Health & Disability Insurance

In this section, we'll briefly cover the differences in the Health, Accident, and Disability Insurance industry as compared to the Property & Casualty insurance industry.

HEALTH, ACCIDENT, AND DISABILITY INSURANCE

Health insurance is broadly defined as insurance against loss by sickness or bodily injury, including disability or death by accident or accidental means. Health insurance does NOT include workers' compensation coverage.

The entire accident, health, and disability insurance industry that is totally separate and apart from the Property & Casualty industry. The greatest difference lies not only in the nature of its policies of insurance, but also because, with the exception of the occasional "headline" case, there is little notable adversity in its administration or the benefits paid by this industry.

The reason for this is that, like the 1st party contracts involved in the P&C Auto industry (i.e. Collision, Comprehensive, Medical Payments, etc.), there is little incentive for attorneys to become involved. Only the most serious injuries, or most egregious behavior on the part of the industry, get the attention of the media, the Bar or the regulators.

It is important that you learn some of the fundamentals of these insurance products, not so much because you'll need them in your P&C claims career, but because you won't need them. There is such a difference between the P&C and Health Insurance industries that you can work your whole life in insurance and not encounter health, accident, or disability insurance issues. This section is included in this course, not only because it is 6% of the New York Independent General Adjuster Licensing Exam, but also for your personal knowledge and benefit in handling your own insurance matters:

1. Definitions of Potential Claims in the Accident, Health, and Disability Insurance Marketplace

Claims covered by these types of insurance generally arise from two sources:

- Injury by Accident – generally flows from some type of traumatic injury to the body and/or its internal organs, and is unexpected and/or unintended by the injured party.
- Sickness or Illness – includes physical illness, disease, or other physical infirmity, including pregnancy. Sickness or illness under any of these policies do **NOT** include mental illness.

2. Principle Types of Claims and Benefits

A. Loss of Income from Disability Income Insurance

There are only a handful of basic Health policies, and there are even fewer Disability Income plans. Disability income insurance is similar to, and operates under, similar concepts as Workers' Compensation, and is designed to replace lost income in the event of total disability and the inability to work for a specified period of time.

Coverage is usually subject to a deductible stated as a specified time period of disability (e.g. 30 days, 3 months, 6 months, etc.) before benefits begin. Thereafter, disability insurance provides a stated monthly benefit for a specified period of time. Benefits can be for either partial or total disability due to either accidental injury or illness.

Like workers' compensation, there are four (4) types of disability:

- Temporary Partial – disability that partial in severity and temporary in duration. Here the individual can usually work a "light or modified" duty job, but may lose income because of it.

- Temporary Total – disability that is total in severity, but temporary in duration;
- Permanent Partial – disability that is partial in severity, but permanent in duration; and,
- Permanent Total – disability that is total in severity and permanent in duration, i.e. an insured will never work again.

Because of the impact that disability can have on an individual's life, or on one's family or dependents, disability income insurance is generally considered a vital component of any comprehensive insurance program.

B. Hospital and Medical Expense

The cost of medical care is comprised of three basic kinds of treatment: hospital expense, surgical expense, and medical expenses. Insurance for these exposures can be purchased as a package, or separately. Reimbursement is usually on a first-dollar basis (i.e. no deductible).

The types of policies typically provided to cover these expenses include:

- Hospital Indemnity Insurance – provides payment of a flat amount per day for the costs of hospitalization (i.e. room and board) only, designed to supplement other coverages which may be inadequate.

  This type of insurance reimburses the insured, or provider, for covered and approved medical services, procedures, equipment, and prescription drugs and pays a lump-sum payment directly to the insured for a covered hospital confinement, outpatient surgery, and emergency injury or sickness.

  If an insured experiences a hospital confinement, outpatient surgery, or emergency accident or sickness, they submit a claim form along with the receipts for services received. They will receive a lump-sum payment as described in the policy and may can use the cash for whatever they choose.

