s online directory allows patients to search for local providers who always accept assignment.

Medicare Part C (Medicare Advantage)

Up until now, the information in this chapter has pertained to what we can call “original Medicare,” which is administered by the federal government. At the time this material was being written, roughly 75 percent of seniors in the Medicare system were enrolled in original Medicare and had the coverage we’ve previously described.

The remaining quarter of Medicare’s seniors were enrolled in “Medicare Advantage.” Medicare Advantage is similar to original Medicare but is administered by private insurance companies that receive federal funding. This semi-privatized version of Medicare is sometimes known as “Medicare Part C” and was preceded by a similar program called “Medicare+Choice.”

Medicare Advantage was created under the assumption that paying private insurers to administer Medicare benefits would save the government money and improve services for seniors. Since most Advantage plans are set up as managed-care systems (like an HMO or PPO), they generally require or encourage patients to seek treatment from a narrower range of providers. Unlike original Medicare, an Advantage plan might require that a patient receive a referral from a primary care physician before seeing a specialist. Alternatively, it may charge the patient more for seeing a provider who is not part of the insurer’s network. Theoretically at least, these limits on access are supposed to ensure that a patient’s status is more centrally monitored and that costly procedures are only ordered when they’re medically necessary.

In exchange for giving up broader access to providers, members of Advantage plans are supposed to receive benefits beyond what’s available in original Medicare. Sometimes these extra benefits involve coverage of treatment or services that are usually not part of original Medicare, such as eye exams, hearing exams or gym memberships. At other times, an Advantage plan will cover the same things as original Medicare but require less cost-sharing from patients.

Medicare Advantage plans generally must cover at least the same kinds of care as original Medicare, but the specifics can be different between the two programs. Whereas original Medicare might require patients to pay a 20 percent coinsurance amount to see a physician, an Advantage plan might require a flat $10 copayment for each visit. There might also be differences in the size of deductibles and the number of times a patient will be insured for a particular kind of treatment. Although some aspects of an Advantage plan can require higher out-of-pocket expenses than original Medicare, the overall benefit package from the private plan must be at least as good as what’s available from the government.

One area where Advantage plans don’t need to match original Medicare is hospice care. Since Advantage plans aren’t required to cover hospice services, terminally ill individuals in Medicare Advantage remain insured for hospice care by the government through Medicare Part A.

Eligibility and Premiums for Medicare Advantage

To be eligible for enrollment in a Medicare Advantage plan, people first need to enroll in Part A and Part B. If someone enrolls in Medicare Advantage and is receiving Social Security, premiums for Part B will still be deducted from the person's checks. The government will then use the money to compensate private insurers for administering Medicare on its behalf. Government payments to participating insurers are based on many factors, such as the number of enrollees in a plan and the quality of service compared to other plans in the area.

In addition to payments received from the federal government, Medicare Advantage plans are often funded through premiums from customers. At the time this course was being written, the government was subsidizing some Advantage plans enough for them to be offered at no additional cost. More comprehensive plans, such as those that included coverage of prescription drugs, levied an additional charge on plan members. In 2014 and beyond, plans won't be allowed to spend more than 15 percent of premium dollars on administrative costs.

Medicare Advantage is open to most Medicare-eligible individuals regardless of their health status. However, people with end-stage renal disease must opt for original Medicare instead of an Advantage plan unless any of the following statements are true:

- Insurance from a Medicare Advantage plan was obtained prior to being diagnosed with end-stage renal disease.
- Insurance from a Medicare Advantage plan is provided by an employer.
- The insured has undergone a successful kidney transplant.

Medicare Part D

During its first 40 years of existence, Medicare hardly paid for any prescription drugs. If seniors or disabled people wanted help with the cost of medications, their options were usually limited to buying a Medigap supplemental insurance policy or spending down their assets until they qualified for Medicaid.

In 2006, Medicare introduced Part D, which allows Medicare beneficiaries to receive prescription drug coverage from private insurance companies. Participating insurers need to meet federal standards regarding deductibles and other kinds of cost sharing, but premiums and other out-of-pocket expenses can differ greatly from plan to plan. Although each plan is generally allowed to choose the specific drugs it will pay for, all Part D plans need to cover the same broad categories of drugs.