- Basic Hospitalization Expense Insurance – provides indemnification for basic expenses such as room, board, nursing care, testing and lab fees, operating rooms and medical supplies. Coverage for these expenses is "all-inclusive" and is limited to a specified dollar limit per day, up to a specified maximum number of days. Payment is made

  Unfortunately, if these limits are not high enough, the insured may be left responsible for the unpaid amount. For example, if the hospital expense benefit is limited to $500 per day for up to 30 days, and the hospital charges $600 per day, the insured would be responsible for the extra $100 per day for the duration of the hospital stay.

- Miscellaneous Hospital Expense Insurance – can be purchased separately to pay for other miscellaneous expenses incurred as result of hospitalization, typically drugs, x-rays, and laboratory expenses. The benefit may be expressed in a number of ways:
  - a multiple of the daily room and board limit (e.g., 10 times the room and board limit of $750, for a total limit of $7,500)
  - a flat rate benefit (e.g., $5,000, $10,000, $25,000, etc.)
  - a percentage of incurred costs up to a stated maximum limit (e.g., 80% of covered expenses up to $15,000, etc.)

- Major Medical Insurance – provides protection against catastrophic medical losses. This form of insurance is typically designed to supplement basic hospital/surgical insurance, subject to significant deductibles or out of pocket expenses. These policies typically carry very high maximum limits (e.g., $1 Million to $2 Million), and limits may apply either on a "lifetime" or "per disability" basis.

- Medicare Supplement Insurance – is available to cover medical costs that are not payable under the Federal Medicare program.

C. Long Term Care

Long term care (LTC), also known as nursing home care, is designed to assist individuals who become dependent on others for care. Assistance may be offered at the individual's home (i.e. home health care), a nursing home, or an adult care center (aka Assisted Living Facility, or ALF).

Long term care is comprised of three types of care;

1. Skilled, continuous nursing care;
2. Intermediate nursing care, provided by registered nurses on a less than 24-hour basis;
3. Custodial care, i.e. assistance with day to day living such as bathing, dressing, etc.

Activities of Daily Living (ADL) – The test for determining the need for long-term care involves an individual's ability to independently and the ability to perform the following activities of daily living:

- Walk
- Dress, feed, and bathe oneself
- Perform other acts of personal hygiene
- Transfer from a bed or sofa to a chair

Almost all LTC policies have benefit limits, and these limits vary from company to company. In addition, these policies have age limits and elimination periods (e.g., 0 to 365 days). The HIPPA law of 1996 also provided that these policies be "guaranteed renewable".

3. Classes of Accident and Health Insurance Policies

A. Individual Health Insurance – is purchased by an individual or family. Because these are "individual" policies, there is no real buying power and the insurer perceives greater risk, coverage is typically more restricted and expensive. The individual pays the entire premium.

Underwriting for individual health insurance policies is done with the utmost care. Factors considered include age, sex, physical condition, prior health history, occupation, and to some degree, family health history.

B. Franchise Health Insurance – (aka "wholesale insurance") provides health insurance for groups that are too small to obtain group coverage. A franchise plan provides individual policies with uniform provisions, although they may differ in benefits. Participants are usually solicited from a workplace with the employer's approval, and individual contracts are issued to each person with individual underwriting. The plan issues participants with an individual contract with individual underwriting and the same provisions.

A franchise plan provides individual policies with uniform provisions, although they may differ in benefits. Individual contracts are issued to each person with individual underwriting. It is usually applied to groups too small to qualify for true group coverage, and the solicitation of cases usually takes place among a workforce with employer consent.

C. Group Health Insurance – is purchased by an employer, an association, or other organization where the purchasing entity pays all or part of the premium for the member (you). Because of the greater purchasing power wielded by the purchasing entity, group insurance policies provide the broadest coverage for the least premium for the individual.

Although group insurance is certainly underwritten with care, the attitude toward "group" risk is much less restrictive because the yearly renewable term contract includes an annual revaluation of the risk, as well as the adoption of remedial measures if the initial valuation was found to be inaccurate. On each contract anniversary date, the underwriter(s) have the

opportunity to adjust the premium rate, conditions of the insurance contract, and the benefits to be provided.

The availability and extent of group health insurance (i.e. broad coverage and affordability), or lack thereof is considered one of the greatest domestic crises in America today.

D. Conversion from Group to Individual Coverage – Employees who are terminated and lose their group insurance are usually permitted to convert their group insurance to individual insurance *without providing evidence of insurability*. Such an option is usually required very shortly after termination, e.g., within 30-31 days after termination. This is referred to as the *conversion period*.

If a terminated employee seeks conversion, the insurer can evaluate the individual to determine the amount of premium and coverage provided. The new "converted" individual policy can include either more or less coverage, and the premium may be higher or lower than the original group rate.

This option is required by the Consolidated Omnibus Budget Reconciliation Act ("COBRA"), a federal law that provides many workers with the right to continue coverage in a group health plan. This federal law applies to employers with 20 or more employees, including the self-insured employers option.

4. Providers of Health Insurance

Providers of health insurance come in all types and sizes, from both private and governmental sources, insured and self-insured, and in limited and comprehensive scope of coverage.

A. Private Health Insurance is provided by the traditional stock and mutual insurers like Aetna, Humana, United Healthcare, et al., membership organizations like Blue Cross Blue Shield, and Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) formed by hospitals and physicians to deliver medical care to their member enrollees.

i. Health Maintenance Organization (HMO) – provides comprehensive health services to its members for a prepaid fixed premium. While this type of provider organization provides health insurance at the lowest possible cost, some argue that the quality of medical care is lower, and the flexibility of choice is more restricted.

ii. Preferred Provider Organization (PPO) – provides health coverage at a lower cost, and has much greater flexibility in one's choice of physician or health care facility. **Many argue that, for just a slightly higher premium than an HMO, type of health insurance plan offers the most comprehensive health coverage at the lowest cost to the individual!*

In a PPO, physicians are paid a fee for service rather than a salary. Also, insureds (also called "subscribers") are not required to use physicians or facilities that have contracts with the PPO and PPOs usually have a greater selection of providers as compared to HMOs.

B. Government Health Insurance is offered through both state and federal governmental plans. Social Security provides disability income benefits and medical benefits are delivered through Medicare. These are guaranteed at the federal level. State governments provide Medicaid and other forms of subsidized care. State government also provides for Workers' Compensation.

i. **Medicare** – This federal program is primarily for individuals 65 years old or older, but also includes people with permanent kidney (renal) failure and other forms of disability. Medicare consists of:

– Hospital Insurance (Part A) includes care at medical institutions such as inpatient, home heath, skilled nursing, and hospice.

– Medical Insurance (Part B) provides physician's services, outpatient care, physical therapy, medical equipment, etc.

– Prescription Drugs (Part D) s the costs of prescription drugs and prescription drug insurance premiums for Medicare beneficiaries.

ii. **Medicaid** – Medicaid is a healthcare program funded by both state and federal governments for individuals with income or funds that is inadequate for appropriate medical care. Applicants for Medicaid are required to go through a rigorous application to prove they do not otherwise have the resources or funds to purchase medical care through other alternative markets. However, once approved, Medicaid provides a full package of benefits, even the long-term nursing home care that is excluded by Medicare.

iii. **Social Security** – formerly known as Old Age, Survivors, Disability, and Health Insurance provides income benefits to workers who become disabled is administered by the federal government, and administrators of this program adhere to a strict and detailed set of definitions and requirements.

5. Limited Health Insurance Policies

While the health insurance programs previously discussed are all very comprehensive in scope, health insurance is also available through "Limited Policies" that provide various specialty coverages:

A. Accident Insurance – provides coverage for expenses, including loss of income, arising from accident.

B. Dread Disease Insurance – provides benefits for only a single illness, such as cancer.

C. Dental Coverage – although rarely provided through individual coverage, the benefits provided through this coverage include preventative maintenance and care with maximum limits per person.

D. Vision Care Insurance – normally provided as an option under group insurance, this coverage will pay specified amounts toward annual eye exams and the cost of eyeglasses every few years.