People in original Medicare can obtain Part D benefits by joining a private plan that's specifically designed to cover medications. People in Medicare Advantage can either choose an Advantage plan that includes drug coverage or join another private plan that's specifically designed to cover medications. To be eligible for Part D through a Medicare Advantage plan, a person must be enrolled in both Part A and Part B. To be eligible for a Part D plan outside of Medicare Advantage, a person only needs to be enrolled in either Part A or Part B.

Premiums and eligibility rules for a Part D plan cannot differ on the basis of a person's age or health status. Premiums will be higher for people who earn more than $85,000 a

year ($170,000 for couples filing joint tax returns). Part D will also cost more for people who declined it in the past but sign up when given another chance. Premiums can be deducted from Social Security payments, taken directly out of a person's bank account, or billed separately to the insured.

Part D is optional for most people in Medicare, but there's an exception for "dual eligibles." A dual eligible is someone who is eligible for Medicare and Medicaid at the same time. Prescription drugs for dual eligibles will first be covered by Medicare Part D. Then, if a dual eligible's drugs are not covered by Part D, the cost of the person's prescriptions might be paid by Medicaid.

Even if Part D is selected, a few drugs will continue to be covered under other parts of Medicare. Drugs administered by a medical professional on an outpatient basis (such as chemotherapy drugs) will still generally be covered under Part B. Drugs provided to someone who has been officially admitted to a hospital will usually be covered under Part A.

The Doughnut Hole

Medicare Part D has helped millions of seniors afford their medicine, but it also has a significant coverage gap. The gap, known as the "doughnut hole," will get progressively smaller on an annual basis because of health care reforms that were enacted in 2010. But the gap isn't scheduled to be entirely closed until 2020.

Someone in a Part D plan usually has to pay a deductible before their insurer will cover any drugs. Once the deductible has been satisfied, the plan will temporarily pick up a significant portion of the person's drug costs. During this period, the insured will be responsible for a copayment (such as $10 or $15) or a coinsurance fee (such as 25 percent of the cost). Once the plan's expenses and the person's out-of-pocket expenses for prescription drugs reach a certain amount for the calendar year, the person falls into the doughnut hole.

Coverage in the doughnut hole has undergone important changes since 2011. During the first five years that Part D was offered, the insured was responsible for all drug costs while in the doughnut hole until he or she had reached the plan's annual out-of-pocket limit. Once the annual out-of-pocket limit was reached, the person qualified for "catastrophic coverage" and was only responsible for a small copayment or small coinsurance fee for the rest of the calendar year. In 2010, the gap between regular Part D coverage and catastrophic coverage cost many seniors nearly $2,000.

In 2011, seniors in the doughnut hole received a 50 percent discount from drug manufacturers on brand-name drugs and a 7 percent discount from the federal government on generics. Those discounts are scheduled to increase gradually until 2020, when the doughnut hole is expected to be closed. At that point, Medicare beneficiaries in Part D will be insured for at least 75 percent of drug costs.

Part D plans will keep track of a person's out-of-pocket expenses and the value of the person's medications to determine when a person will fall into or come out of the doughnut hole. But there are some important exceptions. According to the AARP, the following kinds of drugs aren't included when a Part D plan calculates someone's out-of-pocket expenses or the value of their prescribed medications:

- Drugs bought in other countries.
- Drugs covered by other group insurance.
- Drugs bought through out-of-network pharmacies.
- Free samples.
- Drugs that aren't included in the plan's list of covered drugs.
- The portion of generic drugs that are paid for by the government in the doughnut hole.

Anyone who is in the doughnut hole should still continue to pay their Part D premiums and show their Part D insurance card to the pharmacist when purchasing prescription drugs. Failing to do so will prevent them from getting the aforementioned doughnut-hole discounts and qualifying for Part D's catastrophic coverage.

Formularies and Tiers

Before signing up for a Part D plan, someone who is eligible for prescription drug coverage should review the plan's "formulary." A formulary is a plan's list of covered drugs. Medicare Part D plans generally need to cover the kinds of drugs that a person with Medicare might need, but the specific drugs that are covered will be different in each plan. For example, although a plan might be required to cover at least some drugs that treat diabetes, it might not be required to cover all of them. (In the cases of a few diseases, such as cancer and HIV-AIDS, practically all drugs must be covered.) The list of covered drugs can change during the plan year, but enrollees usually must receive 60 days' notice.

Depending on the plan, the formulary might also list what "tier" each drug is in. A tier is a group of medications that are covered up to the same amount or at the same level. A plan might have one tier made up of generic drugs, a second tier of "preferred" brand-name drugs and a third tier for other brand-name drugs. If a drug is medically necessary, patients and their doctors might be able to convince a plan to move it from one tier to a less expensive one.

Even if a drug is part of a formulary, the plan might put certain conditions on its use. Some drugs won't be covered unless the patient's doctor contacts the plan and provides special authorization. In a process known as "step therapy," a plan might also require that the patient try cheaper drugs before it will cover more expensive ones. There can even be limits related to dosage. If step therapy or dosage limits are a problem, the patient's doctor should contact the plan for an exemption.

If a drug that someone is currently taking isn't part of the plan's formulary, the plan must give the patient a one-time, 30-day supply of it. While the patient is using the supply, he or she can work with a physician to either transition to a different drug or file an appeal.

There are a few kinds of drugs the federal government won't pay for, such as diet pills, fertility drugs and over-the-counter medications. A plan can still cover these drugs, but the cost of them must be paid privately by the plan and not with government subsidies.

Medigap Insurance

Seniors who want protection from the cost-sharing requirements in original Medicare can supplement their Medicare benefits with a private insurance product known as a "Medigap" policy. Medigap policies help pay for deductibles, coinsurance fees and

copayments that are associated with Medicare Part A and Medicare Part B. They cannot be used as a supplement to Medicare Advantage.

Medigap plans are usually referred to by a particular letter (Plan A, Plan B, etc.) Since these plans are standardized by the federal government, all consumers who have the same lettered plan are entitled to the same basic benefits.

As of June 1, 2010, the 10 standardized Medigap plans and their corresponding mandatory benefits are as follows:

- **Plan A:** This plan covers all hospital copayments for Medicare Part A and pays for an additional year of hospitalization if the insured has used up his or her lifetime reserve days. It also covers most coinsurance fees or copayments that are required in Part B and for the first three pints of blood needed during hospitalization. If a patient is in hospice care, copayments for prescriptions and respite services are covered, too. All insurers in the Medigap market must sell Plan A.
- **Plan B:** In addition to the benefits available through Plan A, this plan covers a patient's Part A deductible.
- **Plan C:** In addition to the benefits available through Plan B, this plan covers what the patient would normally pay for days 21 through 100 at a skilled nursing facility under Medicare Part A. It also covers the person's Medicare Part B deductible and includes foreign travel benefits. Other than in emergency situations near the border, Medicare does not pay for medical services rendered outside the United States. Plan C fills in some of that coverage gap by paying for 80 percent of foreign medical expenses in an emergency during the first 60 days of a foreign trip. (There's a $250 deductible and a $50,000 lifetime limit for foreign travel benefits.) Insurers that sell Medigap plans other than Plan A must also sell Plan C or Plan F.
- **Plan D:** In addition to the benefits available through Plan B, this plan includes the previously mentioned foreign travel benefits and pays the patient's portion of days 21 through 100 at a skilled nursing facility.
- **Plan F:** In addition to the benefits available through Plan C, this plan covers amounts charged by a non-participating provider that are in excess of Medicare's assigned charge. (For a review of non-participating providers and assigned charges, please refer back to the section "Charges and Assignment.") People with Plan F have the option of receiving these benefits at a reduced cost in exchange for a high deductible. Insurers selling Medigap plans besides Plan A must also sell Plan C or Plan F.
- **Plan G:** In addition to the benefits available through Plan D, this plan covers amounts charged by a non-participating provider that are in excess of Medicare's assigned charge.
- **Plan K:** This plan covers hospitalization copayments and provides an extra year of hospitalization coverage for people who use up their lifetime reserve days. It also covers 50 percent of (1) Part B copayments and coinsurance fees; (2) a patient's first three pints of blood; (3) hospice coinsurance and copayments; (4) skilled nursing care for a limited number of days; and (5) the Medicare Part A deductible. When a person's annual out-of-pocket expenses for services in Plan

K reach a certain amount ($4,660 in 2012), the plan will pay for 100 percent of covered care.