E. Prescription Drug Coverage – also provided under group plans, benefits generally provide a specifically stated cost per prescription, no matter the actual cost of the medication. Here, the insured is only required to pay the "stated cost", e.g. $5 - $10 per prescription, and the insurance company pays the balance.

F. Credit Disability – This insurance is often provided to those who purchase larger items, from vehicles to real estate, and it covers the debt(s) owned to specific creditors in the event of the disability of an insured. Benefits are limited to the total amount of the indebtedness.

These policies obviously provide limited benefits and limited amounts of coverage that are each suited to a specific purpose. Because of these limitations, state laws usually require that the first page of each policy clearly state, "THIS IS A LIMITED POLICY".

6. Exclusions

Just like property and casualty insurance, several risks are excluded in health policies:

- Dental and/or vision services
- Elective cosmetic medical expenses
- Experimental or investigative medical expenses
- Illness or injury covered by workers' compensation
- Intentional or self-inflicted injury
- Mental illness
- Pre-existing illnesses or conditions
- War or military service

7. Health Insurance Provisions and Coverage Forms

Individual health insurance contracts differ in their renewal provisions and there really are no standardized coverage forms, but certain provisions or policy clauses have been standardized. There are five different types of provisions that receive the most attention by regulators, and they all deal with cancellation, renewal, or termination:

- *Cancelable* health insurance policies retain the right of cancellation, subject to a specific notice requirement (sometimes as little as five days' notice). However, because cancellable policies are very unfavorable for the consumer public, most states have prohibited their use.
- *Non-Cancellable* policies offer the greatest degree of protection with no change in benefits because they cannot be cancelled by an insurer for any reason except nonpayment of premium.
- *Optionally Renewable* policies give the insurer the right to renew or non-renew a health insurance policy upon its expiration. The insurer can renew the policy, renew with an increase in premium, or renew with restrictions on certain classes of insureds.
- *Conditionally Renewable* policies grant the insurer a limited right to refuse renewal based upon certain conditions, such as:
  - The insurer may decide to discontinue certain coverages in certain states or territories;
  - The insurer may decide to stop insuring a particular class of individuals; or,
  - The insurer may refuse renewal based upon material misrepresentation by a person filing a claim.
- *Guaranteed Renewable* policies guarantee renewal *"from the insured's point of view"* to the policyholder to a stated age (usually to age 65 or 70). While the company can't cancel the policy, *it can increase the premium* according to risk classification.

8. Pre-Existing Conditions

Most health insurance policies contain specific exclusions or limitations on pre-existing conditions, and it doesn't matter whether or not these conditions are listed, noted, identified, or described in the initial application for health insurance.

Pre-existing conditions are usually subject to a specific time-requirement, usually 1-2 years. For example, after a 1- or 2-year time period of coverage, pre-existing conditions will be covered unless the insurer has otherwise specifically excluded them.

9. Other Provisions in Group Policies

Certain provisions in health policies are important to remember. Even if you don't handle these type claims, they're good to know for personal knowledge:

- *Grace Periods* – Policies generally provide for a period during which they will remain in force, after the premium due date if unpaid. Examples include a minimum grace period of 7 days for weekly premium policies, 10 days for monthly premium policies, and 31 days for all others.
- *Elimination (or Waiting) Periods* – A policy may contain a provision which states a period of time between issuance and acceptance before sickness benefits begin. This helps to keep the premiums reasonable by eliminating the chance of persons buying coverage only upon discovering they are sick.
- *Waiver of Premium* – This provision states that if the policyholder becomes totally disabled, coverage remains in force but premiums are waived.
- *Double Indemnity* – This provision doubles the death benefit for certain accidents. Examples include death while a passenger on a public conveyance or elevator, collapse or fire in a building, or by boiler explosion, hurricane, tornado or lightning.

- *Incontestability* – Usually after one or two years of coverage, the policy cannot be contested.

10. Application

Individual, and in some cases, group health insurance policies include written application that becomes part of the policy, which an insurer may use to accept or reject based on the information contained therein. The application provides information that includes age, sex, occupation, earnings, present and past health and claim experience, and other information; however, the statements made in the application are considered representations only…and not warranties.

Generally speaking, *fraudulent* misstatements or information can be used to deny claims for current or pre-existing health conditions.

11. A Comparison of Group vs. Individual Insurance

There are important differences between group and individual coverage. While they both offer the same or similar benefits, and coverage plans, here are a few of the differences:

- Who Can Purchase?
  While anyone can apply for and purchase individual health insurance, to secure group health insurance, an individual must meet the size and purpose of the group.

  Policy vs. Certificate
- With individual health insurance, every insured has their own policy. With group health insurance, there is one master contract and employees receive a certificate of insurance.

- Occupational vs. Non-occupational Coverage
  While an individual health policy may cover both occupational and non-occupational accidents or illness, group health insurance *excludes* occupational accidents and sickness.

- Individual vs. Group Health Evaluation
  With individual health insurance, only the health of the individual is evaluated. With group insurance, the health of the overall group is subject to underwriting and evaluation. (Ex: If a group comprised of ten people, with eight who were in excellent health and two were in poor health due to pre-existing conditions, the two in poor health would benefit from the overall "good" health of the group.)

- Selection of Benefits
  With individual health insurance, the individual selects coverage and benefit types from a list of options. Group health coverage and benefit types are the same for all members.

- Continuation of Benefits
  Individual health insurance generally lasts as long as the insured continues to renew the policy. With group insurance, a member's coverage stops if and when he/she leaves the group; however, group insurance can usually be converted to individual insurance (e.g. COBRA), but at a much higher rate.

12. Regulations for Notice, Processing, and Payment of Health Insurance Claims

New York Insurance Law - ISC § 3216 provides the following guidance under individual accident and health insurance:

- Insured's Notice of Claim

  Written notice of claim must be given to the insurer within twenty (20) days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably

possible. Notice given to the insurer or to any authorized agent of the insurer or any authorized broker, with information sufficient to identify the insured, shall be deemed notice to the insurer.

If an insured suffers loss of time on account of disability for which indemnity may be payable for at least two years, he shall, at least once in every six months after having given notice of claim, give to the insurer notice of continuance of said disability, except in the event of legal incapacity.

Delay in the giving of such notice shall not impair the insured's right to any indemnity which would otherwise have accrued during the period of six months preceding the date on which such notice is actually given.

- Standard Claim Forms

  Standard claim forms for health care services shall be used for all accident and health insurance claims, and all insurers providing such insurance shall accept said standard claim forms when submitted by a hospital, physician or other health care provider covering services rendered to an individual.

- Insurer's Responsibility to Provide Claim Forms

  The insurer must provide, within fifteen (15) days, any required claim forms necessary for filing a proof of loss. If such forms are **NOT** furnished within fifteen days after timely, adequate notice shall be deemed to have been given to the insurer.

- Insured's Submission of Proof of Loss

  Written proof of loss for which the policy provides any periodic payment contingent upon continuing loss must be furnished to the insurer within ninety (90) days after the termination of the period for which the insurer is liable.

  In the case of a claim for any other loss, within one hundred twenty (120) days after the date of such loss. Failure to furnish such proof of loss within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible but in no event more than one (1) year after notice was required. In the absence of legal capacity, there is no time limit.

- Insurer's Investigation of Claims/Verification of Loss

  New York's Unfair Claim Settlement Practices Act establishes claim practice principles to be followed by insurers, including all accident and health insurers. That is, to:

  a) Have as your basic goal the prompt and fair settlement of all claims.
  b) Assist the claimant in the processing of a claim.
  c) Do not demand verification of facts unless there are good reasons to do so. When verification of facts is necessary, it should be done as expeditiously as possible.
  d) Clearly inform the claimant of the insurer's position regarding any disputed matter.
  e) Respond promptly, when response is indicated, to all communications from insureds, claimants, attorneys, and any other interested persons.

  To that extent, every insurer shall commence an investigation of any claim filed by a claimant, or a claimant's authorized representative within fifteen (15) business days of receipt of notice of claim. Where there is a reasonable basis, supported by specific information available for review by Insurance Department examiners, that the claimant has fraudulently caused or contributed to

the loss, these provisions are suspended for the period required to investigate the alleged fraudulent aspects of the claim.