- **Plan L:** Plan L covers the same things as Plan K, but it pays for 75 percent of most covered care instead of 50 percent. When a person's annual out-of-pocket expenses for services in Plan L reach a certain amount ($2,330 in 2012), the plan will pay for 100 percent of covered care.
- **Plan M:** Plan M includes almost the same benefits as Plan D, but it only covers half of the Part A deductible.
- **Plan N:** Plan N includes almost the same benefits as Plan D, but it makes the person responsible for as much as $20 for each office visit and $50 for each outpatient trip to the emergency room.

You probably noticed that the preceding list of Medigap plans skipped a few letters. Plans E, H, I and J were offered years ago but are no longer available to insurance applicants. Seniors who had already purchased one of these plans had the option of keeping it or switching to a plan on the list.

In some states, Medigap insurance can be obtained through a Medicare SELECT plan. A Medicare SELECT plan is a Medigap plan with its own network of providers. It's similar to an HMO plan and is often less expensive than a regular Medigap plan.

Medigap Enrollment Periods

If they don't apply for Medigap insurance on time, seniors may be subjected to medical underwriting. In other words, the insurance company might be allowed to charge people more because of their health or refuse to issue a policy at all.

Charging more or denying insurance on the basis of health isn't allowed if a senior applies for a Medigap policy within six months after enrolling in Medicare Part B. However, someone who meets this deadline might still be faced with temporary exclusions for pre-existing conditions. If a senior was treated for a medical condition within six months prior to applying for Medigap insurance, the insurance company can sometimes refuse to pay for treatment of that specific condition until another six months has passed. The temporary exclusion can be shortened or eliminated if the senior was covered by other insurance within 62 days prior to applying for the Medigap policy. For the waiting period for pre-existing conditions to be entirely eliminated, the senior needs to have been covered by the other insurance for at least six months.

Under other limited circumstances, a senior can be guaranteed a Medigap policy without being subjected to medical underwriting and without having to worry about waiting periods for pre-existing conditions. Under federal law, the chance to receive this guarantee generally lasts 63 days and is usually tied to one of the following occurrences:

- Losing Medicare Advantage coverage because the plan has left the area or left Medicare (if the senior switches back to original Medicare).
- Losing Medicare Advantage coverage because the senior has moved out of the plan's area (if the senior switches back to original Medicare).
- Losing group health insurance because the plan is ending (if the plan was used by the senior as a supplement to original Medicare and not as the primary payer).

Additional or more-lengthy chances to purchase a guaranteed Medigap policy are available in most states. For example, many states give a disabled person the right to obtain Medigap insurance at certain times. However, the federal guarantees are only for seniors.

Regardless of when Medigap insurance is issued, the cost to the senior will be different from company to company. At some insurance companies, the cost will be based on how old the senior was when the policy was first issued. At other companies, the cost will change automatically as the senior grows older. (Remember, charging someone more because of age is different from charging someone more because of health.) Other methods of setting premiums are possible as well.

Conclusion

For roughly half a century, Medicare has played a leading role in the availability of quality health care for older Americans and the disabled. But for younger people who are either new to the program or years away from joining, the details can seem intimidating. Someone who will be relying on Medicare needs to know not only what's covered but also when to apply. The sooner you become familiar with how the system works, the easier it'll be to make smart insurance decisions.

Below is the Final Examination for this course. Use the answer sheet included with this book to submit your exam(s).
You may also enroll and complete this course online:
www.BookmarkEducation.com
Your certificate will be issued immediately upon successful completion of the course.

PRINCIPLES FOR INSURANCE PROFESSIONALS

FINAL EXAM

1. _____ occurs when insurance is cancelled against the policyholder's will and treated as if it never existed.
   A. Rescission
   B. Up-coding
   C. Post-claims underwriting
   D. Coordination of benefits

2. In 2006, Medicare introduced Part D, which allows Medicare beneficiaries to receive _____.
   A. hospital care
   B. hospice care
   C. prescription drug coverage
   D. preventive health services

3. When they're forced to eliminate exclusions for pre-existing conditions, insurers in the individual and small-group markets will also be prohibited from charging people more because of _____.
   A. age
   B. geographic area
   C. personal health
   D. tobacco use

4. The HO-4 policy form is for _____.
   A. single-family homes
   B. commercial properties
   C. renters
   D. builders

5. The employer mandate won't apply to businesses with fewer than _____.
   A. 50 employees
   B. 75 employees
   C. 100 employees
   D. 250 employees