- Insurer's Payment of Claims

  New York Insurance Law § 3224-a requires an insurer to pay claims or bills for health care services that are transmitted via the internet or electronic mail within thirty (30) days of receipt, or within forty-five (45) days of receipt of a claim or bill for services rendered that is submitted by other means, such as paper or facsimile.

  Where an insurer's obligation to make payment is not "reasonably clear," the insurer must pay any undisputed portion within the 30 or 45-day timeframes noted above, and also notify the Insured or health care provider within 30 days of the receipt of the claim that: (1) an obligation to pay does not exist and state the specific reasons why, or (2) additional information is necessary to determine liability.

  Payment of any unpaid indemnity (i.e. disability) or death benefits shall be paid to the named beneficiary or to the estate of the Insured if there is none.

  Payment hospital, nursing, medical, or surgical services may, at the insurer's option and unless otherwise directed by the insured at the time of filing proofs of such loss, be paid directly to the hospital(s), medical provider(s), or person(s) rendering such services.

- Physical Examinations and Autopsy

  The insurer, at its own expense, shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder, and to make an autopsy in case of death where it is not forbidden by law.

- Legal Actions

  No action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished. (*In other words, no lawsuit can be filed before 60 days after providing proof of loss, and the statute of limitations for filing such lawsuit is 3 years after providing the proof of loss.)

Here are a few practice questions on issues you will want to remember:

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1. A health policy that provides benefits for a single illness or disease is called a:

   a) Preferred Provider Policy
   b) Single Illness Policy
   c) Major Medical Policy
   d) Dread Disease Policy

2. Which type of health insurance plan offers the broadest coverage at the lowest cost to the individual?

   a) PPO Insurance
   b) Major Medical Insurance
   c) Group Health Insurance
   d) Accident Insurance

3. The provision in an accident insurance policy that doubles the death benefit otherwise applicable for an accident is called:

   a) Waiver of Premium
   b) Elimination
   c) Double Indemnity
   d) Reinstatement

4. What type of health insurance policy does NOT allow the insurer to cancel the policy mid-term (i.e. during the policy period), but may non-renew (i.e. elect not to continue coverage) upon the expiration of the policy?

   a) Guaranteed renewable
   b) Conditionally renewable
   c) Noncancelable
   d) Optionally renewable

5. Which of the following is TRUE concerning health insurance policies?

   a) Group health coverage is typically more restricted and expensive.
   b) Health insurers' attitude toward "individual" risk is much less restrictive group risk.
   c) Underwriting for individual health insurance policies is done with the utmost care.
   d) Those who lose group insurance through termination have no other health insurance options.

6. A policy may contain a provision that requires that passage of a period of time between issuance and acceptance before sickness or illness benefits begin. This provision is called:

   a) Sickness provision

b) Waiver of premium
c) Reinstatement
d) Waiting period

6. The type of organization which provides comprehensive health services to its members for a prepaid fixed fee, and whose goal is preventative care is:

a) PPO
b) HMP
c) HMO
d) Medicare Supplement

7. A selected group of hospitals and medical practitioners in a given area who have joined together in an effort to reduce medical costs is referred to as:

a) Major Medical Groups
b) Health Maintenance Organizations
c) Hospital Indemnity Plans
d) Preferred Provider Organizations

8. The type of health care policy which pays a flat amount per day of hospital confinement, regardless of other insurance is:

a) Comprehensive Major Medical
b) Hospital Indemnity Insurance
c) Surgical Expense Coverage
d) Medicare Supplement

9. The type of health provision that provides the greatest degree of continuation protection to an insured without any change in benefits to the insured is:

a) Noncancelable
b) Guaranteed renewable
c) Conditionally renewable
d) Optionally renewable

10. For consideration of Long Term Care coverage, which of the following would **NOT** be considered an activity of daily living (ADL):

a) Driving an automobile
b) Bathing oneself
c) Walking
d) Feeding oneself

CASUALTY ADJUSTING – QUIZ 32

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