6. Most property insurance companies in the United States use homeowners insurance policies with language written by the _____.
   A. Insurance Services Office
   B. American Insurance Association
   C. Consumer Federation of America
   D. National Association of Insurance Commissioners

EXAM CONTINUES ON NEXT PAGE

7. Unlike liability insurance, property insurance on a driver's own car is usually _____.
   A. unlimited
   B. all-risk
   C. optional
   D. experience-rated

8. Coverage based on the person's own job duties is known as _____.
   A. own-occupation coverage
   B. any-occupation coverage
   C. workers compensation
   D. employer-sponsored disability insurance

9. Unlike other federally funded insurance programs, Medicare eligibility is generally not based on _____.
   A. resident or citizenship status
   B. age
   C. work history
   D. need

10. If someone declines Medicare Part B and later decides to enroll, the person will often be forced to pay _____.
    A. higher copayments
    B. higher coinsurance fees
    C. a higher monthly premium
    D. a higher deductible

11. Between the time it's purchased and the time payments begin, a deferred annuity goes through a(n) _____.
    A. elimination period
    B. accumulation period
    C. payout phase
    D. annuitization phase

12. Whether they are employed by an insurer or hired by a policyholder, ethical insurance professionals must bring consumers and insurers together _____.
    A. in a manner that maximizes the insurer's profits
    B. in a manner that results in low costs for the consumer
    C. in a manner that provides the highest sales commission
    D. only in good faith

13. The annuity owner is the person who _____.
    A. receives death benefits
    B. is the measuring life for the annuity
    C. puts money into the annuity
    D. is responsible for the contract's guarantees

14. For your stay at a nursing home to be covered by Medicare, a doctor must authorize that you need _____.
    A. custodial care
    B. skilled care
    C. preventive care
    D. hospice care

EXAM CONTINUES ON NEXT PAGE

15. Variable annuities appeal to investors who are willing to put some of their principal at risk in exchange for _____.
    A. longer surrender periods
    B. corporate tax breaks
    C. potentially higher returns
    D. deferral of estate taxes

16. On a federal level, an annuity generates no tax bills until the owner or annuitant _____.
    A. receives a payout from the insurer
    B. deposits money into a variable account
    C. reaches his or her life expectancy
    D. reaches full retirement age

17. As their name suggests, term life policies remain in effect for a contractually agreed-upon time and then _____.
    A. are surrendered for money
    B. expire
    C. increase in value
    D. become property of the beneficiary

18. Part B will pay 80 percent of Medicare-approved charges for _____.
    A. hospitalization
    B. doctor visits
    C. prescription drugs
    D. custodial care

19. Non-qualified annuities are funded with _____.
    A. after-tax dollars
    B. pre-tax dollars
    C. employer contributions
    D. Social Security benefits

20. The typical homeowners insurance policy has a coinsurance clause that requires the insured to cover a dwelling for at least _____.
    A. 50 percent of its replacement cost
    B. 70 percent of its actual cash value
    C. 80 percent of its replacement cost
    D. 100 percent of its actual cash value

21. Auto insurance fraud rings tend to be most common in states with _____.
    A. large cities
    B. no-fault auto insurance laws
    C. strict rate regulation
    D. older drivers

22. Medicare Advantage plans generally must cover at least the same kinds of care as _____.
    A. Medigap insurers
    B. long-term care policies
    C. typical employer group plans
    D. original Medicare

EXAM CONTINUES ON NEXT PAGE

23. In most annuitization situations, payouts are fixed at an equal amount and are scheduled to continue _____.
    A. throughout the annuitant's lifetime
    B. for a period of 10 to 20 years
    C. until a surviving spouse passes away
    D. until the chosen stock index decreases

24. Insurance that does not take depreciation into account is known as _____.
    A. commercial property insurance
    B. buy-back value coverage
    C. replacement-cost coverage
    D. market-value coverage

25. If an insurer's medical loss ratio dips below federal standards, the company's customers will receive _____.
    A. financial reports
    B. privacy notices
    C. tax credits
    D. rebates

26. As part of health care reform, adult children have the option of staying on their parents' plan at least until their _____.
    A. 26th birthday
    B. 28th birthday
    C. 30th birthday
    D. 32nd birthday

27. Term life insurance is sometimes called "pure insurance" because, unlike other policies, it lacks investment options and has no _____.
    A. cash value
    B. death benefit
    C. ending date
    D. settlement options

28. Participating providers in Medicare agree to accept _____.
    A. assignment
    B. long-term care insurance
    C. no new patients
    D. all reasonable forms of payment

29. The manner in which a beneficiary receives policy benefits is called a(n) _____.
    A. accelerated death benefit
    B. needs analysis
    C. dividend
    D. settlement option

30. _____ is a long-term contractual arrangement in which an investor gives money to an insurance company and is expected to get it back in either a lump sum or a series of regularly scheduled payments.
    A. Industrial life insurance
    B. Business income coverage
    C. A mutual fund
    D. An annuity

END OF EXAM

BOOKMARKEDUCATION

California Insurance Licensee CE

24 Credit Hours – ONLY $59.00

PLEASE SEE THE INSIDE COVER OF THIS BOOK FOR ANSWERS TO MANY FREQUENTLY ASKED QUESTIONS

TO EARN CONTINUING EDUCATION CREDIT, SUBMIT YOUR EXAM ONLINE AT

www.BookmarkEducation.com

OR COMPLETE THIS ANSWER SHEET, THEN MAIL OR FAX WITH YOUR PAYMENT

Exam questions appear at the end of each course. Use pen or pencil to darken correct choice for each question.

COURSE ONE: Ethics - A Modern Approach (4 Credit Hours)

1. Ⓐ Ⓑ Ⓒ Ⓓ	4. Ⓐ Ⓑ Ⓒ Ⓓ	7. Ⓐ Ⓑ Ⓒ Ⓓ	10. Ⓐ Ⓑ Ⓒ Ⓓ	13. Ⓐ Ⓑ Ⓒ Ⓓ
2. Ⓐ Ⓑ Ⓒ Ⓓ	5. Ⓐ Ⓑ Ⓒ Ⓓ	8. Ⓐ Ⓑ Ⓒ Ⓓ	11. Ⓐ Ⓑ Ⓒ Ⓓ	14. Ⓐ Ⓑ Ⓒ Ⓓ
3. Ⓐ Ⓑ Ⓒ Ⓓ	6. Ⓐ Ⓑ Ⓒ Ⓓ	9. Ⓐ Ⓑ Ⓒ Ⓓ	12. Ⓐ Ⓑ Ⓒ Ⓓ	15. Ⓐ Ⓑ Ⓒ Ⓓ

COURSE TWO: Principles for Insurance Professionals (10 Credit Hours)

1. Ⓐ Ⓑ Ⓒ Ⓓ	6. Ⓐ Ⓑ Ⓒ Ⓓ	11. Ⓐ Ⓑ Ⓒ Ⓓ	16. Ⓐ Ⓑ Ⓒ Ⓓ	21. Ⓐ Ⓑ Ⓒ Ⓓ	26. Ⓐ Ⓑ Ⓒ Ⓓ
2. Ⓐ Ⓑ Ⓒ Ⓓ	7. Ⓐ Ⓑ Ⓒ Ⓓ	12. Ⓐ Ⓑ Ⓒ Ⓓ	17. Ⓐ Ⓑ Ⓒ Ⓓ	22. Ⓐ Ⓑ Ⓒ Ⓓ	27. Ⓐ Ⓑ Ⓒ Ⓓ
3. Ⓐ Ⓑ Ⓒ Ⓓ	8. Ⓐ Ⓑ Ⓒ Ⓓ	13. Ⓐ Ⓑ Ⓒ Ⓓ	18. Ⓐ Ⓑ Ⓒ Ⓓ	23. Ⓐ Ⓑ Ⓒ Ⓓ	28. Ⓐ Ⓑ Ⓒ Ⓓ
4. Ⓐ Ⓑ Ⓒ Ⓓ	9. Ⓐ Ⓑ Ⓒ Ⓓ	14. Ⓐ Ⓑ Ⓒ Ⓓ	19. Ⓐ Ⓑ Ⓒ Ⓓ	24. Ⓐ Ⓑ Ⓒ Ⓓ	29. Ⓐ Ⓑ Ⓒ Ⓓ
5. Ⓐ Ⓑ Ⓒ Ⓓ	10. Ⓐ Ⓑ Ⓒ Ⓓ	15. Ⓐ Ⓑ Ⓒ Ⓓ	20. Ⓐ Ⓑ Ⓒ Ⓓ	25. Ⓐ Ⓑ Ⓒ Ⓓ	30. Ⓐ Ⓑ Ⓒ Ⓓ

COURSE THREE: Insurance Policies: An Essential Resource (10 Credit Hours)

1. Ⓐ Ⓑ Ⓒ Ⓓ	6. Ⓐ Ⓑ Ⓒ Ⓓ	11. Ⓐ Ⓑ Ⓒ Ⓓ	16. Ⓐ Ⓑ Ⓒ Ⓓ	21. Ⓐ Ⓑ Ⓒ Ⓓ	26. Ⓐ Ⓑ Ⓒ Ⓓ
2. Ⓐ Ⓑ Ⓒ Ⓓ	7. Ⓐ Ⓑ Ⓒ Ⓓ	12. Ⓐ Ⓑ Ⓒ Ⓓ	17. Ⓐ Ⓑ Ⓒ Ⓓ	22. Ⓐ Ⓑ Ⓒ Ⓓ	27. Ⓐ Ⓑ Ⓒ Ⓓ
3. Ⓐ Ⓑ Ⓒ Ⓓ	8. Ⓐ Ⓑ Ⓒ Ⓓ	13. Ⓐ Ⓑ Ⓒ Ⓓ	18. Ⓐ Ⓑ Ⓒ Ⓓ	23. Ⓐ Ⓑ Ⓒ Ⓓ	28. Ⓐ Ⓑ Ⓒ Ⓓ
4. Ⓐ Ⓑ Ⓒ Ⓓ	9. Ⓐ Ⓑ Ⓒ Ⓓ	14. Ⓐ Ⓑ Ⓒ Ⓓ	19. Ⓐ Ⓑ Ⓒ Ⓓ	24. Ⓐ Ⓑ Ⓒ Ⓓ	29. Ⓐ Ⓑ Ⓒ Ⓓ
5. Ⓐ Ⓑ Ⓒ Ⓓ	10. Ⓐ Ⓑ Ⓒ Ⓓ	15. Ⓐ Ⓑ Ⓒ Ⓓ	20. Ⓐ Ⓑ Ⓒ Ⓓ	25. Ⓐ Ⓑ Ⓒ Ⓓ	30. Ⓐ Ⓑ Ⓒ Ⓓ

I have completed the above course(s) of study independently:

Sign Student Name: _____ **Date:** _____/_____/_____

STUDENT: (Please Print)

NAME _____

ADDRESS _____ **UNIT OR APT. #** _____

CITY _____ **STATE** _____ **ZIP** _____ **COUNTY** _____

TELEPHONE (Home) _____ **(Work)** _____

E-MAIL ADDRESS _____ **DATE YOU RENEW YOUR LICENSE** _____/_____/_____

PRODUCER LICENSE NUMBER _____ **SOCIAL SECURITY #** _____

REGISTRATION: *(Choose One)*

- ❑ **$59.00 - 24 CREDIT HOURS (ALL THREE COURSES)**
- ❑ $29.00 - 4 CREDIT HOURS ❑ $39.00 - 10 CREDIT HOURS ❑ $49.00 - 14 CREDIT HOURS

PAYMENT: *(Choose One)*

- ❑ **Check or Money Order made payable to BOOKMARK EDUCATION**
- ❑ **MasterCard** ❑ **Visa** ❑ **Discover** ❑ **American Express**
- ❑ **I have already pre-paid for course enrollment. I am only submitting my exam(s) for scoring**

CARD # _____ **EXPIRATION** _____/_____ **CARD VERIFICATION #** _____

NAME ON CARD _____ **SIGNATURE** _____

ENROLL AND COMPLETE YOUR COURSE ONLINE *OR* RETURN THIS FORM TODAY!

TELEPHONE	FAX	MAIL	WEBSITE
(800) 716-4113	**(888) 500-0108**	Bookmark Education 6203 W. Howard Street Niles, IL 60714	**www.BookmarkEducation.com**

We will report your completion to the California Department of Insurance and provide a certificate for your records.